COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Reference: Health funding

WEDNESDAY, 21 SEPTEMBER 2005

CANBERRA

BY AUTHORITY OF THE HOUSE OF REPRESENTATIVES

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STANDING COMMITTEE ON HEALTH AND AGEING

Wednesday, 21 September 2005

Members: Mr Somlyay *(Chair)*, Ms Hall *(Deputy Chair)*, Mr Cadman, Mrs Elliot, Mrs Elson, Mr Georganas, Mr Johnson, Ms King, Mr Turnbull and Mr Vasta

Members in attendance: Mr Georganas, Ms Hall and Mr Somlyay

Terms of reference for the inquiry:

To inquire into and report on:

How the Commonwealth government can take a leading role in improving the efficient and effective delivery of highest-quality health care to all Australians.

The Committee shall have reference to the unique characteristics of the Australian health system, particularly its strong mix of public and private funding and service delivery.

The Committee shall give particular consideration to:

a) examining the roles and responsibilities of the different levels of government (including local government) for health and related services;

b) simplifying funding arrangements, and better defining roles and responsibilities, between the different levels of government, with a particular emphasis on hospitals;

c) considering how and whether accountability to the Australian community for the quality and delivery of public hospitals and medical services can be improved;

d) how best to ensure that a strong private health sector can be sustained into the future, based on positive relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in various levels of government; and

e) while accepting the continuation of the Commonwealth commitment to the 30 per cent and Senior’s Private Health Insurance Rebates, and Lifetime Health Cover, identify innovative ways to make private health insurance a still more attractive option to Australians who can afford to take some responsibility for their own health cover.

WITNESSES

Committee met at 9.32 am

POWLAY, Mr John Frederick, Private Health Insurance Ombudsman

CHAIR (Mr Somlyay)—Welcome. I declare open this public hearing of the House of Representatives Standing Committee on Health and Ageing for its inquiry into health funding. During the inquiry, the committee will explore how the Australian government can take a leading role in improving the efficiency and quality of the health care system. As you are no doubt aware, the Council of Australian Governments meeting on 3 June agreed that senior officials would consider ways of improving Australia’s health care system. The committee’s inquiry should be seen as a separate but complementary process to the COAG process, as our inquiry gives organisations and individuals outside government an opportunity to express their views in a public process. The public are welcome to observe this public hearing, and a transcript of evidence gathered today will be available on the committee’s web site.

You should know that members of parliament are acutely conscious of the pressures on the health care system, as we all receive a steady stream of people coming into our electorate offices with complaints about it. The complaints are often about private health insurance premiums, gap payments and waiting lists. So we too have a vested interest in improving the system. This public hearing will focus on the role of the private health sector in the health system. The aim is to allow the committee to hear diverse and varied views from key stakeholders in a forum that encourages discussion and debate.

All witnesses should be aware that, although the committee does not require you to speak under oath, these hearings are formal proceedings of the Commonwealth parliament. The giving of false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. I now invite the Private Health Insurance Ombudsman to make an opening statement.

Mr Powlay—The Private Health Insurance Ombudsman’s main function is to deal with complaints about private health insurance arrangements. The ombudsman is empowered to conduct investigations of the practices of health insurers and also has the function of providing consumer information and reporting both to the parliament and publicly. We receive about 2,500 to 3,000 complaints a year. The majority of those complaints, as you would expect, come from consumers and are about health funds—around 90 per cent fall into that category. We also receive complaints from doctors and hospitals, and we receive complaints about the actions of doctors and hospitals but only in the context of matters connected with private health insurance.

My initial comments today are in relation to the issue of portability: the ability of consumers to change health funds. I want to address that because it has been a matter that the ombudsman’s office has been involved in to a large extent over a number of years and also because it is an issue that I recognise has been raised in many of the submissions that the committee has received. I should also note that in relation to those complaints we receive about hospitals and doctors, the main issue involved is usually informed financial consent. In relation to the complaints we receive from hospitals and doctors, the main issues are generally health fund hospital contracting and gap scheme arrangements.

Returning to that issue of portability, it is surprising that relatively few consumers do change their health insurer. Most probably think it is not worth the risk or the effort, or else they do not get around to it, even though they might have some dissatisfaction with their current insurer. For instance, over the last couple of years we have surveyed people who have complained to our office about health insurance premium rises: some time after we have dealt with their complaint we have asked them if they took any other action following their complaint. This year we found that, of the group we surveyed, none had actually changed their health insurer, though some were still thinking about it. Last year, a very small percentage had actually decided to change their health insurer. However, if you look at any health fund web site, it will say, ‘It is easy and simple to change to our fund.’ In general, I think that is right. Most people who do actually decide to change can do so fairly easily, without any trouble and without any real disadvantage.

I think it is important to ask what the issue is about portability—what has brought it to the attention of the committee in so many submissions? There are two key issues in the current debate: firstly, how portability should operate following the termination of health fund-hospital agreements; and, secondly, the use of benefit limitation periods to get around portability policy. On the first issue, there has been considerable discussion and debate over the last 18 months or so about what policy should apply when a person transfers from a fund that does not have a contract with a particular hospital to one that does. Because the issue concerns the commercial conduct of health funds and hospitals and potentially affects the bargaining power of the various parties, it has not been possible to reach agreement or even a consensus on the issue. It has been a very emotive issue. In my view, there has been a tendency on both sides to overreact and overstate the issues and to use the debate and any other forum to push their view and try to gain advantage for one side over the other.

Ms HALL—Can you clarify that? Do you mean the hospital and the fund as opposed to the consumer?

Mr Powlay—Yes. I need to be clear about this. There has been vigorous debate over the issues and there are different views about what the legislation, as it is currently worded, requires. There have been strong advocates for changing the current policy. But the current policy is that consumers get full portability, regardless of differences in hospital-health fund contracts, and there is no evidence that I have seen that any fund has ever breached that policy.

One fund has taken action that effectively circumvents it in some cases, through the application of benefit limitation periods, and that is the second issue I referred to. In April 2004, Australian Unity introduced a rule change to apply benefit limitation periods on all of its products for psychiatric and rehabilitation treatments. A benefit limitation period means that the fund will pay only the minimum benefit for the nominated treatments for an initial period of membership, usually 12 months. Most open membership funds have benefit limitation periods on some of their products. What was different about what Australian Unity did was that it applied the same benefit limitation on the same type of treatment on every one of its products—and it applied the limitations to both new members and members transferring from other funds. All other funds, other than BUPA Australia, have waived the benefit limitation periods for transferring members if they have already had the appropriate period of membership with their previous funds.

The Australian Unity changes have been criticised by hospital groups, clinicians and mental health advocacy groups because they undermine portability and because they disadvantage potential members with mental illnesses. There has also been a concern that other funds might follow suit and implement similar barriers to transfer. This issue has also been caught up in the emotion of the portability debate and has also been the subject of considerable overreaction and overstatement, in my view. I have had only a few initial inquiries and complaints about the Australian Unity change. In fact, last year I recorded three complaints about the matter, and only one involved someone who had actually joined Australian Unity. I have provided that case to the committee as a case study.

So it would appear that the Australian Unity change has had the intended effect of discouraging members with mental illness from transferring to the fund, but it does not appear to have unduly disadvantaged individual consumers requiring psychiatric treatment. The reason is that any of those consumers can transfer to any fund other than Australian Unity without experiencing those restrictions. In Victoria, most consumers would have a choice of between 12 and 15 other funds that they could transfer to.

The effect of the Australian Unity change, as I said, is to discourage consumers with mental illnesses from joining that fund but also, as no other funds have implemented similar barriers, it is probably resulting in additional costs to other funds. No other funds have implemented similar rules, and they are accepting transferring members with full portability rights—other than BUPA Australia, which has similar rules in relation to benefit limitations. The department has recently circulated a proposed condition of registration for health funds which would prohibit the imposition of benefit limitation periods on transferring members, and I fully support that proposal.

Ms HALL—I might start where you finished about Australian Unity and BUPA. I wonder if you could comment on what I am about to say. By their action, they have effectively created a barrier for people entering that fund. Do you believe that that is effectively discriminating against people who are suffering from mental illness?

Mr Powlay—Yes, I do think that that is effectively discriminating against people suffering mental illness, particularly given the context of the Australian Unity change. As I said, it applies to all of their full range of products. I should say, by way of background, that I have some understanding of or, if you like, sympathy with the Australian Unity situation. The background to the situation is that, following a major dispute between BUPA and Healthscope hospitals in 2003, part of the settlement of that dispute involved changes to the arrangements between BUPA and Healthscope, particularly in relation to Victorian psychiatric hospitals. Healthscope has, I think, in excess of 70 per cent of the Victorian private psychiatric hospital beds, and the arrangement that was agreed between BUPA and Healthscope following their dispute was that BUPA would pay only marginally above the minimum default benefit for their members in Healthscope hospitals. There was clearly an incentive for those members to transfer to other funds. As BUPA's major competitor—or one of BUPA's major competitors—in Victoria, Australian Unity felt particularly vulnerable to members with psychiatric illnesses transferring to that fund to avoid the large out-of-pocket costs that they might have to pay if they remained with BUPA and were treated at Healthscope hospitals. So that was the main motivation for the Australian Unity change. Unfortunately, as you rightly said, it has had a wider impact, including on new members joining Australian Unity, and it effectively discourages people with mental illnesses from joining Australian Unity.

Mr GEORGANAS—Would you say that patients are protected in the area of portability in terms of exclusions, restrictions, gap payments et cetera? What would your view be on that? Are they protected adequately in that area? How could we provide greater certainty in that area as well? What would your views be on those questions?

Mr Powlay—As I said, the issue around portability has mainly been to do with what portability regime should apply when hospitals and funds go out of contract. The principle of portability in relation to hospital cover is that a person can move between funds and not have to re-serve any waiting periods they have already served with their old fund for the same benefits. They would have to serve waiting periods for any extra benefits that were involved if they went to a higher cover. I believe that that is a reasonable arrangement. It is fair, both to members transferring and to other members of funds.

