8

Private health

… one of the things that is often overlooked is just how significant the private health insurance sector is in terms of total funding. If you look at how much health funds pay collectively around the nation, they actually pay as much for hospital services as any state government. Last year health funds paid more as an industry than the government of New South Wales, which was the biggest payer of hospital services.[1]

Private health sector

8.1 The private health sector makes an important contribution to the Australian health system, complementing services provided in the public sector and providing choice for patients. It is closely integrated with the public sector in many ways, and changes in policy in the public or private sector can have significant flow-on effects to other parts of the health system.

8.2 Private sector participation in the Australian health system encompasses a wide range of services delivered by health professionals (for example, doctors, dentists and physiotherapists) under fee for service arrangements. In this chapter, the committee has concentrated on that part of the private sector covering private health

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1 Australian Health Insurance Association, private briefing 15 June 2005.

insurance and those providers mainly delivering services in a private hospital setting.

8.3 This chapter specifically addresses the terms of reference that require the committee to give particular consideration to how to best ensure that a strong private sector can be sustained into the future and identify innovative ways to make private health insurance a still more attractive option.

8.4 During the course of the inquiry, the Commonwealth has announced a number of significant reforms affecting private health insurance and the role of private hospitals. These changes are broadly supported by the committee and will play a role in strengthening the private sector.

Private hospitals

8.5 Private hospitals in Australia treat almost four in every ten hospital patients (39 per cent of all separations), with around 2.7 million separations in 2003-04.[2] The number of patients treated in private hospitals has increased by over 30 per cent in the past 10 years, with most of the increase from same-day patients in acute and psychiatric hospitals (table 8.1).

Table 8.1 Private hospital separations, 1994-95 to 2004-05 ('000)

	1994-95	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05
Free standing day hospital facilities	189.9	349.0	393.8	433.3	471.7	505.6	537.5
Private acute and psychiatric - same day	465.0	857.0	956.0	1,092.0	1,104.0	1,126.0	1,209.0
Private acute and psychiatric - overnight stay	4,957.0	5,375.0	5,569.0	5,703.0	5,644.0	5,697.0	5,590.0
Total	**5,611.9**	**6,581**	**6,918.8**	**7,228.3**	**7,219.7**	**7,328.6**	**7,336.5**

Source *Australian Bureau of Statistics, Private Hospitals, Australia (2006), Cat No 4390.0, July.*

8.6 In 2004-05, there were 532 private hospitals operating in Australia, including 259 acute hospitals, 26 psychiatric hospitals and 247 free standing day hospitals.[3] Almost two-thirds of private acute and

2 Australian Institute of Health and Welfare, *Australian Hospital Statistics 2004-05* (2006), p 17.

3 Australian Bureau of Statistics, *Private Hospitals, Australia* (2006), pp 21, 35.

psychiatric hospitals and 74 per cent of available beds were in capital cities.[4]

8.7 Not all private acute and psychiatric hospitals are operated on a for-profit basis — 30 per cent are operated by religious or charitable organisations and 14 per cent comprise bush nursing, community and memorial hospitals.[5]

8.8 Ownership structure can significantly affect the operation of private hospitals. Not-for-profit operators generally have a lower obligation to provide information about their operations and are exempt from income tax. Not-for-profit operators may also be exempt from some local government rates and be able to access fringe tax benefit exemptions for salary packaging purposes.[6]

8.9 The Australian Private Hospitals Association provided the committee with a broad outline of the hospital services provided by private hospitals compared to the public sector:

- 56 per cent of all surgery
- 77 per cent of knee procedures
- 71 per cent of Major wrist/hand/thumb procedures
- 68 per cent of same day mental health treatment
- 55 per cent of hip replacements
- 52 per cent of chemotherapy
- 46 per cent of all cardiac valve procedures
- 42 per cent of all coronary bypass operations.[7]

8.10 In 2004-05, private hospitals received income of $6.6 billion, 95 per cent of which was derived from patients (or their health funds).[8] The profitability of private acute and psychiatric hospitals sector has generally been low in recent years, with operating margins averaging around 6 per cent. This does not represent a significant return on the capital invested in these facilities considering that relatively risk free assets such as 10-year government bonds have returned an average of 5.6 per cent since June 2001.[9] Higher operating

4 Australian Bureau of Statistics, *Private Hospitals, Australia* (2006), p 21.

5 Australian Bureau of Statistics, *Private Hospitals, Australia* (2006), p 22.

6 Australian Health Service Alliance, sub 5, p 2; Australian Health Insurance Association, sub 16, pp 32–33; Moore D, City of West Torrens (SA), transcript, 2 May 2006, pp 40–41.

7 Australian Private Hospitals Association, sub 24, p 2.

8 Australian Bureau of Statistics, *Private Hospitals, Australia* (2006), p 9.

9 Reserve Bank of Australia, Bulletin statistical stables: Financial Markets(F Tables), Capital Market Yields – Government Bonds - Monthly - F2, viewed on 8 November 2006 at www.rba.gov.au/Statistics/Bulletin/F02hist.xls.

margins have been achieved in free standing day hospital facilities, which have averaged around 17 per cent since 1999-00.[10]

8.11 The trend in capital expenditure by private hospitals has not directly reflected the increase in activity in recent years, with annual investment averaging around $350 million for acute and psychiatric hospitals and $23 million for free standing day hospital facilities.[11]

8.12 In 2004-05, private hospitals employed over 48,500 full time equivalent staff, with almost 95 per cent employed in acute and psychiatric hospitals and the remainder in free standing day hospitals.[12]

8.13 A report commissioned by the Australian Private Hospitals Association on education and training activities by private hospitals found that the sector as a whole would spend at least $36 million each year on providing education and training, with only $1 million of this funding effort recovered by way of fees.[13] The majority of programs offered (65 per cent) were for nursing students and staff. Medical programs and allied health programs accounted for 18 per cent and 17 per cent of programs respectively.[14]

Private health insurance

8.14 Private health insurance was introduced in 1953 for hospital and medical benefits. The nature of private health insurance has altered several times, mainly reflecting the introduction of universal health insurance coverage via Medibank in 1975 and subsequent adjustments to private health insurance policies.[15]

8.15 As at June 2006, more than 8.8 million Australians were covered by private health insurance for hospital treatment.[16] Private health

10 Australian Bureau of Statistics, *Private Hospitals, Australia* (2006), p 7.

11 Australian Bureau of Statistics, *Private Hospitals, Australia* (2006), pp 20, 34.

12 Australian Bureau of Statistics, *Private Hospitals, Australia* (2006), pp 20, 34.

13 Allen Consulting Group, *Education and training of health and medical professionals in private hospitals and day surgeries* (2005), Report to the Australian Private Hospitals Association.

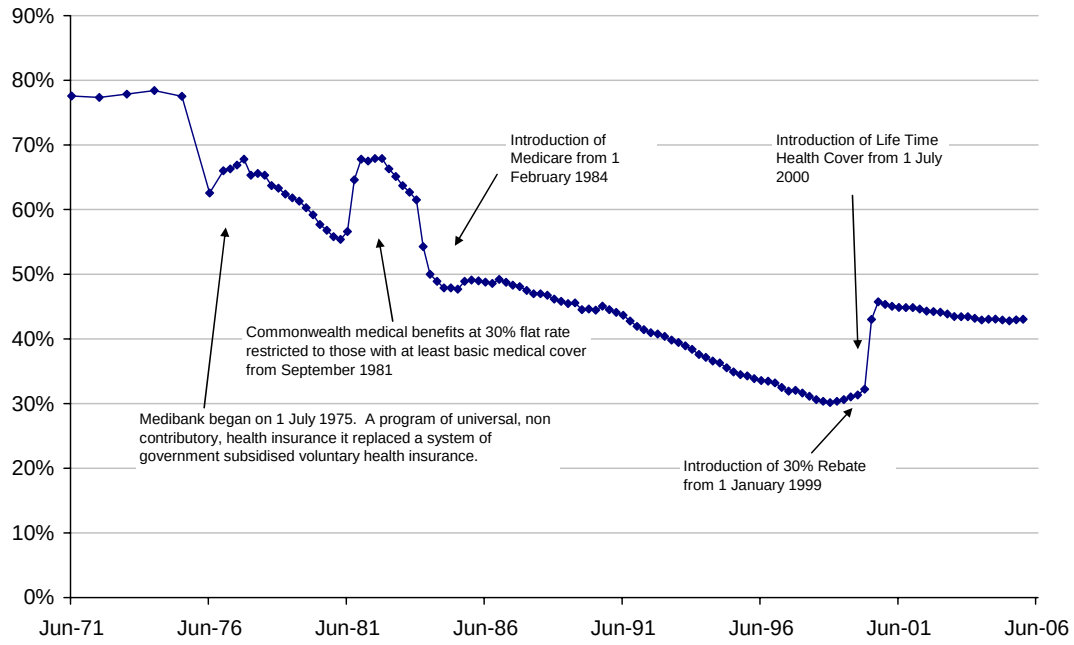
14 Allen Consulting Group, *Education and training of health and medical professionals in private hospitals and day surgeries* (2005), Report to the Australian Private Hospitals Association.

15 Department of the Parliamentary Library, *Australian Health Insurance Arrangements 1969 to 5 March 1983*, Basic Paper No. 14; Duckett S, *The Australian Health Care System* (2004), pp 295–296.

16 Private Health Insurance Administration Council, Industry Statistics, Statistical Trends Membership and Benefits Statistics, viewed on 3 October 2006 at www.phiac.gov.au/statistics/trends/index.htm.

insurance coverage has increased significantly in recent years in response to a range of initiatives to boost membership, including the introduction of Life Time Health Cover on 1 July 2000 — which encourages people to take out private health insurance earlier in life to avoid paying an extra 2 per cent for each year they remain uninsured after their 31st birthday (figure 8.1).

Figure 8.1 Proportion of population covered by private hospital insurance, 1971–2006



Source *Private Health Insurance Administration Council, Industry Statistics, Statistical Trends Membership and Benefits Statistics, viewed on 3 October 2006 at www.phiac.gov.au/statistics/trends/index.htm.*

8.16 The Commonwealth government has made a significant contribution to private health insurance since January 1999 through a 30 per cent rebate on the cost of premiums (increased in 2005 to 35 per cent for people aged 65 to 69 and 40 per cent for people aged 70 and over). In 2004-05, the cost of the rebate was around $2.5 billion, or around $1,000 a year to a privately insured average family.[17]

8.17 Another Commonwealth government policy to encourage people to take out private health insurance is the Medicare surcharge, which was introduced in July 1997. The surcharge applies to singles earning more than $50,000 per annum and couples and most families earning more than $100,000 per annum who do not choose to have private

17 Australian Institute of Health and Welfare, *Australia's Health 2006* (2006), p 310; Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Private health cover increases again*, 15 August 2006.

hospital insurance. The surcharge is an additional 1 per cent of taxable income above the normal 1.5 per cent Medicare levy.