The current debate has been around whether there should be, if you like, some weakening of portability in those situations after a contract dispute. It is a debate about whether the current policy should change, but there are risks. The risks to portability at the moment are that advocates of significant change will be effective in reducing consumer rights in that situation—or in creating a situation where there are disincentives for consumers to transfer in that situation. The other risk is that, in my view, the legislation has some flaws in it in relation to that issue, although it is also my view that there is a clear intent from both the policy makers and the legislators around what was required. But whilst there is some uncertainty around what the legislation definitely requires, there is always the risk that someone will test that.

Ms HALL—I would like to generalise our discussion a little bit; whilst we are talking about mental health there are a couple of other questions that I would like to ask you. One relates to the waiting period in relation to the insurance benefits for psychiatric products. Are there any health insurance products that impose additional restrictions on benefits for psychiatric treatment?

Mr Powlay—A number of funds offer products that provide what are called ‘restricted benefits’ for some treatments. The distinction to be drawn between the restricted benefits and the benefit limitation period is that restricted benefits are ongoing, whereas the benefit limitation period is just for that period. Nearly all funds offer at least one product that has a range of restricted benefits. It is common for psychiatric treatment to be included as one of the restrictions.

Ms HALL—Is that the case with something like dialysis?

Mr Powlay—No. I think there may be one fund that has a product that restricts benefits for dialysis, but it is certainly not common at all.

Ms HALL—Would that once again be an example of discrimination against people with mental illness by health funds?

Mr Powlay—As I said, there are a range of treatments that can be restricted—it is not simply psychiatric treatment. There are a range of other things that are restricted. It is a fairly broad range and it differs between products. Most funds that have these restricted products also offer unrestricted products.

Ms HALL—Are they for equivalent treatments?

Mr Powlay—They are for equivalent treatments. In my view, providing that the fund offers a range of products that includes some products that provide full coverage for psychiatric treatment, the discrimination issue does not arise.

Ms HALL—Could you give us an example of a restriction placed on a member of a fund and then an alternate treatment for the same illness that is accepted by the fund, so that I do not end up feeling that people with psychiatric illness are being discriminated against?

Mr Powlay—The sorts of treatments that are commonly restricted are things like rehabilitation, cardiac treatment, hip and knee joint replacements, plastic and reconstructive surgery—a range of items like those. A fund may, for example, offer one product that pays full benefits for most hospital treatment but only pays minimum benefits for hip and knee replacements, cardiac treatment and plastic and reconstructive surgery. It may then offer another product that pays full benefits for those things but restricts benefits for psychiatric rehabilitation et cetera. So the consumer has the choice in looking at that—

Ms HALL—A choice of whether they want a hip replacement or psychiatric treatment?

Mr Powlay—A consumer has the choice of purchasing a product that provides restricted benefits for hip replacements or of purchasing a product that provides restricted benefits for psychiatric treatment.

Ms HALL—I don’t think you have quite answered my question.

CHAIR—Is there a difference in the premium paid for these products?

Mr Powlay—Yes.

CHAIR—So a contributor can choose whether or not to take out cover for mental health, a hip replacement or cardiac treatment and get cover for every other thing—they can specifically choose not to take that cover and there is a cost saving?

Mr Powlay—Yes. The major reason for the funds offering these products is that they are cheaper and they are attractive to people who are prepared to take the risk that they will not require a hip or knee replacement or cardiac surgery. A lot of these products are obviously attractive to younger, healthy people.

Ms HALL—I don’t think that is quite the question I was asking. The question I wanted answered was: could you give me an example of restrictions placed on members of health funds with psychiatric illness and the alternatives that they have for treatment of that same illness?

Mr Powlay—Right. If someone had a product that only paid restricted benefits for psychiatric treatment, normally that would be sufficient to cover them to be treated at a public hospital as a private patient. The benefits would cover their hospital costs there, so that would be one option for them if they had that restricted product. The other option would be to be treated as a public patient at a public hospital. Of course, one of the problems when you are talking about psychiatric treatment is that the availability and extent of treatment options available in the public system is not adequate compared to other types of medical treatment. So that is certainly one reason why I and previous ombudsmen have been concerned about products that include restrictions for psychiatric treatment.

Ms HALL—I will just mention that later today we are meeting with members who are involved in the National Network of Private Psychiatric Sector Consumers and their Carers. It seems to me as if basically the option is treatment in a public hospital. The point they make is that over 50 to 60 per cent of psychiatric services are delivered in the private sector, so there is quite often a problem with the treatment that psychiatric patients receive in the public sector because it varies from what they were receiving in the private sector before admission to the acute public hospital system. So it does seem that it is less than ideal.

Mr Powlay—I am not knowledgeable enough about the quality or difference in style of treatment within the two sectors, but there is also an access problem in the public system.

CHAIR—Jill, may I interrupt? We have been given a submission by Mr Powlay. Is it the wish of the committee that it be accepted as evidence to the inquiry and authorised for publication? There being no objection, it is so ordered. This is the series of case studies you have there. I was going to ask you a little bit later to go through those, to give us an example of the types of issues that come before you and what your specific powers are—what you can do about them. Also, the Australian Doctors Fund has made a submission. Is it the wish of the committee that the submission from the Australian Doctors Fund be accepted as evidence? There being no objection, it is so ordered. Please continue. I see the psychiatric case studies in here that you have referred to.

Mr GEORGANAS—Are there any restrictions on funding for psychiatric services that are imposed by health funds in their contracts with private hospitals?

Mr Powlay—There are different arrangements between different funds and hospitals for psychiatric programs. One of the difficulties when you are talking about psychiatric treatment is that sometimes the appropriate program for someone may not fit the normal pattern of hospital treatment—for instance, in many cases it is more appropriate for a person to attend, say, once a week for a day a week, or a half-day a week, as an ongoing form of treatment. Sometimes it might be more appropriate for there to be a mix of hospital treatment and some form of treatment in the community.

In those instances, because those arrangements are not the typical hospital treatment, it is usually necessary for the funds and the hospitals to agree on the funding arrangements for those programs as part of their contract. As an example, for those programs that involve regular treatment on, say, a weekly or even a fortnightly basis, under the normal arrangements for funding of hospitalisations the fund would say that a break of seven days between admission constitutes a new admission and might therefore attract the person having to pay a new excess or a copayment associated with each new admission.

Mr GEORGANAS—So it is treated like a new claim?

Mr Powlay—Yes. But funds and hospitals can come to agreement that the fund will cover the program as if it were one admission. The other area is that where the treatment involves some out of hospital assistance of some sort, normally because of restrictions within the legislation, health funds are not able to cover out of hospital treatment through their hospital products. But some funds might come to an agreement with hospitals that they will provide some ex-gratia funding for certain types of community based treatment.

Mr GEORGANAS—So there are restrictions. Is this covered by Medicare?

Mr Powlay—In most cases, probably not.

Mr GEORGANAS—I suppose the answer is: there are restrictions and it is up to the funds and the hospitals to negotiate?

Mr Powlay—There are differences in the arrangements that hospitals and funds come to as part of their contracts. From the hospital's point of view, if one fund agrees to something in their contract and the other fund does not agree to the same thing, that other fund is being restrictive. From the fund's point of view, it would say that it may well have agreed to some other arrangements, that because it does not fit into the normal hospitalisation pattern it is something that needs to be agreed between the parties and that it is open to the parties to agree or not, given that these are commercial agreements. Whether they are restrictions or not lies in the eye of the beholder.

Ms HALL—I am going to generalise a little bit now. As the ombudsman, you have considerable powers. Do you think those powers are sufficient? If not, in which areas do you think they should be extended?

Mr Powlay—I think at present, given the range of functions and responsibilities that I have, the powers are sufficient. Basically, like many government ombudsmen, my powers are limited in the end to recommendatory powers in terms of requiring any party to take some action. So normally in dealing with complaints we would seek to settle the matter by mediation and sometimes suggest solutions to both parties that might resolve the matter to their satisfaction. Occasionally I will go to the stage of making a formal recommendation to one of the parties to take some action, but there is no requirement for them to do what I recommend. The only requirement is that they should let me know what they decide to do in relation to my recommendation.

It could be argued that my power should go further. Personally, I am comfortable with that recommendatory approach. I believe that it is a discipline that bodies like mine should have—that they should seek to influence the parties on the basis of the strength and correctness of their arguments, rather than on any exercise of a power to compel someone to do something. By and large, I do not have a significant problem when I make formal recommendations, particularly with health funds. My recommendations will generally be accepted.

The strongest powers that I have at the moment, given the nature and the history of my role, are in relation to information gathering, the requirement for production of documents and the requirement that people not mislead me or decline to give information. Most of those powers are directed at health funds. I do not have the same powers when dealing with private hospitals or doctors, even though I do investigate some complaints about private hospitals and doctors.

Ms HALL—Do you believe your powers in that area should be extended?

Mr Powlay—I believe there is an argument for that. I cannot say that I have had any significant problems that I am aware of in obtaining information from private hospitals and doctors. I probably have a little more problem with doctors, because they are less familiar with my functions and role. But I certainly think there is a case for extending similar powers to me in relation to private hospitals and doctors when I am investigating health insurance matters. Probably the other significant area I cannot at the moment take complaints on is the area covering providers of allied health services in relation to health insurance arrangements. They are not identified as people who can complain to the ombudsman.

CHAIR—Is that part of the act?

Mr Powlay—That is part of the act, yes.

Mr GEORGANAS—Just for our benefit, can you give us an example of where you have given a formal recommendation and that recommendation has not been taken up? In what circumstances does that happen and in what circumstances do they get taken up? Is not taking up those formal recommendations the norm?

Mr Powlay—Normally, the sorts of recommendations that I would make to a health fund would be to pay benefits when they had previously decided not to pay.

Mr GEORGANAS—Have you found that they occasionally do not take up those recommendations?

Mr Powlay—Overwhelmingly, they do. There have been instances where they have not. In some cases, they come back to me with some additional information, and I have probably formed the view that their response was probably reasonable. In some cases they have come back and said, ‘No, we don’t agree to implement the recommendation,’ and they have done that because they do not agree with my arguments. I may have thought that that was not reasonable but, nonetheless, given the extent of my powers, I accept that and seek to negotiate whatever I can to try to resolve the complaint.

Ms HALL—Approximately what percentage of your recommendations would be accepted by health funds?

Mr Powlay—More than 90 per cent. There is a case study in relation to doctors’ gaps—which I have provided to you—which is the last case study. This case involved a person receiving a bill from an anaesthetist without being given any advance notice of the anaesthetist’s fee. In the end, I made a recommendation to the doctor that he waive a good proportion of that fee. The doctor did not accept the recommendation. In fact, in that case the doctor increased his bill following my recommendation. Eventually, I was able to negotiate him down to his original amount. That is one example of where someone has not accepted my recommendation.

CHAIR—What proportion of the complaints you get are about informed financial consent?

Mr Powlay—Overall, the biggest group of complaints that I get it is clearly about people being dissatisfied with health fund benefits. I get about 1,500 of those complaints a year. Of those about 800 involve either hospital benefits or medical benefits for the medical gap, and to some extent the issue of informed financial consent is involved in all of those. We certainly look at informed financial consent. I guess about eight to 10 per cent of the complaints that I get would be where informed financial consent is the main issue—so we are talking about 200 to 250 complaints. Nearly all of the complaints that I get about doctors' actions or hospital actions are about informed financial consent or the lack of it.

CHAIR—As members of parliament, every time health insurance premiums go up we get quite a bit of flak from our electorates. To the lay person, which most of us are, it is very difficult to understand why premiums should rise by 10 or 12 per cent each year. The private hospitals tell us that they are not getting the money, that the money that they receive increases by about three per cent per annum whereas the fees are going up 10 or 12 per cent per annum. Doctors fees are also going up, hence the gap. What is going wrong with the system?

Mr Powlay—That is a very difficult question. Firstly, in relation to why premiums go up, I think you identified most of the cost drivers. In relation to hospitals, hospitals will say that at most they are picking up an increase of three per cent on their unit price. What is happening to drive hospital costs more significantly is the extent of utilisation of hospitals. So whilst hospitals may say they are only picking up a three per cent increase on their unit price they are picking up a much larger increase in total revenue, or income, because more people are being hospitalised and more private health insurance members are now going to private hospitals for treatment. Private hospitals are doing a wider range of things than they used to. There is much more pressure on the public system now, so more people are opting for private hospitals. So utilisation is a key factor and that is associated with things like population ageing and with things like an improved capacity to treat some things. So that is probably the dominant pressure. At your hearings in North Sydney the gentleman from the Australian Health Services Alliance gave a good analysis of what is driving health insurance costs.

Apart from that, we all know that within the health system costs are rising. That is evident in the public system, in public hospitals, and in the private sector as well. So the cost of what health insurers are insuring people for is rising significantly, not only because health inflation is running at above CPI but also because of this utilisation factor and because of things like increased doctors' charges and the cost of technology. So when the cost of what you are insuring yourself for rises it makes sense that the cost that you pay for the insurance rises. It is not like with house insurance, for example. You can keep your house insured for a couple of hundred thousand dollars even though it may be worth $500,000. But if you up the amount you are insuring for then the cost will go up. With health insurance it is not a fixed amount that you are insuring yourself for. You are insuring yourself for services and, if the cost of those services is going up, the cost of insurance must go up. It is unreasonable to think that it would not.

CHAIR—With regard to the people who have private health insurance with those premiums going up at that rate, I was asking whether or not you, as the ombudsman, as part of your processes feel a growing anger amongst fund members that these premiums are rising so rapidly.

Mr Powlay—When health insurance premiums go up I am very busy as well. But the number of complaints that I have got about health insurance premium rises has been declining significantly over the last couple of years. So I am not getting more complaints. The complaints tend to be concentrated among members of those funds who have had quite large increases compared to the average of funds. So, for example, in 2002, the Australian Health Management Group had a very large increase on many of its products and they represented more than 50 per cent of the complaints that I got about health insurance premiums. This year, NIB and a couple of other smaller funds have had very substantial increases on some of their products—in the order of 15 to 17 per cent. They constituted a large component of the complaints I get.

Ms HALL—Do you have the power to look at the fairness of those increases and make a recommendation to the health fund on whether or not they should have had an increase of that level?

Mr Powlay—No, I do not. The process for examining the fairness or reasonableness of those increases is effectively encapsulated within the legislation in that health funds need to submit their proposals for increases. They are scrutinised by the department and by the Private Health Insurance Administration Council, which reports to the minister. The minister has the power to disallow premium increases.

Ms HALL—But the minister no longer approves those increases in the way he did in the past. It has changed the approval of the increases.

Mr Powlay—No, it has not changed. What has changed is that, in relation to other changes to fund benefits, the funds are no longer required to submit those in advance for scrutiny. But, in relation to fund premium increases, it is pretty much the same as it has been except that funds know that if they submit premium increases less than the rate of CPI they will not be subjected to the same level of scrutiny.

Ms HALL—Has there ever been an example of the minister not approving an increase?

Mr Powlay—Not that I am aware of in my time as ombudsman but there certainly was previously, I understand. What is more likely to happen is that in that process of scrutiny by the department and the Private Health Insurance Administration Council, questions will be asked of certain funds and it may be that the funds in that process change their proposals before they get to the minister. I do not know. The process is largely invisible to me. It is probably better to ask the Private Health Insurance Administration Council, which is more involved in the process than I am.

Ms HALL—Would a recommendation be that it should be more transparent?

Mr Powlay—I think there are good arguments for more transparency in the premium-setting process, not so much around that approval process but around explaining the basis for individual premium increases. I certainly do get concerned when I see funds increasing their premiums at the sort of level that we saw with NIB and AHMG in that previous example. Generally it is an indication that the fund has not increased them enough in the past. The NIB case is a classic situation. NIB has been a fund that has competed significantly on price, has been well placed in the market on price and whose fee increases have been below average for many years. But last year it seems to have apparently reached the point where it could not sustain that on some of its products, and so we saw the large increases.

Ms HALL—How long have you been Private Health Insurance Ombudsman?

Mr Powlay—Since November 2002.

Ms HALL—Thank you.

CHAIR—I might ask you to go through these cases with us. We asked you to provide individual cases. Could you run through them and tell us why you chose these particular ones and the category—was it because they had special problems that had to be dealt with, or were these typical?

Mr Powlay—I chose these to illustrate the main issues in the two areas that I thought I could usefully provide case studies for that have been raised in submissions to the inquiry. Taking you through them—I will not go through each case study in detail; I will just talk in general terms—case studies A and B are both about administrative problems that impact on portability. The reason for providing you with two of those types of case studies is that, by and large, at present the complaints that I get about portability are not about a fund refusing to provide portability when it should; they are more about administrative breakdowns in the process. In both case study A and B there were issues about delays by the losing fund in providing information to the gaining fund to allow it to correctly assess the person’s benefit. As a result, in both cases, the new fund imposed a lifetime health cover loading on the person, even though they had had continuous private health insurance cover. They had imposed that loading because they did not get the information from the old fund in a timely manner.

In both cases the contributor to some extent contributed to the problems themselves, particularly in the second case study. This was a case of a lady who transferred funds three years ago and came to us recently after she discovered that she had been paying two lots of health insurance for three years only when she had run out of money in her savings account and the bank had to tell her that she did not have sufficient funds. To a large extent she contributed to that problem. She received mail from both funds. The mail she received from the old fund she put in the bin unopened, because she had just assumed it was marketing material from the fund trying to get her to rejoin. The mail she received from her current fund she obviously did not read or, if she did, did not understand adequately to realise that she was paying a 54 per cent lifetime health cover loading when she did not have to.

In many of the cases I investigate the main elements are administrative problems between the funds and the contributor themselves contributing to the problem by not checking on the situation at the time that they transfer. In many instances people end up paying for two health insurance policies at the same time. It then becomes extremely difficult for the consumer to negotiate between two health funds, and they often need the assistance of my office in doing that.

CHAIR—What was the outcome of that case?

Mr Powlay—The outcome of both cases is that we managed to get a refund from the relevant funds and, in one case, get the extra money credited against the lady's future membership. In neither case did the member end up out of pocket. Case study D illustrates an important issue that has been raised with you in your submissions. It is to do with portability of gap cover schemes. A practice of specialist doctors in a regional town made a decision to recommend to all of its patients that they transfer to a locally based health fund whose gap scheme cover the doctors liked. It enabled them to charge the amount that they wanted, it was a known gap scheme and it did not require them to register in advance or commit to only charging a certain level. So the practice advocated that all its patients transfer to the local fund.

We had contact with one lady who got this advice and checked with us. I was concerned about what was going on and the impact on that fund. I contacted the health fund itself and found that the fund had realised that it had experienced an influx of new members and that all of them had claimed a hospitalisation pretty soon after joining. Most of them were obstetrics cases, so they were fairly expensive hospital benefits. The manager of the fund ended up contacting the practice about their actions and explaining that he did not feel that they were doing him a great favour by referring all these people to him. They agreed to stop the practice. This was a small, locally based fund. Only a relatively small number of people transferred but, because of the benefit costs involved, it had a substantial impact on the fund and the next year the fund had to put its premiums up by 30 per cent.

That illustrates the issue of doctors advising patients about their health funds. 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.

Ms HALL—Do you strongly recommend that the committee look at this?

Mr Powlay—I strongly recommend that the committee look at the issue both of doctors and of hospitals advocating that members move to particular health funds. It is very destabilising for the whole industry and in my view there are ethical and practical arguments against it.

CHAIR—I am pleased you chose that example.

Mr Powlay—Case study E is an example of informed financial consent in a hospital situation. I should say that, by and large, I am very satisfied with the informed financial consent arrangements that private hospitals have in place. They have generally good arrangements with health funds to check on the eligibility of members, and most private hospitals take their responsibilities in relation to informed financial consent seriously. I get relatively fewer complaints about informed financial consent for hospitals than I do for doctors. However, when it goes wrong in hospitals you are talking very large amounts of money. So there are a smaller number of complaints but they are very concerning.