8.18 The proportion of different segments of the population covered by private health insurance is uneven, with differences according to age, place of residence and income levels.[18] In regional areas, there are fewer incentives to take out private health insurance due to the lack of private providers, including private hospitals and other allied health professionals.[19] MBF Australia noted that private health insurance was purchased by people on a wide range of income levels:

> The latest [Australian Bureau of Statistics] survey confirmed that more than 1 million people on household incomes less than $18,200 per annum have private health insurance, 2.3 million on household incomes less than $33,000 are privately insured. Almost half of the insured population have gross household incomes less than $51,000. So nearly 4 million people with hospital cover earn less than average weekly earnings.[20]

8.19 Community rating has long been a central feature of private health insurance in Australia. Unlike other insurance products, health insurance is not related to individual risk. The principle of community rating is that persons should not be discriminated against in obtaining or retaining hospital coverage. In setting premiums or paying benefits, funds cannot discriminate in relation to a member on the basis of health status, age, race, sex, sexual orientation, and use of hospital, medical or ancillary services or general claiming history.[21]

8.20 Private health insurance may cover all hospital accommodation and care expenses or the patient may have to pay a gap (or an out-of-pocket cost). The amount the patient will have to pay will depend upon the type of cover they have purchased and whether the doctor and/or hospital and health fund have a gap agreement or gap cover scheme in place.

8.21 Hospital cover can only cover the costs of services provided when patients are admitted to hospital. Where medical services are

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18 Australian Bureau of Statistics, *National Health Survey: Summary of results* (2006), Cat No 4364.0, p 67.

19 Catholic Health Australia, sub 25, p 33; McCafie G, Australian Council of Social Services, transcript, 21 September 2005, p 66; Combined Pensioners and Superannuants Association of NSW, sub 9, p 10; MBF Australia Limited, sub 29, p 11.

20 MBF Australia Limited, sub 29, p 11.

21 Department of Health and Ageing, sub 43, p 25.

provided on a non-admitted basis such as outpatient services, patients are responsible for paying the gap between whatever the doctor charges and the Medicare benefits schedule rate.

8.22 There are around forty registered health insurance funds operating in Australia, of which 14 have restricted membership — only allowing membership to people who belong to a particular organisation or community. Only four funds operate on a for-profit basis, with the remaining funds using any surpluses generated for the benefit of contributors (box 8.1).[22]

Box 8.1 Private health insurance funds

Open funds – not-for-profit	**Restricted funds – not-for-profit**
Australian Health Management Group	ACA Health Benefits Fund
Cessnock District Health Benefits Fund	CBHS Friendly Society
Credicare Health Fund Limited	Defence Health
GMHBA	Health Care Insurance
HBF Health Funds	Lysaght Peoplecare
Health Insurance Fund of W.A.	Navy Health
Central West Health	Phoenix Health Fund
Health-Partners Inc	Qld Teachers' Union Health Fund
Hospitals Contribution Fund of Australia	Railway & Transport Health Fund
Latrobe Health Services	Reserve Bank Health Society
Manchester Unity Australia	SA Police Employees' Health Fund
MBF Australia Limited	Teachers Federation Health
Medibank Private	The Doctors' Health Fund
Mildura District Hospital Fund	Transport Health
N.I.B. Health Funds	
Queensland Country Health	**Open funds - For-profit**
St Luke's Medical & Hospital Benefits Association	Australian Unity Health
United Ancient Order of Druids Friendly Society	BUPA Australia Health
Westfund	Grand United Corporate Health
CY Health	MBF Alliances
GMF Health	

Source: Private Health Insurance Administration Council, Registered Health Benefits Organisations Operating in Australia, viewed on 15 November 2006 at www.phiac.gov.au/healthfunds/list.htm.

22 Department of Health and Ageing, sub 43, p 22.

8.23 Consumer choice of health funds is limited due to the high concentration of membership (six funds holding approximately 76 per cent of the market), the number of closed membership funds and the strong regional focus of some funds. The Department of Health and Ageing noted that only one fund operates on a national basis.[23]

8.24 The Department of Health and Ageing manages a number of regulatory issues including the assessment of the annual premium increases requested by health funds. The premium round process requires health funds to justify their premium increases to the government. This is now done at around the same time each year and announced in March. Each health fund makes a submission to the Minister for Health regarding their proposed premium increases.[24]

8.25 The Private Health Insurance Administration Council closely scrutinises these submissions and the Department of Health and Ageing provides advice to the Minister on the submissions. The *National Health Act 1953* (the Act) only allows the Minister for Health to disallow an increase for the following reasons:

- might result in a breach of the Act or conditions of registration;
- imposes an unreasonable or inequitable condition affecting the rights of contributors;
- adversely affects the financial stability of the fund; or
- is contrary to the public interest.[25]

8.26 The committee noted that an application for a rise in premiums has been disallowed on only one occasion.[26]

8.27 Health funds purchase health services from a range of providers. The majority of benefits are directed to private hospitals, which have experienced a declining share of total fund benefits over time (figure 8.2).

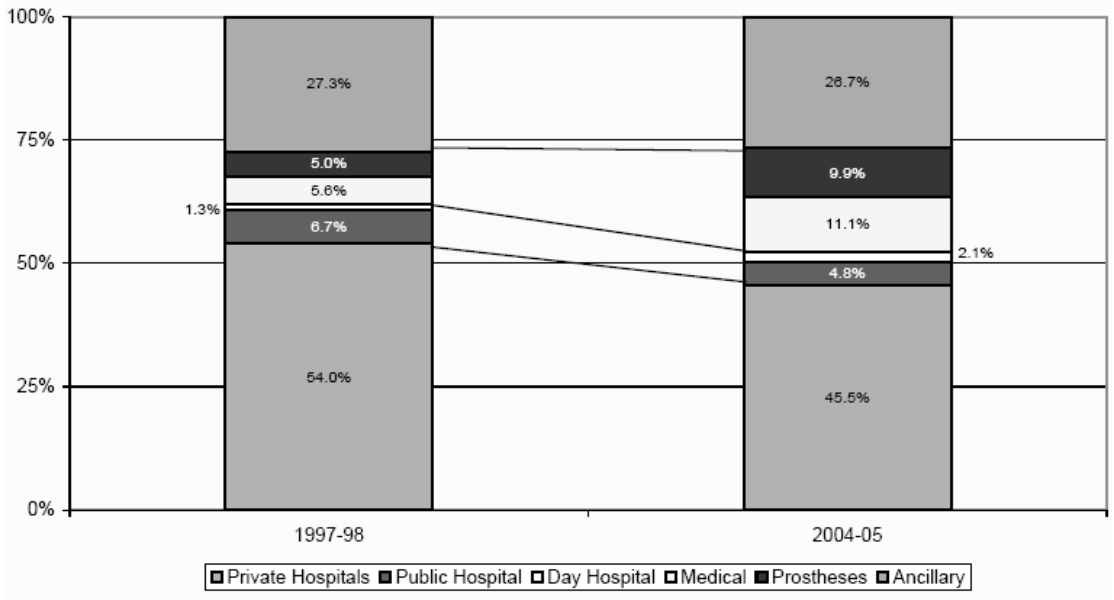
23 Department of Health and Ageing, sub 43, p 23.

24 Department of Health and Ageing, sub 43, p 26.

25 Department of Health and Ageing, sub 43, p 26.

26 Hon Michael Wooldridge, Minister for Health, media release, *Minister moves to guard consumers against health insurance premium rises*, 28 March 2001.

Figure 8.2 Private health fund payments, 1997-98 to 2004-05



Source *Private Health Insurance - policy issues, Presentation to PHIAC Directors Education Program Linda Addison, Assistant Secretary Private Health Insurance 21 February 2006, viewed on 12 October 2006 at www.phiac.gov.au/publications/presentations/melbfeb06/addison.pdf.*

8.28 Despite the significant increase in private health insurance membership since July 2000 the overall profitability of the industry has remained relatively unchanged, with the value of benefits paid to members increasing largely in line with total income (table 8.2).

Table 8.2 Private health insurance fund finances, 1999-00 to 2004-05

	1999-00	*2000-01*	*2001-02*	*2002-03*	*2003-04*	*2004-05*
Contribution income ($m)	5,462	7,132	7,265	7,885	8,637	9,384
Investment and other income ($m)	214	226	66	194	296	373
Total income ($m)	5,676	7,358	7,331	8,079	8,933	9,757
Benefits ($m)	4,578	5,663	6,558	7,055	7,630	8,238
Management expenses/other ($m)	717	843	805	829	852	893
Expenditure ($m)	5,295	6,506	7,363	7,884	8,482	8,928
Surplus/deficit ($m)	381	852	-32	196	447	626
Surplus/deficit as % of contribution income	7.0%	11.9%	-0.4%	2.5%	5.2%	6.8%
Contribution income growth (%)	10.9%	30.6%	1.9%	8.5%	9.5%	8.7%
Benefits growth (%)	6.2%	23.7%	15.8%	7.6%	8.2%	8.0%
Proportion of contribution income returned as benefits (%)	84%	79%	90%	89%	89%	88%

Source *Department of Health and Ageing, submission 43, p 23; updated for 2004-05 from Private Health Insurance Administration Council, Operations Of The Registered Health Benefits Organisations Annual Report 2004-05 (2005).*

Making private health insurance more attractive

8.29 A range of policies have successfully increased the number of people covered by private hospital insurance by 3.2 million since December 1998, with the proportion of the population covered rising from 30.2 per cent to 43 per cent.[27]

8.30 Since the inquiry commenced the Commonwealth has implemented a number of policy changes and announced several budget initiatives to make private health insurance more attractive. Since March 2005, the number of people covered by private hospital insurance increased by 140 000 people, with the proportion of the population covered by private hospital insurance rising from 42.9 per cent to 43 per cent.[28]

8.31 Notwithstanding the success these policies to make private health insurance attractive to the community— it is clear that there are several challenges to attracting new people to take out private health

27 Private Health Insurance Administration Council, Industry Statistics, Statistical Trends Membership and Benefits Statistics, viewed on 12 October at www.phiac.gov.au/statistics/trends/index.htm.