This case involves a gentleman who had heart surgery. He happened to have a policy that had one of those restrictions on cardiac surgery, but he did not realise it. He was admitted to two hospitals, neither of which obtained his informed financial consent to the charges. The second hospital, where the major surgery was performed, did do a check with the health fund a couple of days after he had had the surgery, found out that he was not fully covered for cardiac surgery and therefore had to advise his wife that he would be up for about $7,000.

This case is another where my recommendation was not necessarily taken up—although I have not given up on this one. I recommended that both hospitals waive their accounts, on the basis that they had not met their informed financial consent responsibilities and that if they had the gentleman would have had other options he could have taken to avoid the cost. Both provided a response to me to say that they saw this problem as stemming largely from the practice of health funds having restrictions on cardiac surgery. Clearly, either the health fund had not advised the patient properly or they would have known they had a restriction—or, alternatively, if the health fund did advise the patient properly, they knew they had a restriction and therefore the consumer was at fault. I do not accept any of those arguments. I looked at the advice provided by the health fund and I thought it was reasonable. Nonetheless, the two people involved did not really understand, and many times, particularly when someone is in a life-threatening situation, as this gentleman was, the details of their health insurance policies are the last things that spring to mind.

CHAIR—You said he had other options—what other options did he have?

Mr Powlay—The other option would have been to transfer to a public hospital. That would have been clearly open to the gentleman in this situation where urgent heart surgery was required. That would not necessarily have been a drain on the public system, because their policy fully covered them to be treated as private patients in the public system.

CHAIR—But not for cardiac?

Mr Powlay—No, it covered them fully for cardiac to be treated as a private patient in the public system. It did not cover enough to cover the full private hospital fees. I am still attempting to negotiate something with the hospital in that case.

Ms HALL—Good luck.

Mr Powlay—The final case study is the one I referred to earlier, and I will not go into it. It involves an anaesthetist who did in fact visit his patient the day before his surgery but did not discuss his charges. When we wrote to the doctor, he indicated that it was not his policy to discuss charges with patients in the pre-operation consultation, because most people were not worried about that and because it might not be good for them to know about it—and, in any case, they could not do anything about it anyway.

I do not strike that attitude often, but occasionally there are some doctors who will adopt this approach in relation to their patients. I suspect they are fairly paternalistic in their other dealings with their patients as well. In this case, as I said, I recommended that the doctor reduce his bill down to the MBS amount, so that the patient would have nothing to pay, as was promised. The doctor did not respond to my recommendation, but he sent the patient a bill for a higher amount, because the patient had not paid within the 30-day period that entitled him to a discount. I had some further discussion with the doctor, and he did agree to at least go back to his original bill amount and allow the person some time to pay.

CHAIR—For example, what recourse is available to a patient in the circumstance that a doctor says, ‘There will be a gap of $500,’ and the patient then gets a bill for $1,500 from that doctor?

Mr Powlay—I guess in theory there would be legal recourse, but that matter has not really been tested at law to my knowledge.

CHAIR—Is it a common occurrence for that to happen?

Mr Powlay—It is not a common occurrence. Generally, if doctors do go to the trouble of providing information about their fees beforehand, they are reasonably accurate. I always accept that things can happen on the operating table and the doctor may have had to spend more time or may have found something extra that needed to be done that may have added to the cost. That can be reasonable. I do produce a brochure called *Doctors’ Bills*, which gives some advice to people in that situation about how to deal with it.

CHAIR—Can you send us a copy of that?

Mr Powlay—I can certainly do that, yes. But basically there are some options. Most people are not aware, but generally doctors can be reasonable about their bills if you talk to them and you have a genuine problem. Often they will be prepared to negotiate or discount the bill, unlike the doctor in my case study.

Ms HALL—Would you recommend to the committee that, on the issue with doctors and informed financial consent and hospitals, there should be some sort of legislative change to the current practice? Maybe that is an area that needs to be addressed. Whereas now we have some doctors who are quite good at ensuring that everybody is aware of what the financial implications for them will be, there are other doctors that are not quite so forthcoming. Do you think that should be a requirement?

Mr Powlay—The short answer at present is no, I do not think it should be a legislative requirement. My reason for saying that is probably similar to what I said to you about my recommendatory powers. I would prefer to see these things done by voluntary compliance where at all possible.

Ms HALL—That is hard for the pensioner that I have to deal with who gets a bill for $3,000 on top of what they get back from their health fund.

Mr Powlay—I have seen some improvement with regard to complaints about IFCs from doctors. I have also done a lot of work over last year with the AMA on their informed financial consent policy and informed financial consent form. I think there are efforts under way to lift the profile of informed financial consent with doctors. My counsel, if you like, at this stage would be that some of those measures should be allowed to be tested to see if they do substantially address the problem, before legislating. But if I were to appear before you in two years time and the problem was still as it is, I may be inclined to be more firmly recommending a regulatory approach. I should say that is in the context of my bias against compulsive regulation where voluntary compliance is possible.

CHAIR—We have run out of time. I would like to thank you for appearing today. It was very informative. I know there are things in the pipeline with regard to the private health sector that the government is considering at present which involve your office. When those are decided or announced, we perhaps might invite you to come back if these things happen quickly enough. If you are following the progress of the inquiry and you want to provide us with further information that you think we should, we would welcome it from you. Thank you.

Proceedings suspended from 10.38 am to 10.58 am

HOPKINS, Ms Helen, Executive Director, Consumers Health Forum of Australia

CHAIR—Welcome. Although the committee does not require you to speak under oath, you should understand that these hearings are a formal part of the proceedings of the parliament and that giving false or misleading evidence is a serious matter and is considered as a contempt of parliament. Do you wish to make a brief introductory statement before we proceed to questions?

Ms Hopkins—I have provided a little summary which includes an overview of the Consumers Health Forum of Australia. I think it is important to understand that our organisation is membership based. Our members are from health consumer organisations all round Australia. They range from quite large groups like Diabetes Australia or Arthritis Australia through to quite small community groups and even quite small disease based groups. Therefore we have a fairly wide range of views about the health system but we try to pull out the common issues for health consumers that we can work on at a national level and that would be difficult for them to work on either because of their small size or because they focus on their particular disease area. In the context of this inquiry it is probably well known to the members of the committee that, over a number of years, Consumers Health Forum has been concerned about the way the health system sits. It is very easy to get lost between a hospital discharge and what happens in the community and to end up back in hospital again because something went wrong that may have been avoidable.

Ms HALL—Could you walk us through those concerns you have and, after you have done that, your recommendations to address those concerns?

Ms Hopkins—One of our concerns is recognising that our members are people who use the health system a lot and have often been in hospital, have had a lot of specialist visits and things like that. A very common concern is that one part of the health system does not know what the other part is doing. For example, somebody can be discharged from hospital back to community care and there may not be anybody at home to help them—or perhaps they are discharged on a weekend when they do not necessarily have their fridge full and their clinical instructions are to not drive for four weeks. Or perhaps they have a small quantity of medications from the hospital and they are supposed to go back to their GP very soon to get prescriptions, but their GP probably will not have seen the discharge summary from the hospital and may not even know that they have been in there. They may need some community services that are not necessarily in place. Even if some effort has been put into having the services in place, the services may not exist in their area so that they do not have access to the support they need. Silly things can go wrong. For example, the medications they were given in the hospital may be different brands to the ones they have in the cupboard back at home and they do not know they are the same and so they take both.

Very often in these sorts of interface situations, things can go wrong. Many health consumers who have been in the system for a long while are very concerned about that. I guess we do not have a grand plan for how that might work, but what we have tried to focus on is better communication between the different parts of the health system. Our members have had a strong interest in some of the proposed electronic health record initiatives, for those sorts of reasons. With electronic health records, it will be more likely that you and your health care providers will have the information consolidated at the time it is needed. Then everything will not rely on you—when you are sick—being really good at remembering what went wrong before. It will also help you to be able to identify all the problems you might have when you go home.

CHAIR—Do these problems happen when people are discharged from public hospitals and private hospitals?

Ms Hopkins—I will just go back one step. The other point I should make that arises from our summary is that some of our members do not have access to the private health system at all. You will hear from ACOSS this afternoon. They will be able to present some of those views. It has been quite challenging for Consumers Health Forum to decide whether we should pick up the private health issues.

The feedback we get is that a lot of our members are using the private health system. People with arthritis will often hang onto their private health insurance because they know they are going to need joint replacements. They know that it is not going to be emergency surgery; it is going to be elective surgery. They know that it is going to hurt a lot and they want to have access when they decide they need it, rather than having to go onto a waiting list. A lot of elderly people are holding on also, and that might be for something as simple as the fact that the private hospital is down the road and their spouse can come and visit them if they need to be hospitalised, whereas, if they have to go to the public hospital in the city, their spouse might not be able to manage the bus trip.

Ms HALL—Does this mean that your comments are geared mainly towards the private sector?

Ms Hopkins—I think our comments apply across the sector, although probably we have a little more concern about the safety and quality area because we are less well aware of what happens in the private sector around control and monitoring.

Mr GEORGANAS—In the briefing background that we got in the paper, you talk about how some of your members, because of long-term illnesses or health problems, are out of the work force—obviously, because they cannot work—but they are still continuing to carry their health insurance when they can least afford it. In other words, they are obviously going without in other areas. Do you want to tell us a little bit about that?

Ms Hopkins—It is a common story that we get. I should be really clear that we have never had any funding to go into consultations about private health care, but we do a lot of work with people with chronic conditions around quality use of medicines and around the electronic health records project that we are working on at the moment. We absolutely get the feedback that people have very high health care costs and that they need to weigh up in their minds how they are going to allocate their own spending. A lot of the work around private health insurance actually came from the work we have been doing around the cost of medicines, where people would identify that, although their medicines were subsidised if they had an ongoing illness, they have to pay for physiotherapy, and maybe the first line treatment or the maintenance treatment is a lifestyle option. Rather than swallowing a whole heap of painkillers, people are deciding whether they should be having physio or acupuncture or something like that. So they were explaining how they very carefully weighed up the amount of money they could spend on each part and how they made decisions about who—or even which family member—would be using the money to buy the medicines because they had to keep all of these other costs open. I think we often overlook the fact that, even with the subsidies, a lot of people are on quite low incomes and perhaps struggling a bit to keep working—to stay in the system. They are not on concessional benefits, so every little incremental bit adds up. They really carry a much higher cost than most of us to keep going.