28 Private Health Insurance Administration Council, Industry Statistics, Statistical Trends Membership and Benefits Statistics, viewed on 12 October at www.phiac.gov.au/statistics/trends/index.htm.

cover and retain existing health insurance fund members. These include concerns by health fund members about out-of-pocket costs and rising premiums.

8.32 While there is not universal support for the continuation of the private health insurance rebate in its current form,[29] many inquiry participants noted its effectiveness in making private health insurance more affordable and its contribution to maintaining the coverage of private health insurance among the population.[30] A health fund member's response to the Australian Health Insurance Association noted that:

> My wife ….. and I are self-funded retirees who have relied heavily on private health insurance (name of fund) for oncology services during [my wife's] treatment for non-Hodgkin's lymphoma during the past five years. We have received the 30 per cent rebate from its introduction, enabling us to continue to remain with the private health system since joining (fund) on 14 August 1959. That we received a rebate of $995 on the premium of $3318 paid last financial year guaranteed that we could continue with private health insurance.[31]

8.33 The committee considers that the private health insurance rebate remains essential in making private health insurance more affordable and supports its retention to make private health insurance more affordable.

Recent policy changes

8.34 There have been a number of major policy changes and initiatives relating to private health insurance since the inquiry commenced (box 8.2).

29 Combined Pensioners and Superannuants Association of NSW, sub 9, p 7; Australian Council of Social Service, sub 25, p 5; City of Darebin (Vic), sub 34, p 4; Marion O'Shea, sub 89, p 2.

30 Catholic Health Australia, sub 35, p 3; Australian Private Hospitals Association, sub 24; pp 3-4; Australian Health Insurance Association, sub 16, pp 40–42.

31 Australian Health Insurance Association, sub 16, p 41.

Box 8.2 Private health insurance related reforms and initiatives, 2005–2006

Rebate increase – From April 2005, the private health insurance rebate increased to 40 per cent for people aged 70 years or older and to 35 per cent for people aged from 65 to 69 years.[32]

Strengthening the powers of the Private Health Insurance Industry Ombudsman – From July 2006, the powers of the Ombudsman were extended to cover the investigation and resolution of consumer complaints about the services they receive from their private health insurance.[33]

Strengthening the portability of health insurance – From December 2005, people transferring between health insurance funds were no longer required to re-serve their waiting periods.[34]

Supporting better consumer information about private health insurance – Health funds will be required to publish standard information that will include premiums, waiting periods, exclusions, hospital and medical gaps, and excesses. A website will be developed and managed by the Ombudsman to allow consumers to make product comparisons.[35]

Improvements to products: Broadening coverage to out of hospital services – From April 2007, health funds will be able to offer products that cover a broader range of health care services that do not require admission to hospital but which are part of an episode of hospital care or substitute for or prevent hospitalisation.[36]

Rewarding loyalty for long term private health insurance members – From July 2010, people who have a Lifetime Health Cover loading and who have held private health insurance with a loading for ten years continuously, will have their loading removed.[37]

Consolidation of regulatory framework – The current legislative framework will be consolidated as far as possible into a single Private Health Insurance Act. The focus will be on regulating private health insurance products, rather than the activities of health funds as is now the case. It is expected that the new Act will commence in November 2007.[38]

Improved risk equalisation arrangements – From 1 April 2007, new risk equalisation arrangements will operate to improve the level of risk sharing between funds; to protect small funds from catastrophic claims; and to remove an existing financial penalty on single parents.

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32 Hon Tony Abbott MP, Minister for Health, media release, *Private Health Insurance Rebate increases today for older Australians*, 1 April 2005.

33 Hon Tony Abbott MP, Minister for Health, media release, *New powers for the Private Health Insurance Ombudsman*, 9 November 2005.

34 Hon Tony Abbott MP, Minister for Health, media release, *Private health insurance: more portable*, 1 December 2005.

35 Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Greater choice in private health*, 9 May 2006.

36 Department of Health and Ageing, sub 143, p 5.

37 Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Greater choice in private health*, 9 May 2006.

38 Department of Health and Ageing, sub 143, p 6.

The new arrangements will be sufficiently flexible to incorporate the introduction of cover for broader health care services.[39]

Assessing applications for premium increases — Under the proposed consolidated private health insurance legislation, applications for premium increases must be approved unless the Minister is satisfied that the proposed change would be contrary to the public interest. The Government will issue guidance on the factors to be taken into account by the Minister in exercising this power.[40]

Uniform quality standards for privately insured services — From July 2008, uniform safety and quality standards will apply to privately insured services to ensure services are provided by suitably qualified providers and in accredited facilities. The standards will be developed with the private health industry and the Australian Commission on Safety and Quality in Health Care.[41]

8.35 Inquiry participants nominated several of these areas as requiring reform, including broadening the coverage of private health insurance to out of hospital services, strengthening portability and providing better information to consumers about health insurance products.[42]

8.36 The committee supports these changes, which should have the effect of making private health insurance more attractive. While the Department of Health and Ageing has undertaken some modelling to determine the likely effects of a number of these changes on the proportion of the population, the purpose of the proposed changes is to provide value to consumers, improve competition in the industry, and ensure the sustainability of the sector.

Addressing private health insurance cost drivers

8.37 Despite strong government support for private health insurance, the attractiveness of private health insurance products is likely to be significantly affected by the quantum of future price increases. In recent years, private health insurance premiums have risen at a faster

39 Department of Health and Ageing, sub 143, p 6.

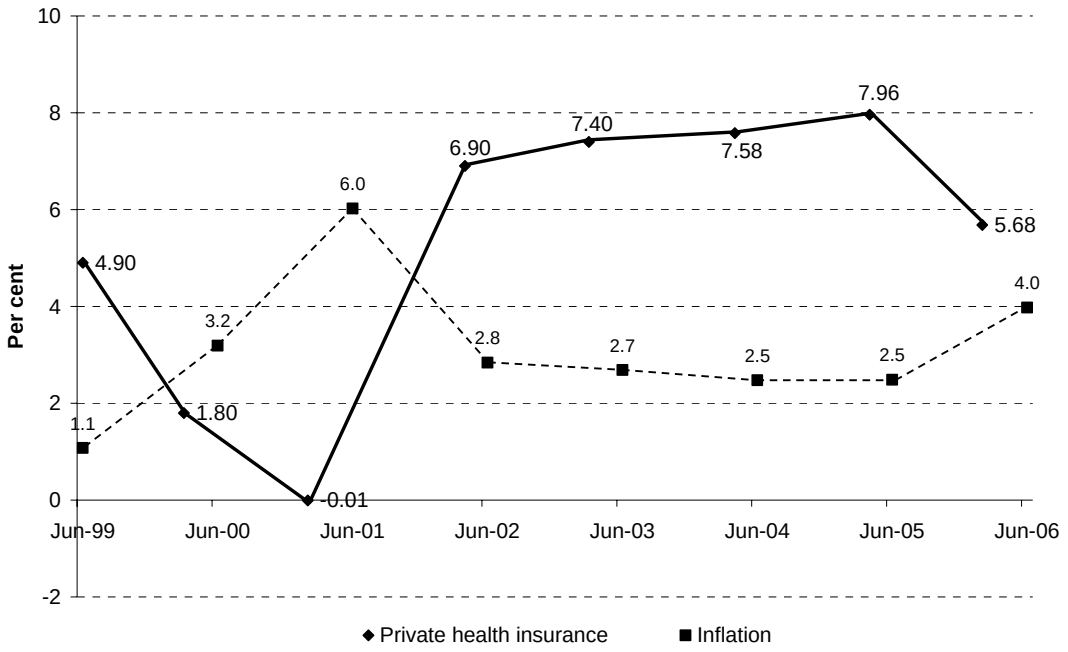
40 Department of Health and Ageing, *Private Health Insurance Bill 2006: Guide to the exposure draft* (2006), p 6.

41 Department of Health and Ageing, sub 143, p 7.

42 Australian Health Insurance Association, sub 16, pp 2–3; Health Insurance Restricted Membership Association of Australia, sub 6, p 3; Fitzgibbon M, NIB Health Funds, transcript, 20 July 2006, p 70; Health Group Strategies, sub 116, p 49; Australian Private Hospitals Association, sub 24, p 12; Strategic Planning Group for Private Psychiatric Services, sub 20, p 28; Hopkins H, Consumers' Health Forum of Australia, transcript, 21 September 2005, p 18.

rate than inflation, which has averaged 3.1 per cent per year since June 1999 (figure 8.3).[43]

Figure 8.3 Average private health insurance premium increases, June 1999 to June 2006



Source *Minister for Health media releases, 1 June 1999, 16 February 2000, 8 March 2001, 26 February 2002, 14 March 2003, 27 February 2004, 2 March 2005 and 24 February 2006.*

8.38 Premium increases, however, are not entirely related to the rising cost of services. They also reflect changes in the average number and mix of services per member.

8.39 The Australian Health Insurance Association told the committee that:

> … all of the studies that have been done indicate that, when premiums are somewhere between three per cent and 3.5 per cent of average weekly earnings, people seem to be prepared to pay that. In fact, our membership numbers are growing. They have grown consistently in the last nine or so months. But if one looks at surveys, there is clearly a red alert from members about the costs of private health insurance.[44]

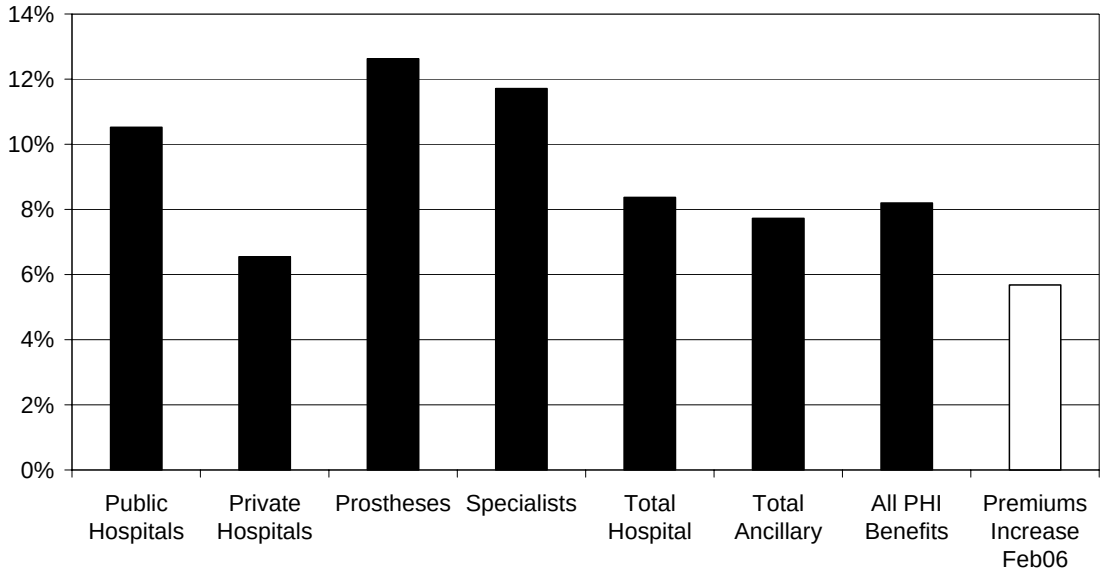
8.40 Effective strategies to address the drivers of rising private health insurance premiums are necessary to ensure that the private sector remains strong.

43 Australian Bureau of Statistics, *Consumer Price Index, Australia* (2006), Cat No 6401.0, July, p 9.

44 Armitage M, Australian Health Insurance Association, transcript, 4 September 2006, p 27.

8.41 The Australian Health Insurance Association noted that there were several categories that contributed most to premium increases in 2005, with the most significant being prostheses, specialists and payments to public hospitals (figure 8.4).

Figure 8.4 Annual change on private health insurance (PHI) fund benefits paid, Year ending March 2006 (per cent)



Source *Australian Health Insurance Association, sub 156, p 2.*

8.42 Strategies to address the major areas of expenditure growth suggested by health funds include:

- deregulation of health insurance products to expand opportunities to provide services that substitute for, or prevent, in-hospital treatment (see previous discussion on private health insurance industry reforms);[45]
- supporting appropriate billing systems to allow true simplified billing;[46]
- improving the quality and safety of care to provided to reduce avoidable infections and readmissions;[47]

45 Health Insurance Restricted Membership Association of Australia, sub 6, p 3; Australian Health Insurance Association, sub 16, p 26; Fitzgibbon M, NIB Health Funds, transcript, 20 July 2006, p 70; MBF Australia Limited, sub 29, pp 24–25; Australian Divisions of General Practice, sub 15, p 6.

46 MBF Australia Limited, sub 29, p 26.

47 Australian Health Insurance Association, sub 16, p 26.

- more rigorous clinical and economic prostheses list, as well as indications and restrictions on use;[48]
- strengthening informed financial consent and providing greater information to patients about doctors' gap fees;[49] and
- encouraging greater competitive tension between health funds and private hospitals by supporting broader provision of information on the part of private hospitals and changing the floor for contract negotiations by abolishing or changing the requirements for qualifying for 2nd tier status.[50]

8.43 As previously discussed, the committee supports the Commonwealth's reforms to broaden the coverage of private health insurance to offer products that cover a broader range of health care services.

8.44 While arrangements for broader coverage are still under consideration, the committee is concerned about the potential for quality of care to be compromised if care is provided outside of a hospital setting. It is important that the final arrangements are based on providing appropriate services that include equivalent safety and quality standards that are required for similar services in hospitals.

8.45 To address the rising costs of prostheses, the Australian Health Insurance Association suggested that there should be a more rigorous assessment process prior to widespread use,[51] noting that:

> If 25 per cent of these joint replacements are going wrong, we would like to see that changed quite specifically—particularly when that is not impossible from other examples that we see when we look around the world. The frequently quoted example is Sweden. They have had a joint replacement registry for over 25 years and their similar joint replacement requirement is seven per cent, not 25 per cent. Every time the percentage of revisions comes down by one per cent, the system saves $15 million plus. If we had the same joint revision rate as Sweden, I have seen it quoted that we would

48 MBF Australia Limited, sub 29, p 26; Armitage M, Australian Health Insurance Association, transcript, 4 September 2006, p 24.

49 MBF Australia Limited, sub 29, p 26.

50 Australian Health Insurance Association, sub 16, p 3; MBF Australia Limited, sub 70, p 25.

51 Australian Health Insurance Association, sub 16, p 3.

> save in the vicinity of $75 million to $150 million. That is clearly a significant saving.[52]

8.46 The National Joint Replacement registry recently noted that a one percentage point reduction in the rate of revisions for joint replacements (equivalent to around 1,200 per year) would save in the order of $16–$32 million per year.[53] Some of the proposals to improve the outcomes of joint replacement surgery included:

- the development of clinical guidelines by the orthopaedic profession for joint replacement surgery; and
- a re-evaluation of the regulatory activities governing hip and knee replacement prostheses in Australia to be based on proven clinical advantage of new prostheses.[54]

8.47 The committee supports efforts to increase the understanding of the outcomes of using different types of prostheses through registers such as the Australian Orthopaedic Association National Joint Replacement Registry. While the Therapeutic Goods Administration assesses new prostheses for their safety, an assessment of the cost effectiveness of new medical devices is not undertaken.

8.48 The committee sees significant merit in extending to prostheses an outcomes-based assessment framework that leads to the timely use of cost-effective prostheses.

Recommendation 20

8.49 **The Australian Government introduce an outcomes-based assessment process that:**

- **examines the clinical benefits of new prostheses prior to their widespread use in Australia; and**
- **reviews the effectiveness of prostheses currently in use**.

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52 Armitage M, Australian Health Insurance Association, transcript, 4 September 2006, p 24.

53 Graves S and V Wells, 'A review of joint replacement surgery and its outcomes: appropriateness of prostheses and patient selection', prepared for the for The Australian Centre For Health Research Ltd, October 2006, p 7.

54 Graves S and V Wells, 'A review of joint replacement surgery and its outcomes: appropriateness of prostheses and patient selection', prepared for the for The Australian Centre For Health Research Ltd, October 2006, p 9.

Unexpected out of pocket expenses

8.50 People are concerned about their out-of-pocket costs for medical services, particularly when these are unexpected.[55] Unexpected costs can reduce the attractiveness of private health insurance.

8.51 There are three ways in which privately insured people can incur out-of-pocket (or 'gap') expenses when they go to hospital and it is possible for a patient to have out-of-pocket expenses arising in any or all of these ways:

- on doctors' fees for medical services;
- because they have a health insurance product which involves some risk-sharing; and/or
- on hospital accommodation charges, if their health fund does not have a contract with the private hospital to which they are admitted.[56]

8.52 In 2004-05 the average payment by patients where a gap was paid was $103.98.[57] In the March quarter 2006, around 82.6 per cent of in-hospital medical services were provided to patients with no out-of-pocket costs, with a further 5.3 per cent of services were provided with a known gap.[58] Both the size of the average gap paid and the proportion of services where gaps are not paid have increased in recent years (figure 8.5).

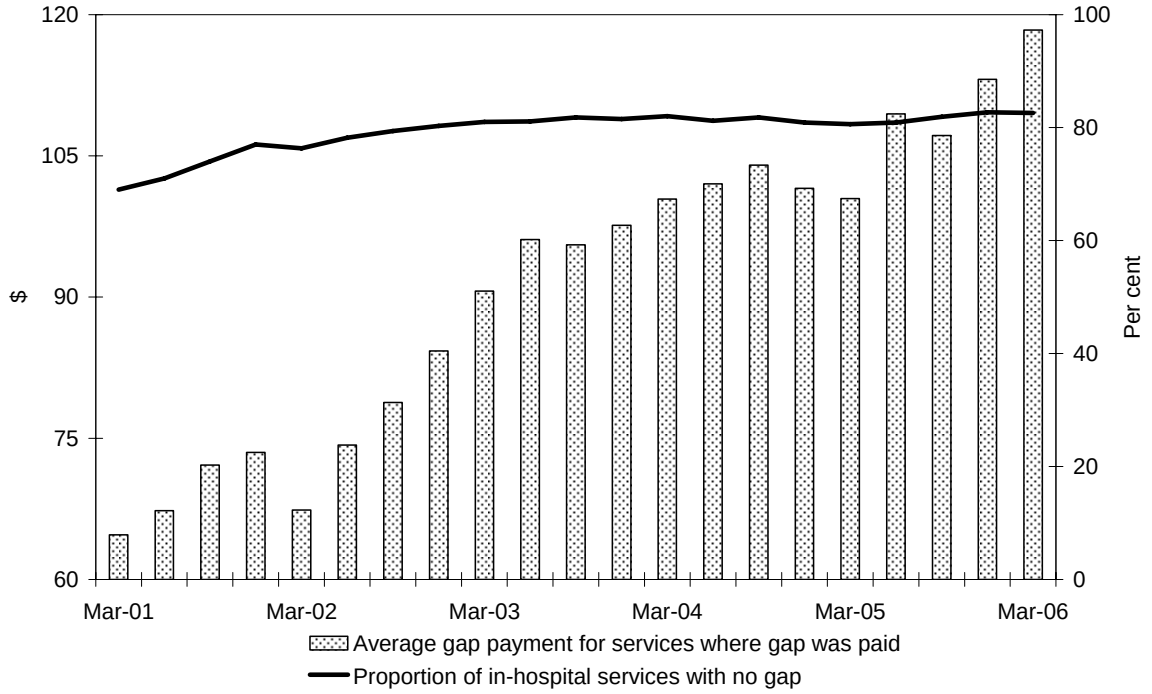
55 Brown D, sub 125, pp 2–4; Australian Health Insurance Association, sub 16, p 30; Health Insurance Restricted Membership Association of Australia, sub 6, p 4; Private Health Insurance Ombudsman, sub 75, pp 6–7; MBF Australia Limited, sub 70, p 4;

56 Department of Health and Ageing, sub 43, p 33.

57 Private Health Insurance Administration Council, *Operations of the Registered Health Benefits Organisations Annual Report 2004-05* (2005), p 50.

58 Private Health Insurance Administration Council, Industry Statistics, *Medical gap for insured in-hospital services – March quarter 2006*, viewed on 25 July 2006 at www.phiac.gov.au/statistics/medicalgapinfo/gapmar06/index.htm.

Figure 8.5 Medical gap for insured in-hospital services, March 2001 to March 2005



Source *Private Health Insurance Administration Council, Industry Statistics, Information on Gap Services and Payments, viewed on 26 July 2006 at www.phiac.gov.au/statistics/medicalgapinfo/index.htm.*

8.53 Some gap cover arrangements permit doctors to charge patients an out-of-pocket cost over and above what the health fund will cover. However, the level of cost to be borne by the patient will be controlled by the terms of the gap cover arrangements in place between the doctor and the health fund. Where doctors are not participating in gap cover arrangements at all, there is no control over what they can charge and therefore no limit on what the patient might have to pay out of their own pocket.