Ms HALL—Had you finished your submission? I apologise for interrupting you.

Ms Hopkins—I have covered some of the things that I wanted to say, but I did also want to pick up something that I have touched on. A lot of our interest in how the private health sector performs has been around financial issues that you have probably heard a lot about before. 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. That can result from not being aware that there are a whole lot of different health professionals who are going to charge them if they have an operation. It can result from the extent of the gap being really rather larger. We all heard that the minister had to pay $200 when he was in hospital earlier in the year. We have a lot of very upset people coming back and saying, ‘He can afford to pay $200, but what would I do? I am on a pension and $200 is a lot of money for me to have to pay.’ Those are some of the issues.

We have been keen to see better informed financial consent arrangements. Perhaps we need to recognise the challenges of that. You need to be very articulate to ask the questions that you need to ask, at a time when you are not very well and feeling concerned about your health. People may not do as well as they should in negotiating their way through that. They have a very strong trust relationship; they are going under the knife so, of course, they want to have trust in the person who is going to do the surgery and the anaesthetist or whatever. So there is the ‘trusted health professional’ thing too, which makes people tend to step away from asking all the questions about how much it costs. From our perspective, it is very important that health providers know that they have to be very proactive and clear about what things cost, because people often are not in a good position to do all their homework at the time they are making those decisions. It is easier if it is in the distance a bit, but it can be quite hard if you are having—

Ms HALL—Could you recommend any actions that could be taken for health providers to be more proactive?

Ms Hopkins—We think there is a strong need for much better communication for health consumers and the public about some of the choices they might need to make. Our concern is that at the moment the onus for that is on the health funds. Our experience has been that people see that not as independent information but as marketing information. We feel that there should be good information sources for consumers—which, I believe, there may be. I have seen a recent piece of research on some of the pieces of information that are around, but the main finding from the research, from our point of view, was that nobody had seen the information before they did it. It is really key that we start to have a better communication strategy that perhaps comes from some of our independent sources. Most people would not even know there is a Private Health Insurance Ombudsman. We can only do so much. We can put questions on our web site and that sort of thing.

CHAIR—We felt that one of the weaknesses of this inquiry was that we had virtually zero submissions from consumers. It is very important that the focus of this inquiry is ultimately the patient and the welfare of the people in the system—

Ms Hopkins—I am pleased to hear you say that.

CHAIR—and this is why we invited you to come along and talk to us. We were quite surprised that consumer groups did not take the opportunity to make submissions and get organised together to make a case to the committee.

Ms Hopkins—You have to appreciate that consumer organisations are fairly pressed to respond. It was certainly our intention to make a submission, and I can only apologise that we did not put one in. By the same token—

CHAIR—I am not being critical.

Ms Hopkins—The particular term of reference we are looking at today is very strong on how the private health sector can be sustained into the future, based on positive relationships between the various service providers. It is not included in the terms of reference that consumers need to be part of that whole thing for it to be a positive relationship. The most efficient hospital is the one with no patients in it. It is very concerning that at the moment there seems to be an attitude, particularly in the private health area, that it is best to let the stakeholders sort it out.

To go back to resourcing for consumer organisations, we have been slightly caught in this area because, as you can appreciate, we have quite a small secretariat. We do not like to speak unless we have done fairly wide consultations with our members, and we have not had funding to consult specifically on private health insurance. One of the ways that we have been able to contribute to the outcomes to date has been through our consumer representatives program. We provide a lot of consumer representatives—there are about 100 consumer representatives on about 200 national health related committees. Private health came back onto our agenda in the secretariat as those committees shut down. So at the moment the only area in which we have any work going for consumer representatives is around the prostheses reforms.

Nobody wants to sit on a committee that is not doing anything, but, in some ways, if our best way to contribute a consumer perspective is through that process, it is taken away and the way forward is around stakeholder negotiations, it is very easy for that consumer voice to be excluded from all of the behind the scenes discussions. This is perhaps why I come to you. I feel a little apologetic because we would very much like to be able to put a much stronger position, but we have not been in a position to do so.

CHAIR—As members of parliament, we are at the coalface and we have the constituency complain to us about their treatment. They do not know the difference between state, local and federal government—they do not know what the interactions are. They think, ‘You’re the federal government—fix it.’ We have this problem with health insurance premiums going up and then, when people eventually have to use their health insurance, there is a gap that they were not aware of. Even with informed consent, it still comes as a shock to find out that you might have a $500 or $5,000 bill to pay when you have been paying health insurance for 40 years: you think you have coverage and you do not. We wanted consumer groups to tell us why people do not know that—I know from my own experience that I did not know that and I was quite surprised not only by the gap but by the extent of the gap when I had surgery—and what can we do as a government to inform people that these things exist, that they have to address them and that when they pay their health insurance they should know exactly what they are paying for and what they can expect in the event of having to use it.

Ms Hopkins—I think the government has some responsibility for taking on some of that communication because, as I said earlier, it seems to be left to the various stakeholders at the moment, and that is not actually where people are going to hear it. You get stuff from your health insurer with all sorts of complicated things in it and you do not sit down and think, ‘I must read that.’ As we have already discussed, you do not have that discussion with your health care professionals until you need to use your insurance. What do you do when the $500 or $5,000 is too much for you?

Mr GEORGANAS—Are you saying there is a bit of a blur between what is marketing and what is information by the health insurance providers?

Ms Hopkins—Absolutely. There are a lot of requirements for information to be communicated, but the sources of communication are seen by people as marketers of a product rather than—

CHAIR—They see it as junk mail.

Ms Hopkins—Yes. In other areas we have focused a lot on a whole range of communication strategies, ones that get the sort of information that we are talking about out through the community networks that people use and rely on, rather than focusing on the junk mail from health insurers. I do not believe there has ever been that focus in the private health area. In the area of medicines, for example, we have argued very strongly that, if you are going to run a whole lot of messages for doctors telling them how to prescribe well, you need to run parallel messages for consumers saying, ‘This is what the deal is, and these are the questions to ask of your doctor, and do you know there are home medication reviews available?’ There has been some progress in that through the National Prescribing Service Community QUM program, which has some Commonwealth funding. I think that is not necessarily the answer, but we need a similar sort of commitment to community communication.

CHAIR—Is the issue too complex for people to understand?

Ms Hopkins—It is too complex to understand if you get one of those complicated brochures, or—what do you call that thing where you are supposed to compare all the health funds? We did advocate for key features statements so that what you had to look at would be really clear. The brochures are too complicated for you to sit down and read. But I think we need key messages, such as, ‘If you have private health insurance you need to check every couple of years what your exclusions are.’ I think there are fairly simple messages that are just not being promulgated.

Mr GEORGANAS—In the background material that you provided, you say that many consumers do not have a good understanding of how adequate their health fund is or how good their policy is until they have to use it. It is a bit like a parachute: you do not know how it is going to work until you pull that cord. What are you finding the main complaints are at the point where they do have to use their insurance?

Ms Hopkins—The gap is the main subject of complaints—the unexpected gap and the extent of the unexpected gap.

Mr GEORGANAS—In your experience, that would be the main complaint?

Ms Hopkins—Yes. The other subject of complaint is where people are not qualifying for things, and I think that is probably going to increase, as more young people take on fairly restricted packages. There is quite a strong need to review it over time.

Mr GEORGANAS—So, if someone was to put information out, it should be to say, ‘Ask about the gap and about what exclusions you have’? Would they be the two main points?

Ms Hopkins—I think it would be slightly more complicated than just to say, ‘Ask about the gap’, because the other thing that really confronts people is that they know they will have a gap—for instance, they know they will have a gap for the surgeon—but they do not know how many little gaps they will have, which will all add up.

Ms HALL—You mentioned that you felt you could supply us with more information. Firstly, would you like to take the opportunity to put in a written submission detailing more of the issues that you have raised? I am sure we would love to receive it.

Ms Hopkins—I would be happy to expand on what you have before you and to put something in so that you have it on the record.

Ms HALL—The other issue I want to address is mental illness. Were you here earlier?

Ms Hopkins—I did not hear the mental illness part.

Ms HALL—We have heard and read about some of the problems that people with mental illness experience within the health system—particularly relating to private health. Would you like to share with the committee any thoughts that you have in this area?

Ms Hopkins—Once again, we are hampered because we have not been out there asking those questions. I can tell you that we have put quite a focus on mental illness in the work that we are doing around communications about medicines, because it has been identified as such a high-need area by our members—and an area where there is such a high gap. Through that process, I have become aware that one of the concerns that that group has is whether or not they will get excluded. I am not really clear on what this concern is, but it is to do with people who have a long-term condition and have a need for acute admissions from time to time. They have some concern that funds might pass them around and that the fund that they belong to might not provide some of the benefits that they need and that if they change fund they might not have the same benefits or there might be a waiting period or something like that. But I would not say I was well informed about the extent of that. Certainly it is the sort of question that we could ask a little more specifically through our mental illness groups. They are among those groups that hang on to private health insurance to get access if they can.

Ms HALL—Would it be fair to say that the communication issues are the issues that the mental health groups raise with you—and, in addition to that, accessing health services through their health funds?

Ms Hopkins—Concern about accessing health services through their funds would be the fairer representation of what I have heard, because we have not gone into details about what constitutes those concerns.

Ms HALL—What percentage of your complaints have come from people with mental health issues?

Ms Hopkins—We are not really complaints driven.

Ms HALL—Okay. How often are issues raised?

Ms Hopkins—We have been running community engagements, which are fairly small group sessions, around Australia. We have had a little bit of a focus on mental health over the last year or so. Those issues have come up in those sessions, but I could not give you a sense of those in a numerical way.