8.54 In some cases consumers can misinterpret as a 'gap' payment the out-of-pocket expenses they are required to bear through taking out an insurance policy that offers reduced benefits in return for a lower premium. For example, some products require a one-off 'excess' payment or a daily co-payment towards the cost of hospital treatment, or may exclude or restrict the level of benefits payable by the health fund for certain services.[59]

59 Department of Health and Ageing, sub 43, p 33.

8.55 The Consumers' Health Forum of Australia told the committee that:

> A person who has decided to hold onto their private health insurance often does not really test out how well it is going to work for them until they have to use it. It has been a big concern that, having held on, they then often get surprise gap payments that were rather more than they expected. These can result from not having the right health cover. Maybe they took it out a long time ago or maybe the health cover has changed and they do not know all of the exclusions that now exist.[60]

8.56 It is important that holders of private health insurance regularly review the level of benefits for which they are covered. As part of a 2006-07 budget initiative, health funds would be required to provide consumers with standard product information for each product they sell and the Private Health Insurance Ombudsman will be funded to create a new website to provide consumers with information that makes it easier to compare health funds and the products they sell.[61]

8.57 The 2006-07 Budget also included additional funding for information campaigns to raise public awareness of the benefits private health insurance, including an ongoing direct marketing campaign targeting consumers who, from 1 April 2007, face deadlines under Lifetime Health Cover.[62]

8.58 The committee considers that it is important that these campaigns include a component that adequately informs consumers about the need to evaluate the type of health cover that they have purchased on a regular basis.

8.59 The benefits to be paid by health funds towards hospital accommodation charges are agreed under contract between individual health funds and individual hospitals. Generally, a patient's hospital accommodation charges will be fully covered if they are treated in a hospital that has a contract with their health fund. However, if a patient is treated in a hospital that does not have a contract with their health fund, the patient may encounter a significant out-of-pocket cost.

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60 Hopkins H, Consumers' Health Forum of Australia, transcript, 21 September 2005, p 18.

61 Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Greater choice in private health*, 9 May 2006.

62 Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Greater choice in private health*, 9 May 2006.

Informed financial consent

8.60 Informed financial consent is the consent to treatment obtained by a doctor from a patient, prior to treatment whenever possible, after the doctor has sufficiently explained his or her fees to the patient to enable the patient to make a fully informed decision about treatment.

8.61 Health fund members considering hospital treatment need to discuss fees and benefits in detail with their doctors and health funds to determine whether there will be any out-of-pocket cost. Doctors using health fund gap cover arrangements are required to advise patients in advance of the likely cost of medical treatment and the patient is then able to agree whether to go ahead with treatment. However, there is no requirement for doctors who are not participating in gap cover to inform their patients of likely costs.

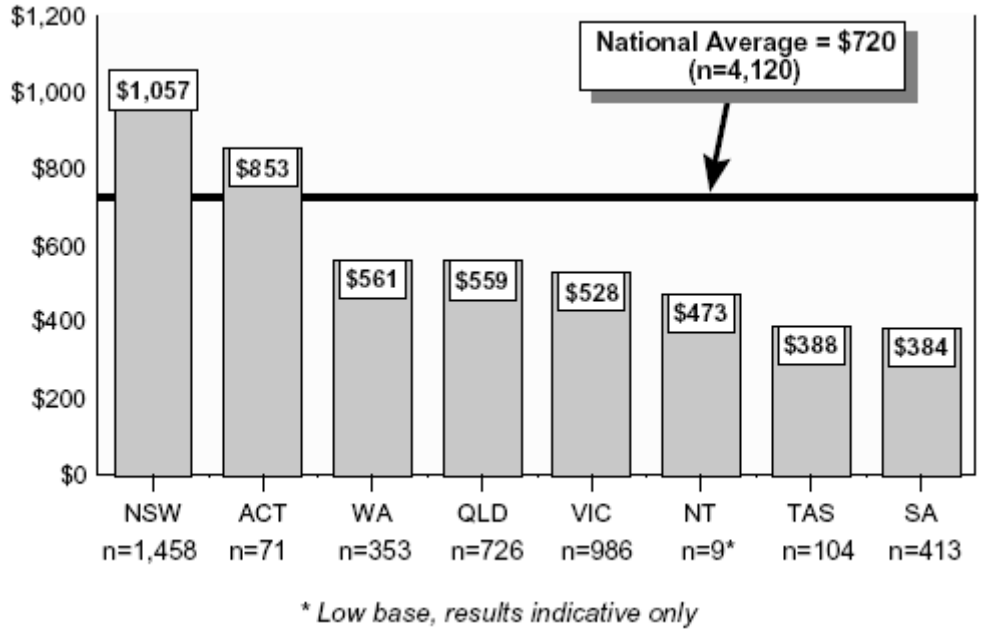
8.62 A recent survey of informed financial consent commissioned by the Department of Health and Ageing found that:

- 44% of in-hospital episodes involved a gap.
- 21% of in-hospital episodes involved a gap and a lack of [informed financial consent] IFC.
- In 2004 an estimated 800,000 service occasions involved a gap and a lack IFC (based on projections of all in-hospital patients).
- Lack of medical IFC (and presence of gap) is more evident amongst pre-planned admissions (21%) than emergency admissions (14%).
- Satisfaction with cost information available prior to admission is significantly higher among same-day patients (65%) versus overnight patients (58%).
- Lack of IFC is more associated with higher gaps.
- Among patients with a gap exceeding $1,000 (9% of all patients sampled), 55% reported lack of IFC from one or more medical professionals.
- When a gap occurs the average gap per episode is $720.[63]

8.63 The survey also noted that the average size of gap per episode varied significantly between states and territories (figure 8.6).

63 Department of Health and Ageing, *Summary of key findings – Informed financial consent/patient election consumer survey* (2004), TQA Research, exhibit 2, p 1.

Figure 8.6 Average dollar gap for those having a gap, by jurisdiction



Source *Department of Health and Ageing, Informed financial consent/patient election consumer survey (2004), TQA Research, exhibit 2, p 22.*

8.64 The committee is aware that the Australian Medical Association (AMA) is campaigning to assist doctors to provide information to patients about doctors' fees.[64]

8.65 One solution to ensure informed financial consent was proposed by the Australian Health Insurance Association:

> … have the principal specialist responsible for the organisation of the team and responsible for either arranging the gaps or advising the patient of what the gaps would be. One could take it even further, indeed. I am sure this would be unacceptable to the medical profession, but it could be done in the way that my builder uses. There is no reason why the specialist could not charge a bulk amount for all of the team and be responsible for paying them.
>
> I do not pay the carpenter, the bricklayer, the plumber or the electrician; I pay my builder and he sorts it out with all the other guys. I trust my builder to pick good tradesmen to do all the work and I go and talk to them myself. I have got a private-patient relationship with the carpenters at the moment, but I do not pay them. For some reason, we have not

64 Australian Medical Association, Informed Financial Consent: Let's Talk About Fees, viewed on 29 September 2006 at www.ama.com.au/web.nsf/doc/WOOD-6S9822.

> been able to put that into health care, and it seems to me rather illogical.[65]

8.66 The committee notes that the Australian Government has made it clear that if there is no significant improvement by May 2007, it will move to legislate to require doctors to obtain informed financial consent. To measure how effective voluntary action has been in improving the incidence of informed financial consent the Department of Health and Ageing will repeat the consumer survey in late 2006 and early 2007.[66]

8.67 Patients are dissatisfied when they experience out-of-pocket costs where doctors do not tell them about the potential costs that they face. Patients are entitled to know in advance the likely full cost of their treatment, including those assisting surgeons such as anaesthetists. The committee recognises that there may be instances where it is difficult to obtain informed consent, such as in emergency situations.

Recommendation 21

8.68 **The Australian Government amend private health insurance legislation to require that a single coordinating doctor be required to obtain informed financial consent from a patient in relation to all treating health professionals in all but the most exceptional circumstances (such as emergencies). The patient should consent in advance to the cost of the full range of services provided by all health professionals involved in the patient's care.**

Portability

8.69 The portability of health insurance benefits between health funds is an important element of consumer choice. Fund and provider self interest must never be allowed to influence a person's decision about his or her health cover choices.

8.70 Several inquiry participants noted that portability can be used to the disadvantage of individual health funds and for the benefit of practitioners in situations where medical practitioners provide advice to patients about which particular health fund to join.[67]

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65 Schneider R, transcript, 21 September 2005, p 61.

66 Department of Health and Ageing, sub 143, p 8.

67 Powlay J, Private Health Insurance Ombudsman, transcript, 21 September 2005, p 12;

8.71 While transfer to a recommended health fund may have a favourable outcome for the patient in terms of out-of-pocket costs for that doctor's fees for a particular episode of treatment, the committee notes that doctors wouldn't (and shouldn't need to) have a detailed understanding of other implications of changing to the fund (eg. for other doctor fees, hospital bills or allied health services).[68]

8.72 The Private Health Insurance Ombudsman told the committee that:

> I am strongly of the view that doctors should not be able to do this. The AMA ethics statement counsels doctors against advising their patients to purchase any type of product. There are many other implications for people of changing their health insurance, other than just what happens to that particular doctor's bill. Although doctors will argue that they are doing this for the benefit of their patients, when you unpick it all it is all about how much money they can charge. That is my view.[69]

8.73 The practice of medical practitioners recommending to patients to move between funds to access particular benefits does not appear to be widespread.[70] The Committee welcomes the Ombudsman's comment, nevertheless expresses its concern at the potential destabilising effect on the industry and the possible mixing of financial considerations with clinical decision making by medical practitioners (see below).

8.74 The committee noted the Private Health Insurance Ombudsman had prepared and gained agreement to protocols setting out what hospitals and funds should and shouldn't say to patients in contract dispute situations:

> Hospitals may also choose to communicate with current, former or potential patients. These communications may include:
>
> - Advice on which funds have [Hospital Purchaser Provider Agreements] (HPPAs) with the hospital

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Ginnane G, Private Health Insurance Administration Council, transcript, 21 September 2005, p 30; Australian Health Insurance Association, sub 16, p 23; Health Insurance Restricted Membership Association of Australia, sub 6, p 4.

68 Private Health Insurance Ombudsman, sub 83, p 3.

69 Powlay J, transcript, 21 September 2005, p 12.

70 Private Health Insurance Ombudsman, sub 83, p 4.

- Advice on which funds no longer have HPPAs with the hospital
- Advice on the potential for out of pocket expenses for treatment of members of a non-contracted fund
- Advice on how to avoid out of pocket expenses

The communications must not:

- Advocate that the member transfer to a particular health fund or class of funds (eg. those with which the hospital has a current contract/HPPA.[71]

8.75 The committee welcomes the development and implementation of such a protocol between hospitals and health insurance funds. However, in the case of advice from doctors, there appear to be two competing views on how a resolution can be achieved:

- legislating to discourage practitioners from giving such advice;[72] and
- gaining agreements with doctors through education and voluntary compliance.[73]

8.76 The Private Health Insurance Administration Council (PHIAC) told the committee that:

> I am aware that the National Health Act has quite a substantial fine—I think it is $50,000—where health funds encourage high-risk members to move to other health funds. That was actually put into the legislation some years ago to prevent risk shedding, if you like. That applies only to health funds. Certainly PHIAC believes it ought to apply to everybody that behaves in that manner—other providers, hospitals and doctors.[74]

8.77 The committee noted the Australian Medical Association's view that:

> … provided the doctor does not exercise any compulsion over the patient and provided the patient is the main beneficiary of the advice, there is nothing wrong with doctors providing advice and in fact the provision of such advice is demanded

71 Private Health Insurance Ombudsman, sub 83, p 4.

72 Ginnane G, Private Health Insurance Administration Council, transcript, 21 September 2005, p 30; Private Health Insurance Industry Administration Council, sub 85, p 2.

73 Private Health Insurance Ombudsman, sub 83, p 4.

74 Ginnane G, transcript, 21 September 2005, p 30.

by patients and is necessary for the efficient operation of the private market.[75]

8.78 The committee considers that it is important to establish more robust guidelines to discourage medical practitioners and private hospitals providing specific advice to patients about changing health funds. The development of such guidelines needs to be accompanied by appropriate resources for education and guidance material to assist doctors in handling requests from patients for their advice.

Recommendation 22

8.79 **The Australian Government, in conjunction with the Australian Medical Association, establish guidelines for private hospitals and health funds that discourage medical professionals and private hospitals providing specific advice to their patients about transfer private health insurance funds and/or products.**

8.80 The committee appreciates that medical practitioners are under increasing pressure to provide informed financial consent on the one hand and an ethical requirement to avoid advising their patients to purchase any type of product on the other. These pressures are not likely to diminish, with the marketing of new health credit products by financial institutions through medical practices.[76]

Improving the value of private health insurance

8.81 Individuals purchase private health insurance for a number of reasons. A key influence for many people is aversion to risk and the benefits of risk pooling.[77] This is supported by a recent Australian Bureau of Statistics survey, which noted that 'security, protection and peace of mind' was the most common group of reasons for having private health insurance (43 per cent of those insured).[78]

8.82 The Health Insurance Restricted Membership Association of Australia noted that:

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75 Australian Medical Association, sub 84, p 1.

76 Consumer Law Centre of the ACT & Care Inc Financial Counselling Service, sub 154, pp 2–6.

77 Industry Commission, *Private Health Insurance* (1997), p 169.

78 Australian Bureau of Statistics, *National Health Survey: Summary of results* (2006), Cat No 4364.0, p 13.

> It is unfortunate that private health insurance is viewed by many consumers differently to other insurance they purchase. Consumers have expectations that they will recoup their contributions to private health insurance in the short term as compared to their house insurance, or even motor vehicle insurance where they hope never to recoup their contribution.
>
> This factor alone makes the product unattractive to many in the community, particularly the young and healthy who are needed to keep the system viable.[79]

8.83 Some other factors that are important in decisions about whether to take out private health insurance are likely to include:

- allows for a choice of doctor and choice of hospital;
- quicker access to treatment; and
- financial considerations.[80]

8.84 The reasons that lead to an individual purchasing health insurance are likely to change over an individual's lifetime. A range of factors, such as a person's age, income, family responsibilities and changing government policies will affect decisions about which type of health insurance product to buy or whether to remain insured.

8.85 Perceptions about the value of private health insurance are at the forefront of decisions to take out private health insurance.[81] Assessing value needs to consider the range of incentives ('carrots') and disincentives ('sticks') put in place for people to take out private health insurance.

8.86 Inquiry participants suggested a range of measures that would increase the attractiveness of private health insurance using additional carrots, sticks, a combination of approaches or the provision of additional information including:

- discounting for low claiming members — awarding a 'loyalty bonus' via a discount in premiums if a member claims less than a

79 Health Insurance Restricted Membership Association of Australia, sub 6, p 4.

80 Australian Bureau of Statistics, *National Health Survey: Summary of results* (2006), Cat No 4364.0, p 68;

81 MBF Australia Limited, sub 29, p 32.

certain dollar value per annum or where claims have been reduced by say 10 per cent compared to the previous year;[82]

- Australian Tax Office to advise paymasters of the surcharge and provide them with details of appropriate pay-as-you-earn (PAYE) deduction amounts. The system should also require paymasters to alert employees of their potential exposure to the levy prior to deducting the necessary PAYE amount. This would allow prospective surcharge payers to determine whether they wished to take out insurance or pay the surcharge in a prospective manner;[83]
- remove the current disincentive arising from fringe benefits tax on employer subsidised health insurance;[84]
- increasing the private health insurance surcharge to 2 per cent (currently 1 per cent);[85]
- increasing the Lifetime Health Cover loading to 3 per cent (currently 2 per cent);[86] and
- enhancing the viability of rural and regional private hospitals through funding service planning and capital equipment purchases.[87]

8.87 While these suggestions may lead to small changes in the number of people with private health insurance, the committee considers that the broader changes recently announced are likely to be of greater benefit in attracting and retaining people to hold private health insurance.

8.88 Some of these suggestions should, however, be revisited if the broader changes do not have the expected impact in supporting the proportion of the population covered by private health insurance.

Medical savings accounts

8.89 Medical savings accounts (MSAs) (also referred to as Health Savings Accounts) are often raised in Australian and overseas health reform debates as an alternative private insurance and health savings

82 MBF Australia Limited, sub 29, p 32.

83 Australian Health Insurance Association, sub 16, p 38.

84 Australian Health Insurance Association, sub 16, p 4; MBF Australia Limited, sub 29, p 7; Health Insurance Restricted Membership Association of Australia; sub 6, p 6.

85 Catholic Health Australia, sub 35, p 34.

86 Catholic Health Australia, sub 35, p 34.

87 Catholic Health Australia, sub 35, p 33.

model.[88] They were first introduced in Singapore in 1984 as part of a major restructuring of that country's health system. While there are a variety of types of MSA, they can be generally defined as 'the voluntary or compulsory contribution of payments by individuals, households or firms into a personalised savings account that serves to spread the financial risk of poor health over time'.[89]

8.90 There are two main components to MSAs:

- a single or family savings account from which routine medical expenses are paid. Contributions are made by some combination of the individual, employers or government. Individual contributions are usually tax exempt. There may be restrictions on the type of medical services that can be purchased through these accounts. As with other types of insurance there may be deductibles or co-payments; and
- accompanying this savings account is a high-deductible insurance plan to cover catastrophic medical expenses. The premiums for this insurance may come from the savings account. There can be considerable variation in the application of catastrophic insurance. However, in most models coverage does not begin until a threshold of expenditures has been reached.

8.91 The precise balance between each of these components varies enormously from country to country. Other variations between MSA models include the mix between public or private funding, the question of whether there is a 'safety net' mechanism for disadvantaged persons (and how this is funded), the question of whether contributions to MSAs are voluntary or compulsory, and

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88 For Australian examples, see Delaat W, *PBS reform for a healthy Australia*, speech to the National Press Club, Canberra, 3 August 2005; Gross P, 'Radical reform of Medicare and private health insurance inevitable, says Gross', *Healthcover*, December 2002—January 2003; Gross P, 'Support for Medical Savings Accounts to augment private health insurance', *Healthcover*, June-July 2002; Schwartz S, *Saving Australia's health care system: nostrums or cures*, speech, Bert Kelly Lecture Series—No. 3, 25 November 1998. For international examples, see Gratzer D, 'It's time to consider Medical Savings Accounts', *Canadian Medical Association Journal* (2002), vol 167, no 2; Gollatz J et al., 'Combining mandatory health insurance and Medical Savings Accounts', *Health Insurance and Managed Care Interface* (2002); Ramsay C, 'Medical Savings Accounts: Universal, Accessible, Portable and Comprehensive Health Care for Canadians', *Fraser Institute—Critical Issues Bulletin* (1998); Massaro T. and Y. Wong, 'Positive experience with Medical Savings Accounts in Singapore', *Health Affairs* (1995).

89 Dixon A, 'Are Medical Savings Accounts a Viable Option for Health Care?', *Croatian Medical Journal* (2002), vol 43, no 4.

whether MSAs cover all or only a particular segment of the population.

8.92 There appear to be three main benefits for introducing MSAs:

- to encourage savings for the expected high costs of future medical care;
- to encourage consumers to avoid over-consumption of healthcare (known as the problem of 'moral hazard') by exposing them to the cost of health services; and
- to mobilise additional health system funding.[90]

8.93 Several inquiry participants advocated that greater consideration should be given to the use of MSAs in an Australian context.[91] While most referred to broadly exploring the use of MSAs, Health Group Strategies put forward a more detailed proposal on how MSAs could be incorporated or trialled in Australia (box 8.3).

8.94 Medical savings accounts are a feature of health funding arrangements in Singapore, the United States, China and South Africa. The committee noted that a New Zealand health insurer had recently introduced a MSA product as an alternative to private health insurance.[92] Some of the features of the MSA product introduced in New Zealand include:

- health management account (like a bank account), exclusively for health- and wellbeing-related transactions, with a member's card that works like an EFTPOS card and an optional overdraft facility;
- access to a growing network of health merchants that welcome *activa* members and accept *activa* cards as payment;
- special offers for members on health-related products and services;
- a 'Serious Health Event Benefit' that pays members a lump sum (dependant on age) if they experience a major health problem; and

90 Hanvoravongchai P, *Medical Savings Accounts: lessons learned from international experience*, Discussion Paper No. 52 (2002), World Health Organisation, p. 1.