Ms HALL—Could you give us a little bit of an idea of the structure of the Consumers Health Forum of Australia—and maybe in doing that could you tell us something about the mental health groups that are affiliated with you?

Ms Hopkins—We have about 90 members at any one time. A national organisation might belong to the Consumers Health Forum. In mental illness we do have about three or four mental health groups that belong as national members but when we go out to them and say, ‘We’re going to have some project funding and we’re going to be able to run these engagements around medicines. Who is interested? Let us know,’ what might happen is that the interest comes either from their state members or from a particular region in their state membership. For us that is a really rich way of getting that input, but our ongoing relationship is with the national body. The extent to which we get our stuff out or get stuff in from the lower ones is rather dependent on either us having project funding to go to the smaller groups or the mental illness group itself having funding to take what we say out to their group—and having the will to do so.

CHAIR—You are an Australia wide organisation. Do you find great differences or variations in the problem that we are talking about between states?

Ms Hopkins—The biggest difficulty for us in differentiating between the states is that some states have quite strong, funded, state consumer groups, like the Health Consumers Council of WA—

CHAIR—Funded by the state, though.

Ms Hopkins—It is funded by the state government. There is also the Health Consumers Alliance of South Australia, which is fairly new, and the Health Care Consumers Association of the ACT. They have a pretty good handle on what is going on in their states, whereas the others states are in a much more difficult situation. It is much more difficult for us to know what the state situation might be because they are made up of a number of disparate illness groups that do not have a common state thread to draw that together. I do not think I can answer you on a particular state basis.

Ms HALL—Could you supply us with a list of the groups that are affiliated with you?

Ms Hopkins—Certainly, it is in our annual report.

Ms HALL—Do your members raise with you issues that relate to private-public health, where there are problems with passing either from the private to the public or the public to the private? If so, what are those issues and what strategies would you recommend to address those?

Ms Hopkins—The biggest issue that comes up is the decision making about whether to go private or public in a public hospital. To be frank, I cannot imagine that many of our members would knowingly put up their hand and say, ‘I want to be a private patient in a public hospital so that I can pay $5,000, whereas the person next door will not,’ although they do have the loyalties I am sure you are aware of to individual practitioners and that sort of thing. So that decision making would be one issue. There is some concern that that can be a little bit pressured. The question is often, ‘Do you have private health insurance?’ and, if you say, ‘Yes,’ you are therefore private, rather than there being a discussion of people’s rights to choose. On the issue of moving from a public hospital to a private hospital—

Ms HALL—Or vice versa.

Ms Hopkins—or vice versa, I do not think we have good feedback on that. I think that most people would hope that, should their condition deteriorate and should they need services, they would be transferred to the hospital that could treat them more readily, which might be the private-public in a number of situations. As far as the public to private is concerned, the issue that comes up more is around elderly people not having the next place to go to, and I do not think that is so much a private hospital issue as a sort of residential care issue.

Ms HALL—You are saying that people who are waiting for placement in residential care remain in public hospitals instead of going across to that residential care facility?

Ms Hopkins—It comes a little bit differently to us. People in either a public or a private hospital who are going to have to go into residential care get to a certain day where the staff basically come and say, ‘You have to go,’ and they often do not particularly know that that is going to happen. They feel very pressured to find somewhere in a very short time frame, and they feel a lot of angst.

Ms HALL—Is that more common in public or private?

Ms Hopkins—Our feedback has been that it is a common problem in either place, but I would not be able to tell you where it was more common. It has been an issue of concern that has been raised with us. I would imagine that it would depend on the resourcing of either hospital as to how well they were able to help people make that transition, but the difference between the two has not been part of the feedback.

Ms HALL—In relation to mental health again, have any of your members raised issues about people being unable to access mental health services within private or public hospitals?

Ms Hopkins—Access is a big issue which is raised. Again, I think the issue of concern that we hear about is the access, rather than, ‘I couldn’t get into a private hospital,’ or ‘I couldn’t get into a public hospital.’ But, where they do not have private health insurance, obviously they need public hospital access, and that would be the bottom-line issue.

Ms HALL—Are there any greater issues or different issues related to the seamless transfer between the two systems in relation to mental health?

Ms Hopkins—Do you mean seamless transfer between public and private or hospital and the community?

Ms HALL—You can answer both of those.

Ms Hopkins—I can probably only answer about hospital and the community because, as in the other situation, we have not really done anything that would differentiate the two. But I think that being discharged or coming into hospital are times of great difficulty for people. The concerns that I raised, for example, around medications are very much amplified for people with mental health conditions, because they often have quite complex and high medication needs.

This is probably a public issue but in rural Australia at a recent engagement we did some concerns were raised that people with mental health problems needed to go to the hospital to get their medications. There were a lot of access issues for them in the community around their medications, and they had a lot of concerns. They did not want to front up to people and talk about all of their mental health background. The timing is very difficult. We know there are some concerns, particularly around getting the medication they need and sometimes needing an admission to get the medication or sometimes not having a good outpatient arrangement in place, but we probably do not have the details between the public and private.

Ms HALL—Did you say that it is probably more public than private, because private care facilities are not available in the rural areas?

Ms Hopkins—Yes. Certainly the feedback we get from rural Australia is ‘Why should we even bother with private health insurance? We have no access anyway.’ That is true. They have no local access. It is not going to help them the way that it helps the pensioner who can go and visit his wife five kilometres down the road. The other concern is that those people also have long-term health problems and may not realise that they are going to have a wait in a public hospital. They often do not realise the implications of all the other costs, should they need to go for fairly lengthy treatment in a major centre, because that can have real flow-on impact on their whole family and their livelihood, and it can cost a lot to have anybody there to support them while they are in the hospital.

CHAIR—It is in private hospitals’ interests to get patients out of hospital, because they need the beds. It is in the interest of the funds to get them out of hospital, because it is very expensive just to keep them there. Yet funds are restricted from paying benefits to people who are not in hospital. Could you see advantages if funds were allowed to pay for services in the home?

Ms Hopkins—I will make one comment before I answer that specific question. With respect to discharge from hospital, that is the other issue that comes up for people: they are often discharged before they feel ready to cope. That input came to us in consultations about the public health system, but I think it is equally applicable to the private health system: people feel they are being shuffled out before things are quite in place. We have not consulted on what our members would think about having private health insurance better able to cover community care. I know our members were not really keen about private health covering gym shoes, because they felt that, because there were such high health needs, we should not be focusing on that sort of thing.

In work that we have done around models like the co-ordinated care trials and that sort of thing, it has very often been the experience that the community services that are available to provide the support you need when you go home are not there. I do not think people would thumb their noses at having much more access to good community services if there was a strategy to get it, but I could not say that that was our position.

Mr GEORGANAS—I suppose a lot of the people Consumers Health Forum of Australia represent are people with chronic illnesses. How do the people who access private health cover through one-off incidents differ from those people who suffer chronic illnesses? What are the differences in the health insurance industry for those people?

Ms Hopkins—There are a lot of differences. People with chronic conditions think a lot more about what could be done better, because they know they will have to go back again. Often they have joined health consumer organisations because something did not go fabulously and they can see room for improvement and they want it to be better for the next person. But the other thing is that, if you have a chronic condition, you know that you will have to go back again, so you may be rather more careful about being critical, particularly of your health professionals, because you are going to need their help again. The same thing applies to the hospital if it is the one you need to go to. On the one hand, they are a much more experienced group of health system users but, on the other hand, they are quite personally vulnerable to criticism and complaints. People think very hard about making a complaint, in case it disadvantages their future health care. That is actually why it is important to try to keep having a health consumer organisation perspective in these things. I can say things about your doctor that you cannot say.

Ms HALL—So what you are saying is that there is an imbalance in the power relationship and that people with chronic illnesses are disempowered to a degree?

Ms Hopkins—To a degree, they are disempowered. They need to keep that relationship going; they need it to be okay next time. They do not want to be a blacklisted patient.

CHAIR—We have come to the end of our time. Thank you very much for appearing before us. We have got some valuable information from the consumers’ perspective. If you follow the progress of the inquiry over the coming weeks and you feel you want to tell us some additional information, I invite you to please send it to the committee.

Ms HALL—A submission would be great.

CHAIR—A submission would be great, yes.

Ms Hopkins—Okay.

CHAIR—Thank you very much.

[11.43 am]

GINNANE, Mrs Gayle, Chief Executive Officer, Private Health Insurance Administration Council

CHAIR—I thank you for appearing today. Although the committee does not require you to speak under oath, you should understand that these are proceedings of the Commonwealth parliament and the giving of false or misleading evidence is a serious matter which may be regarded as contempt of parliament. Having said that, do you wish to make a brief introductory statement before we commence questions?

Mrs Ginnane—I thought it might be useful if I actually explained what PHIAC is, what we do and why we exist. We are the Private Health Insurance Administration Council. For fairly obvious reasons, we abbreviate that to PHIAC. We are a body corporate under part VIAA of the National Health Act. We are the Commonwealth regulator of the financial aspects of private health insurance.

The act quite specifically says that we have four main purposes, which are: to foster an efficient, effective and competitive industry; to protect the interests of consumers; to minimise the level of health insurance premiums; and to ensure the prudential safety of individual registered organisations. We have a number of functions set out under the act, but the major ones are monitoring the financial performance of the registered health funds and administering the reinsurance system, which is a support mechanism to share amongst the health funds risk from older members and chronic users of the health insurance system.

We are also required to produce statistics on the industry. We produce the membership and coverage statistics, we produce statistics on gaps and quite a lot of other financial information and we provide an annual report to parliament on the operations of the registered health benefits organisations. We are also required to produce some consumer information, and to do that we have made a booklet called *Insure? Not Sure?* It is almost out of print; we are in the process of reviewing and updating it. We will go to the health funds, probably early next year, seeking to update it, print it and make it available.

Ms HALL—Would you be able to send the committee a copy, please?

Mrs Ginnane—Yes, we will do that.

CHAIR—Who gets that publication?

Mrs Ginnane—We have made the publication available on our web site, and we also provide hard copies, generally speaking, to health insurance funds, because they fund us.