91 Health Group Strategies, sub 116, p 35–38; Australian Doctors' Fund, sub 45, p 5; Medicines Australia, sub 42, p 22; MBF Australia Limited, sub 29, pp 30–31; Australian Medical Association, sub 30, pp 21–22; Leeder S, transcript, 5 July 2005, p 66; Fitzgibbon M, NIB Health Funds, transcript, 20 July 2006, p 69.

92 Gross P, 'Time to try the Kiwi way on health cover', *Australian Financial Review*, 29 September 2005, p 63.

- an optional cost effective health insurance plan, to provide members with a safety net for unexpected events.[93]

Box 8.3 Detailed proposals for Medical Savings Accounts in Australia

An approved Medical Savings Account (MSA) that can pay for:

- a mandatory high deductible, minimum coverage health insurance plan that allows new incentives (including no-claim bonuses) to reduce risk factors and trivial claims;
- at the insuree's informed choice, an optional catastrophic plan that covers high-cost care at a lower premium than today's insurance;
- the insuree's choice to meet co-payments imposed at the point of service from the MSA.
- the individual or household with a personal MSA would receive each year a risk-rated income—based subsidy from the government, applicable only to health insurance coverage;
- using much the same calculation proposed by advocates of the Health Reform Commission the subsidy would be the cashed-out value of all government subsidies for Medicare, PBS and private health insurance, indexed for inflation;
- low income groups would have the same subsidy, but there would be a need to consider safety nets;
- any MSA balance at the end of the year would be rolled over and would be tax-exempt. Any MSA balance at death would pass to the estate of the deceased;
- as in some US MSA's, healthy behaviour would entitle the insure to a higher interest rate on the MSA balance if they maintained weight loss or stopped smoking for 2 years in a row, or they would receive lower private health insurance premiums in year 3;
- individuals could opt for care at public or private hospitals, and all hospitals would be paid by today's casemix method but weighted higher for hospitals submitting data on their safety, efficiency and clinical quality;
- the market for transparent quality and safety, supported by health insurers and state governments advertising agreed performance data, would allow consumers to see what they are buying; and
- the MSA would pay 100 per cent for all preventive care, offer discounted weight reduction products and pay bonus interest rates on the MSA balances, all embedded in US and South African MSA models. This is an economic incentive that will appeal to the young, as the take-up rates of the new New Zealand accounts suggest.

Source: Health Group Strategies, sub 116, pp 35–36.

93 Activa, viewed on 29 September 2006 at www.activa.co.nz/.

8.95 The Parliamentary Library identified a number of important limitations for MSAs that would need to be considered prior to adoption in Australia:

- MSAs by themselves are not effective instruments for financing the health expenses of the chronically ill and poor (both of whom tend to deplete their accounts more quickly than they can add to them and therefore require some form of safety net). Given that, under the current Australian system, it is the cost of treating patients in these categories that consumes much of government expenditure, it could be argued that MSAs would not significantly reduce government expenditure on health;
- demand for health care is a function not only of consumer purchasing power but also of consumer expectations and health needs;
- the assumption that, under MSAs, 'consumer power' might also be decisive in reducing the cost of health services tends to underplay the important role of government involvement in keeping health costs under control; and
- some argue that MSAs may lead to 'perverse' decisions by consumers in relation to their healthcare—for example, healthy people with high balances may be encouraged to seek relatively trivial services, while the very sick, afraid of exhausting their MSAs, may be more likely to economise their use of services. On the other hand, there is some evidence from the US provider of MSAs, CIGNA Healthcare, indicating that consumers can reduce healthcare expenditure while also making greater use of preventative health measures. While the evidence from CIGNA [Healthcare] was mainly about the use of medication in control of chronic illnesses such as diabetes, Paul Gross has argued that with proper information and support, MSAs can also be used to provide incentives for consumers to adopt more healthy lifestyles.[94]

8.96 The recent deregulation of health insurance products offers significant scope for health insurers to develop a health insurance product that incorporate features of MSAs or a separate MSA outside the standard health insurance product framework.

8.97 The committee considers that there is merit in undertaking more research into how MSAs could be introduced into the Australian health financing system.

94 Parliamentary Library, *Medical Savings Accounts – a possible health reform option for Australia?*, Research note no 26 2005-06, 23 March 2006.

Recommendation 23

8.98 **The Department of Health and Ageing undertake further research to examine how medical savings accounts could be introduced within the Australian health financing system as a health savings and insurance vehicle.**

Sustaining a strong private health sector

8.99 A strong private sector relies on positive relationships between insurers and service providers. Important too are relationships with the public sector — a high degree of integration can make the best use of available resources and fair competition between private and public providers can drive improvements in technical efficiency.

Better integration of private and public sectors

8.100 Many participants noted the importance of better integrating the private and public sectors as a way of maximising the effectiveness of available resources and providing for better continuity of care for patients.[95]

8.101 The need for a close relationship between the public and private sectors is due to several factors including:

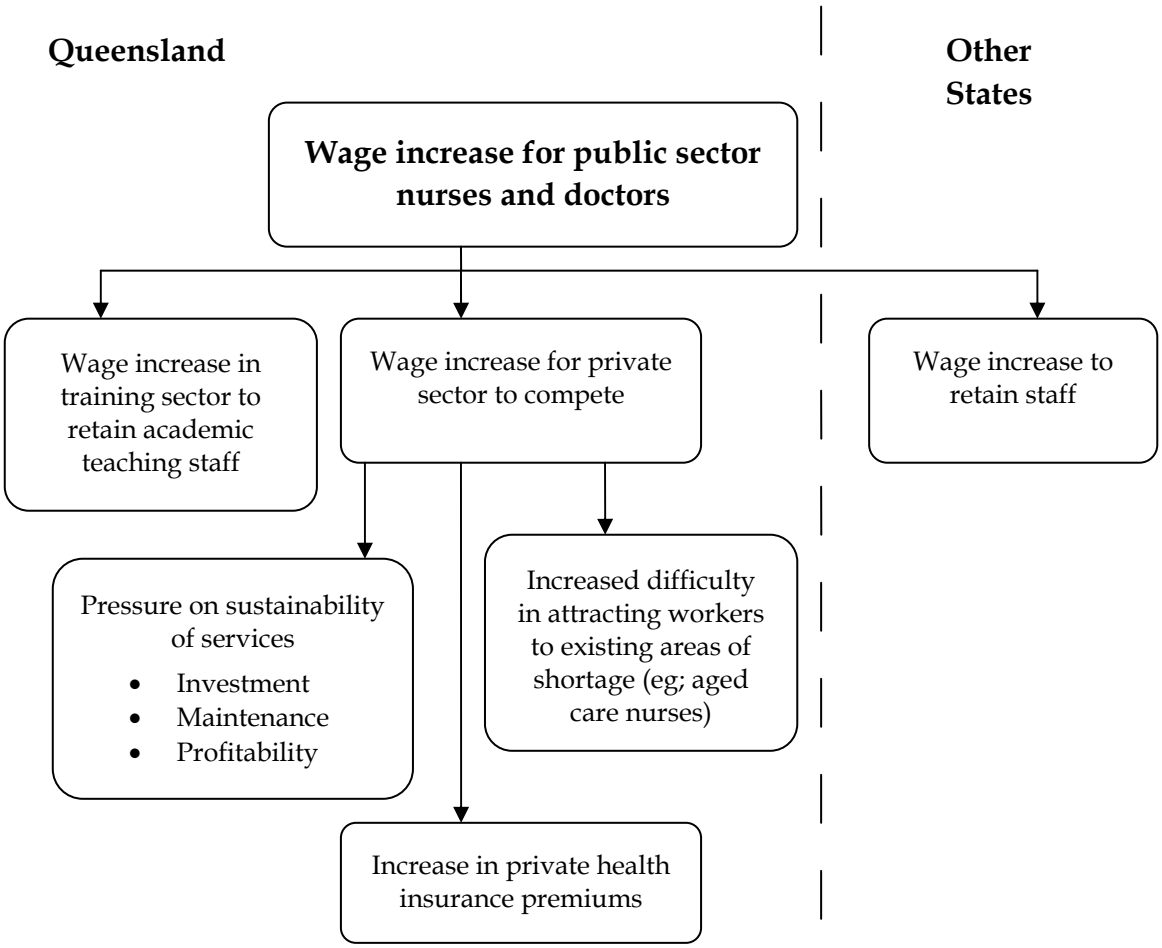
- the use of shared resources (staff and facilities) — including in some areas the co-location of public and private hospitals, with patients, staff and medical services moving freely between the public and private facilities;
- continuity of care for patients treated across sectors;
- the treatment of public patients in private facilities;
- planning the development of future facilities and workforce requirements;

95 Australian Healthcare Association, sub 62, p 12; Australian Association of Gerontology, sub 53, p 5; Strategic Planning Group for Private Psychiatric Services, sub 20, p 5; Local Government Association of NSW and Shires Association of NSW, sub 18, p 14; Health Care Reform Alliance, sub 127, p 75; Macquarie Health Corporation, sub 55, p 7; National Network of Private Psychiatric Sector Consumers and their Carers, sub 14, p 12; Bankstown City Council (NSW), sub 13, p 4.

- part public funding (through the Medicare Benefits Schedule) of privately provided services; and
- patient choice about provision of service in a public or private sector setting.

8.102 The impact of changes in the public sector on the private sector was recently highlighted in Queensland, following a decision of the Queensland Government to significantly increase pay rates for public sector nurses by 25.3 per cent over three years to March 2009.[96] The flow-on effects of this decision were experienced by universities, private health funds, private hospitals, aged care providers, holders of private health insurance and by other states (figure 8.7).

Figure 8.7 Integration of public and private sectors — impact of increases in pay rates to public sector nurses



Source *Australian Private Hospitals Association, transcript, 7 April 2006; Australian Medical Association (Queensland), transcript, 16 March 2006; Wronski I, James Cook University, transcript, 16 March 2006, Department of Health (SA), transcript, 2 May 2006.*

96 Hon Steven Robertson, Minister for Health (Queensland), media release, *Queensland Health Nurses offered almost $1B pay deal*, 2 March 2006.

8.103 The need for a process to recognise and support this integration was supported by several participants.[97] Catholic Health Australia noted that the Commonwealth, as a key stakeholder in the private health industry, can play a role in fostering greater industry dialogue:

> … the Commonwealth is best placed to convene such meetings, which could be known as the Australian Private Health Council. This Council could meet say twice per year and its deliberations could be used to inform industry participants, as well as Ministers and their Departments, on developments within the industry and any policy issues or proposals arising from those developments which may need to be addressed.[98]

8.104 The need for improved dialogue at a state level was also recognised by the Australian Private Hospitals Association:

> The lack of acknowledgment by state governments of the existence of the private sector creates major problems in developing any real relationships and synergies between the two. They have no interest in the private sector at all. Every now and then there is an inquiry which stimulates some interest, and because they have been told they have to do this they exhibit interest for a while.
>
> The most recent example was only a couple of years ago in New South Wales. That dies after a few months and you hear nothing more about it.[99]

8.105 The committee considers that the Commonwealth should support mechanisms to promote better communication between the public and private sectors as part of the national agenda (discussed in chapter 3). These arrangements should also provide for the participation of the states, who are also involved in a broad range of planning and regulatory issues.

Contracting arrangements

8.106 The relationship between health funds and private hospitals can involve a degree of commercial tension. There is always potential for

97 Catholic Health Australia, sub 30, p 20; Health Group Strategies, sub 116, p 47.

98 Catholic Health Australia, sub 30, p 20

99 Clark L, Australian Private Hospitals Association, transcript, 24 August 2005, p 12.

negotiations to break down as in any commercial relation, and sometimes they do.

8.107 Contracting between health funds and private hospitals determines, among other things, the amount a fund will pay for hospital accommodation and nursing care when a fund member is treated. Health funds are free to choose with which facilities they will seek a contract, having regard to the needs of their members. These decisions may take into account, for example, the types of services offered at a particular facility, the number of similar facilities within a locality and the residential profile of their membership.

8.108 Private hospitals and private day hospital facilities receive hospital benefits from health funds through either a hospital purchaser provider agreement that they have negotiated with the fund or, where a contract does not exist, the Australian Government determined default benefit. Health funds are required to cover all eligible members that receive hospital treatment even where the fund has no contract with the hospital, with payments at a 'default rate'.

8.109 There are two levels of default benefits:

- the basic default benefits — primarily paid for private patients in public hospitals. In setting the basic default benefits the Australian Government increases the benefits each financial year by March on March consumer price index (2 per cent for 2003-04). The average benefit for overnight shared ward accommodation for 2004-05 was $255; and
- the second tier default benefit — introduced because of concerns about health funds commencing selective tendering processes. The benefit is no less than 85 per cent of the average of rates referred to in the relevant fund's contracts, for comparable hospitals in each state for an equivalent episode of hospital care. To qualify for second tier benefits, a hospital must meet agreed quality criteria.

8.110 A key issue for health funds and private hospitals was the nature of contracting. MBF Australia noted that:

> Fund members have benefited from HPPAs through:
>
> - certainty of fee coverage for services at hospitals with an HPPA ("known" gap);
> - higher benefits for services at hospitals with an HPPA, including "no-gap" policies for hospital accommodation; and

- lower premiums than would otherwise have been the case, due to the ability of health funds to manage the cost of hospital services through negotiating the HPAAs and efficiencies introduced into the private hospital system as a consequence.[100]

8.111 The Australian Private Hospitals Association took a different view towards contracting arrangements, noting that:

> The strategy of negotiation seems to one of attrition and tender, and I would use the word 'tender' in inverted commas. The tender ends up being an opportunity to renegotiate. They start at minus 1.5 per cent and slowly go up, and it takes months. Who benefits? The health funds benefit because they keep the cash that they would have paid out in normal increases. They are not taking into account the financial movements, the costs and the actual money they are keeping. So essentially it is a take it or leave it, or scare them, approach with significant downsides to hospitals if they go off contract and go into co-payments.[101]

8.112 While contacting between funds and hospitals does create tension within the industry, there are a range of ongoing cooperative arrangements that have been established to improve health outcomes for patients in private hospitals (box 8.4).

8.113 Suggestions by participants to improve contracting arrangements inevitably are based around changing the bargaining power of each negotiating party. Some of the changes to contracting and negotiating arrangements proposed by health funds include:

- abolition of default benefit rates — mandatory default benefits are used as a negotiating lever to force funds to pay higher prices and reduce their ability to negotiate pay for performance criteria. They may also reduce the quality of care provided by facilities that are unable to secure a contract;[102] and
- increasing information requirements for private hospitals — imposing requirements on hospitals to publish a range of financial and clinical data would give health funds an improved basis to

100 MBF Australia Limited, sub 29, p 25.

101 Toemoe G, Australian Private Hospitals Association, transcript, 24 August 2005, p 4.

102 Australian Health Insurance Association, sub 16, p 33; MBF Australia Limited, sub 29, p 26; sub 47, p 2.

negotiate contracts and to provide essential information to consumers about the hospitals in which they are being admitted.[103]

Box 8.4 Strategic Planning Group for Private Psychiatric Services — a case study of private sector collaboration

The Strategic Planning Group for Private Psychiatric Services (SPGPPS) brings together a coalition of providers, funders and recipients of mental health services with the commitment to facilitate progress in the provision of mental health services in the private sector.

Members of the SPGPPS include the Australian Medical Association, The Royal Australian and New Zealand College of Psychiatrists, The Royal Australian College of General Practitioners, Commonwealth Department of Health and Ageing, Department of Veterans' Affairs, Mental Health Consumers and Carers, Australian Private Hospitals Association and the Australian Health Insurance Association.

Several members of the SPGPPS contribute to the development and collection of a minimum data set, from which de-identified data forms the basis for quarterly reports are prepared and distributed to participating hospitals and private health insurance funds.

The National Network of Private Psychiatric Sector Consumers and their Carers (National Network) is funded by several members of the SPGPPS to represent Australians who contribute to Health Funds and who receive treatment and care, within the Australian private sector, for their mental illness or disorder. The National Network provide a point of reference and a mechanism for consumer and carer participation and advice to key organisations, committees and working groups requiring private sector input.

While there are many differences between constituent groups, the SPGPPS model has enabled participants to find consensus and a way forward on many difficult and contentious issues. The SPGPPS, originally established in 1993, has recently negotiated funding arrangements with its members for the period 2007–2009. From 1 January 2007, the SPGPPS will be restructured into the 'Private Mental Health Alliance'.

Source: SPGPPS, sub 20; SPGPPS, transcript, 21 September 2005; transcript, 24 May 2006.

8.114 Comments on contracting arrangements relating to private hospitals included:

- retaining default benefits — Provides protection to hospitals and patients and supports the private sector in taking some pressure off public hospitals;[104]

103 MBF Australia Limited, sub 29, p 26; Australian Health Insurance Association, sub 16, pp 32–33; Australian Health Service Alliance, sub 5, pp 2–3.

104 Wainwright D, Australian Medical Association, transcript, 23 August 2005, p 16; Roff P, Australian Private Hospitals Association, transcript, 23 August 2005, pp 15–16.

- increasing the transparency of health insurer's negotiations with private hospitals — To provide information to hospitals about the weighting of the criteria that will be used to assess whether a hospital is offered a contract (financial, market and services, quality and safety, compliance, and efficiency) and how hospitals are compared with each other;[105]
- better sharing of risks between health funds and hospitals — A range of risks that have been transferred to hospitals by health funds, potentially adding to the costs of private hospitals including the bundling of pharmacy into the overall payment system, capping inpatient days and critical care days through the use of aggressive step and the collection by hospitals, rather than by the health fund, of patient contributions;[106] and
- delaying contract negotiations — delayed renegotiations well beyond the date of expiry (in some cases by 12 months or more) with no ability for retrospective payments results in hospitals not receiving indexation for significant cost increases beyond their control (e.g. nursing wage increases, medical supplies and technology costs and professional indemnity premiums).[107]

8.115 While the committee appreciates that there can be tension between health funds and private hospitals, competition is an important element in promoting choice and improving efficiency. Nevertheless, it is important that health funds support the long-term profitability of efficient private hospitals to provide adequate funds for continued investment in high quality health care and timely expansion of capacity.

8.116 The committee considers that, in light of the significant regulatory changes to the private health insurance industry that are currently underway, it may be too early to contemplate changes to the contracting environment between health funds and service providers.

Promoting 'fair' competition

8.117 Several inquiry participants noted that funding arrangements do not always provide for 'fair' competition between private and public

105 Australian Private Hospitals Association, sub 24, p 9.

106 Australian Private Hospitals Association, sub 24, p 14.

107 Australian Private Hospitals Association, sub 24, p 14.

sector providers — in some cases the private sector appears to be favoured whilst in others the public sector may have advantages.[108]

8.118 Competition between the public and private sectors can be important to promote efficiency in service delivery. Competition also pays a role in encouraging the appropriate investment in new technologies or the development of new facilities.

8.119 The Australian Diagnostic Imaging Association noted that some public hospitals were encouraging their clinicians to undertake private sector work, even when there were large numbers of tests that had not been examined by radiologists:

> We are aware and concerned that there are 8,000 unread films in the state of Queensland right now in the public system; there are hundreds of films at Westmead Hospital not being read.
>
> … it concerns us that we are competing against public hospitals who have already had their equipment paid for and who have already had their staff paid for through other grants, yet they are working on Medicare work in the private sector.[109]

8.120 The Commonwealth and industry groups are addressing some of the uneven playing fields between public and private sector providers. For example, in pathology services, only private sector providers are eligible to receive a patient episode initiation (PEI) fee, which is intended to cover some of the fixed costs involved in testing, including collecting and managing a sample. From May 2007, public providers will also be entitled to a PEI fees. While the payment amount ($2.40) is substantially below the PEI paid for a range of tests, public and private providers have agreed to a process that may lead to removing the distinction between public and private providers.[110]

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108 Australian Diagnostic Imaging Association, sub 21, p 1; Graves D, Royal College of Pathologists of Australasia, transcript, 5 July 2005, p 9; Kindon D, Australian Association of Pathology Practices Inc., transcript, 7 April 2006, p 26; Clark L, Australian Private Hospitals Association, transcript, 24 August 2005, p 6; Schneider R, Australian Health Insurance Association, transcript, 23 August 2005, p 75.

109 Barnier G, transcript, 26 May 2006, p 57.

110 Department of Health and Ageing, *Pathology Quality and Outlays Memorandum of Understanding between the Australian Government and the Australian Association of Pathology Practices and the Royal College of Pathologists and the National Coalition of Public Pathology, 1 July 2004 to 30 June 2009* (2004), clause 8.2–8.3.

8.121 Providing a level paying field between public and private sector providers is important to introduce some market forces in the health sector. Where possible, the Commonwealth and the states should look at developing costing rules or other ways of providing for fair competition with private sector providers.