CHAIR—It is not aimed at the consumer?

Mrs Ginnane—Not directly at the consumer, no. We as a small organisation do not have the resources to produce it in those numbers and distribute it that way.

Ms HALL—On your funding by the private health insurance industry, tell me what is the formula.

Mrs Ginnane—The formula is basically based on the size of the fund. The number of persons covered is counted in what we call single equivalent units. A single membership counts as one, and all other types of membership—single-parent families, couples and families—count as two memberships. We establish a budget under the levy act and we determine the levy of the health funds, in effect, in proportion to their membership. Our budget from the levy from the funds for next year is $4.435 million.

We also have the power, in the event of the failure of a private health fund, to levy other funds to pay the benefits for consumers, which is called a collapsed fund levy. We have never imposed such a levy, but it is there as a consumer protection mechanism and, in that sense, it is similar to a provision under the life act. We have an independent board: a commissioner and a board of four members. We report to the parliament through the Minister for Health and Ageing.

Ms HALL—Who appoints people to the board?

Mrs Ginnane—Appointments are by the minister, but we have very specific skills requirements around those and we have people that are highly experienced in the area of financial services on that board.

The industry is composed primarily of mutual and friendly societies. There are currently 39 registered organisations, with a merger that occurred on 1 July between Federation Health and Latrobe Health Services in the Victorian Latrobe Valley. Five of those funds are operating on a for profit basis. The others are not for profit, but I have to say as a regulator that I like to see them profitable, because that ensures their long-term survival.

There are two specific categories of funds. There are open funds, who must take everybody who comes through the door, whether they are risky or not. The only requirement is that health funds can impose a waiting period when a member first joins health insurance. The issue of portability has largely been addressed by the ombudsman. There are also restricted membership funds, which are organisations perhaps based around employers, unions or a profession. There are 14 of those organisations in the industry at present. They have exactly the same rules as the open funds, except insofar as they can impose that membership restriction—that is, that you have to belong to the company, the union or the profession to join that organisation.

Ms HALL—So that is the only restriction? It is not a restriction on health?

Mrs Ginnane—No, it is not a restriction on health; it is only a restriction on the organisation itself. For example, Teachers Federation Health is based around the New South Wales Teachers Federation. Our statistics as at 30 June 2005 indicate that 42.8 per cent of the population or 8.699 million Australians have private health cover. That is a 0.1 per cent decrease in terms of the proportion of the population covered, but it is actually an increase of nearly 72,000 people since 30 June 2004.

The information we have—and we have quite detailed information on the health funds, as you would imagine, that being our principal responsibility—is that the industry is presently financially sound. The audited annual accounts, however, are not due to us until the 30th of this month. We will compile that into the report that we present to the parliament later this year, and at that time we will know exactly what the outcome has been for this year. However, whilst there has been an underwriting profit, it has been marginal. Most of the profitability this year—and the industry has made a profit—has come from their investment income. Health funds break even, or slightly better than that, on their insurance operations. That covers the background.

Mr GEORGANAS—One of your roles is obviously protecting the interests of the consumer. When a health fund decides to increase its premium, what process do you go through? Could you outline the checks and balances?

Mrs Ginnane—We go through a substantial process in the pricing process, working in very close concert with the Department of Health and Ageing. The applications come to the department, and they must be certified by an actuary, so there is actuarial advice there that the rate increase that they are applying for is already sufficient. We then go through and examine the assumptions and the work of the actuary. Obviously, actuaries have access to more information than we do. We are receiving summary information but, generally speaking, we are looking at and examining the reasonableness of the rate increases. Where we think it is important to seek extra advice, we do so. In the last couple of years, we have sought additional advice from the Australian Government Actuary when reviewing some of the applications that have come to us. We then provide our advice back to the department, which gets absorbed into the advice that goes to the minister and he has the power, as the ombudsman noted earlier, to disallow. It is not actually an approval process and never really has been. It has always been a disallowance process.

Mr GEORGANAS—Have there been any examples where you have recommended that a particular insurance fund should not increase its costs?

Mrs Ginnane—Generally speaking, queries have been raised before we get to the point of making a recommendation. The fund may come back with a revised application. On one occasion, PHIAC recommended that a rate increase be higher than applied for, because, based on the information available to us, it was not sufficient to enable the organisation to meet its capital requirements.

Mr GEORGANAS—But you have never actually given a recommendation not agreeing with their increase?

Mrs Ginnane—No. It has been my experience with the funds that they are very conscious of their pricing. They try to get the balance right between making sure that they meet all of the capital requirements, but also knowing that around eight per cent per annum appears to be what health inflation is and they have to raise sufficient moneys to keep up with that position.

Mr GEORGANAS—Then why is there such a variation between the rate increases?

Mrs Ginnane—If all health funds were starting from the same base with the same amount of capital in their organisations and maintained that position, I think you would find that the rate increases were very similar. In fact, increasingly they are. There is a dampening of the range, if you like, of price increases that we are seeing. However, occasionally funds get it wrong. An example that the ombudsman mentioned earlier was NIB, where they had been competing on price for some time and their members started to claim and they needed to raise the rate significantly. Another example the ombudsman gave was where in fact doctors had encouraged members to change to a health fund and that particular health fund incurred a substantial financial penalty as a result of that. That organisation was under regulatory action from PHIAC because we were concerned about its future solvency and its ability to maintain its existence, if you like, and that resulted in a 30 per cent rate increase.

CHAIR—What sort of regulatory action?

Mrs Ginnane—PHIAC's regulatory attention in that case was having the fund report monthly and requiring them to put in place a proper recovery plan, either to ensure their future or, if they did not believe they could recover appropriately, to look at alternatives to protect their contributors, which might have included a merger with another organisation.

CHAIR—There is nothing under your powers to discourage doctors from doing that?

Mrs Ginnane—No. PHIAC has no power to do 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.

CHAIR—You think it should apply?

Mrs Ginnane—Absolutely. All parties in the industry ought to be treated equally in relation to similar behaviours.

CHAIR—Are you recommending to us that there ought to be an amendment to the National Health Act to that effect?

Mrs Ginnane—It is certainly PHIAC's view that that should apply also to doctors and hospitals if it applies to health funds.

CHAIR—Hear, hear. I agree with you.

Ms HALL—You mentioned earlier that you keep statistics on gaps. Would you like to share with us a little bit of information on that please?

Mrs Ginnane—PHIAC produces this particular publication on a quarterly basis. The information is required to come to us. Basically what we look at is a number of different ways in which the gap payments are made in accordance with either medical purchaser provider agreements, which are established under the act, or other types of agreements. We look at what the patient out-of-pocket costs are on average. Our statistics are based purely on individual services, so we would only have the data on the anaesthetists and the assistant surgeons. What we cannot do is pull that together and look at what the average gap would be for a patient having a hip replacement. We simply have individual services.

Ms HALL—Is there any area that stands out?

Mrs Ginnane—No, because at this stage we do not collect the data on specialty. We are simply looking at total numbers. For a period of about three years we have quite significant statistics. Basically our statistics indicate that about 80 per cent of services are provided with no gap but the gap is growing for the remaining ones. The logic of that is that health funds can come to agreements with doctors and providers who are prepared to negotiate within the limits that health funds believe they can reasonably pay. It is the higher cost providers that will not come to agreements—for whatever reason, they are high cost. So consumers will probably tend to have larger out-of-pocket costs if they are using some of those providers.

CHAIR—It has been suggested to me that the nature of the work force of the medical profession and the ageing profile of specialists who are phasing out their working careers and working fewer hours but are attempting to maintain the same level of income has had a large influence on the size of the gaps. Have you seen evidence of that?

Mrs Ginnane—I have no information that I could use to comment on that. It seems to me to be a reasonable assumption but I certainly have no evidence about it, one way or the other.

Ms HALL—Other evidence we have received indicates that anaesthetists tend not to communicate information quite so readily to their patients beforehand, just by the nature of their job. But your research and evidence does not—

Mrs Ginnane—No. We do not collect it by specialty.

Ms HALL—indicate one way or the other for us.

Mrs Ginnane—No. I just have no information.

CHAIR—Should you?

Mrs Ginnane—The information would have to come from health funds, and collecting statistics is costly. If it is appropriate for PHIAC to collect that information then government can ask us to do that and we will implement such a collection. But certainly we tend to try to get a balance between sufficient statistics to provide the information government needs and not imposing too big a regulatory burden on the health funds. Health funds would probably say it is still too big anyway but it is always a balancing act.

Ms HALL—It is a way that government can look at addressing issues if the statistics are very useful.

Mrs Ginnane—Certainly the information should be available at health fund level. It would probably also be available from another collection of data called the hospital casemix protocol data collection, which is received by the department, and they may be able to put that information before you.

Ms HALL—Is there a move within the industry towards larger and fewer health funds? Have you noticed that over a period of time?

Mrs Ginnane—I have been at PHIAC for some years now. There were 48 funds when I first became associated with the industry and there are now 39. What is interesting, though, is that in recent years the changes have been in the middle of the market, generally speaking. Large funds have market size and can compete very effectively with each other. Small funds are very good at establishing a niche, and they have a niche market which they often look after very well. I have visited health funds where every member who comes through the door is greeted by name; it is very hard to beat that as a marketing strategy.

Ms HALL—It is!

Mrs Ginnane—There appears to be a bit more impetus towards a merger among the middle sized health funds. In fact, PHIAC is at the moment dealing with a merger that took place between Australian Unity and GU—Grand United—at the friendly society level late last year, with the Federal Court's approval, and over time we will see the merger of the three health funds owned by that entity into one. There have been three health funds that have disappeared as a result of regulatory action—two of them quite definitely because of financial failure, and a third fund where there was a higher risk of financial failure, and significant other failures. That led to the organisation being better managed as a merged entity.

Mr GEORGANAS—The size of the membership obviously plays a big role. Being a regulator and seeing these things on a regular basis, would you say that, for the future, mergers would be the way to go, to ensure that we get a bigger membership in funds to make them more viable, instead of having 38 different funds?

Mrs Ginnane—There are a lot of small health funds, but they have been very effective in sharing costs. For example, the Australian Health Services Alliance—which has made a submission to you, I think—negotiates on behalf of most of the small health funds. It does hospital negotiation. That is a very cost-effective way of negotiating agreements, without the individual funds having to go out and do it 39 times. Equally, they have a computer system called HAMBS, which covers most of the smaller health funds. There are in fact a lot of small health funds that have outsourced critical functions, and that allows them to operate effectively. So I do not necessarily see a huge push toward fewer funds. The funds are actually spread out quite significantly around Australia. In fact, whilst there are 39 registered organisations, there is probably a maximum of 12 to 15 funds active in the markets of New South Wales and Victoria and probably only six or seven in the smaller states. So consumers do not necessarily have a choice of 39 funds. They have a smaller number to choose from, depending on where they are.

Ms HALL—Let us use Medibank Private as an example: with the government looking at doing a scoping study, the possible privatisation of Medibank Private and talk that maybe MBF will be the purchaser, MBF—and this is as an example—would be put in a situation where they would be by far the largest health insurance fund in Australia. Would that give them the ability to distort the market?

Mrs Ginnane—I think that is a competition issue that really needs to be addressed by the ACCC. From our perspective, Medibank Private is the largest of the 39 health funds. As a regulator, we do not regard its ownership as relevant; we simply deal with it. The competition regulator would decide whether or not any sale to any other entity in the industry is appropriate. It is not an issue for us.

Ms HALL—So you do not look at price manipulation at all?

Mrs Ginnane—If we became aware of any information around price manipulation, we would refer it to the ACCC. We have a right and a responsibility to refer breaches or apparent breaches of any Commonwealth law that come to our attention to the appropriate regulator. At times we have referred matters to ASIC and to the Australian Taxation Office.

Mr GEORGANAS—I suppose part of the role is to minimise the premiums. We have seen, I think, since 2000 a 33 per cent increase across the board in premiums, which is far higher than in most other areas. What do you put that down to? Obviously they have come through your office. For example, is it because of an increase in older people becoming members?

Mrs Ginnane—The Lifetime Health Cover policy in 2000 lowered the average age of private health insurance by about 2.3 years, but we have seen it start to increase again as the population ages. The information that we have and that we put in our report is that it is a combination of a lot of factors. There is a technology issue. For example, we have seen prosthetics double as a proportion of benefits paid on behalf of contributors in the last five years. Doctors' gap payments have been well in excess of overall inflation. Hospitals have received a lower payment in percentage terms than inflation but have had significantly increased usage. Our statistics indicate a growth in usage. They have had increased bed occupancy rates, and I think the ombudsman alluded to that earlier. There is a whole stack of different factors, such as the cost of pharmaceuticals and the fact that pacemakers are much more commonly used now but give quality of life. None of those can be looked at in isolation.

Health funds have seen certain parts of their business with inflation rates well in excess of 10 per cent and have, generally speaking, kept their increases to about eight to nine per cent over the last few years. I hesitate to be seen as defending the industry, but I think they do the best they can to minimise their prices because they are conscious that price is a factor. They take complaints, and we do too. It is very useful having the ombudsman, because I send most of those complaints to him. He is the complaints agency. Generally speaking, health insurance operates on margins that would simply not be acceptable to listed companies in any other insurance sector. They have very low underwriting margins, they have very low profitability and their management expenses are less than half of what we see in the life and general insurance industries. So, whilst I am sure they could always be more efficient and effective and do things better—and I think they are striving to—they also do some things well.

Mr GEORGANAS—The 30 per cent rebate was brought in five years ago. Are the funds in a better position now in terms of sustainability than they were when the rebate was brought in?

Mrs Ginnane—I think their capital position is about the same as it was at the time. The rebate has certainly helped consumers and helped to keep people within the private health insurance sector, but the capital position of the industry does tend to be a bit cyclical, and the position now is probably—off the top of my head; I would have to go back and check the figures to be certain—not hugely different from what it was five years ago.

CHAIR—Why is it cyclical?

Mrs Ginnane—I am not 100 per cent certain, but what we have seen in the past is that when health funds are or are seen to be quite profitable they take quite a lot of criticism—they are seen as ripping off their consumers, to use the vernacular—so they are less likely to be as tough as they might otherwise be in their pricing applications. Instead of asking for the eight per cent that they probably ought to, they might ask for seven per cent. So their position deteriorates over a couple of years and then, when they have to put their prices up to cope with the fact that they may be going to breach the prudential requirements, often the increase might be greater than it would have been if they had had an even level of pricing all the way through.

CHAIR—Is that uniform across the industry or does it happen one fund at a time?

Mrs Ginnane—It tends to happen a fund at a time, quite often, which is why you see some of the bigger increases on occasions, as we have done. Over the last few years, there have been two or three funds each year that have been outliers. Some of that has been as a result of PHIAC intervention, such as the one I mentioned before, which the ombudsman also referred to, because the organisation would not have survived without that price increase.

CHAIR—When the large price increases happen, is there much movement between funds?

Mrs Ginnane—There does not appear to be a lot of movement between funds. It is not particularly easy to tell. We do get some statistics on that, but they often lag the actual movement. But health fund membership seems to be fairly sticky. Generally speaking, people tend to stay with the fund they have been with. I think there is some evidence to suggest that the members that have joined since life-time health cover are a bit less sticky than the people that were in health funds before that, but it is anecdotal.

CHAIR—Your evidence has been very comprehensive. There are not many questions left to be asked either. But, as I have said to the other witnesses, if, during the course of this inquiry you become aware of something you should tell us that could be useful to us, we would appreciate hearing from you. Thank you for your evidence today.

Proceedings suspended from 12.11 pm to 1.06 pm

GEE, Ms Christine Alexia, Vice-President, Australian Private Hospitals Association; Chair, Australian Private Hospitals Association Psychiatry Committee; and Chief Executive Officer, Toowong Private Hospital

MACKEY, Mr Paul, Director, Policy and Research, Australian Private Hospitals Association; and Member, Strategic Planning Group for Private Psychiatric Services

McMAHON, Ms Janne Christine, Independent Chair, National Network of Private Psychiatric Sector Consumers and Carers; and Member, Strategic Planning Group for Private Psychiatric Services

OSBORNE, Mr Brian Leslie, Health Funds Representative, Strategic Planning Group for Private Psychiatric Services; and Chair, Australian Health Insurance Association Mental Health Committee

PRING, Dr William James (Bill), Australian Medical Association Observer, Strategic Planning Group for Private Psychiatric Services

TAYLOR, Mr Phillip John, Executive Officer, Strategic Planning Group for Private Psychiatric Services

CHAIR—Welcome. The committee does not require you to speak under oath, but you should be aware that these hearings are a formal proceeding of the parliament and that giving false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. Your field is becoming more of a concern in Commonwealth and state arenas. Seldom does a meeting in the government party rooms go past where mental health is not raised as an issue, and I am sure, Jill, it is also raised in the opposition party rooms. Would you like to make a brief introductory statement before we proceed to questions?

Mr Taylor—Firstly, I would like to thank the committee for the opportunity to appear today. The SPGPPS is a group that is convened by the Australian Medical Association. It is chaired by the Royal Australian and New Zealand College of Psychiatrists. The SPGPPS has functioned since 1996 as a strategic alliance of the major partners in the private psychiatric sector. The AMA, the college, the Australian government Department of Health and Ageing, the Department of Veterans’ Affairs, private health insurance funds, private hospitals, general practitioners, consumers and carers are all currently represented on the SPGPPS. The group operates on a consensus basis, and it has worked to produce some constructive and innovative change in the private sector.

Today I am joined by representatives of SPGPPS stakeholder organisations, who are able to speak on behalf of private hospitals, private health insurance funds, clinicians and consumers and carers. We have previously provided a submission and background material to the committee on the work of the SPGPPS, its centralised data management service and the National Network for Private Psychiatric Sector Consumers and Carers. We do not intend to expand on that during this opening statement, but my colleagues and I would be happy to take questions and to participate in the discussion, particularly in relation to the practical outcomes that can be achieved when diverse stakeholders work together.

I would like to pass on apologies from the Chair of the SPGPPS, Dr Yvonne White, who is currently in Egypt. Finally, with the permission of the committee, we would like to suggest that Ms Janne McMahon commence with her presentation of consumer carer issues in her capacity as Chair of the National Network of Private Psychiatric Sector Consumers and Carers. The national network provided a separate submission to your committee. After Ms McMahon’s presentation, we can answer questions in relation to the work of the SPGPPS and its centralised data management service.

Ms McMahon—When I checked the web site earlier in the week it was interesting to note that it appears our submission is the only one from a consumer and carer organisation, certainly within mental health, so I would particularly like to thank the committee for allowing us to speak to you today from a user perspective. It is important to state that I am a consumer of mental services and have been so since the late 1980s.

The national network represents Australians who contribute to health funds and who receive their treatment and care from the Australian private health sector for mental illness. We are the authoritative voice for consumers and carers concerning the policy and practices of provider and funder organisations in private mental health. It is also important to state that we clearly hear the calls and agree that private health cover must be sustainable and affordable. We understand that the costs of providing health care are increasing each year. We are told and we know that medical procedures and technology have improved, and medication costs escalate, demands increase and staff salaries increase. These have a flow-on effect to the cost of providing health and hospital care. I would, however, like to highlight that the only medical procedure that happens in mental health that we are aware of is ECT—electroconvulsive therapy.

I would also like to highlight that the cost of funding mental health care in the private health sector is a very small proportion of the whole, yet it is increasingly apparent that psychiatric care and rehabilitation are being targeted to decrease the overall health budget funding. It is clearly documented that the health costs for the over-65 age group are spiralling upwards, yet to suggest that this area be targeted for reducing costs would be met with outrage. We represent the most disempowered people in the community, and to suggest that they be further disadvantaged really is not acceptable.

Consumers are increasingly being caught up between hospital and health fund commercial-in-confidence negotiations. It is not appropriate to expect a mental health consumer—or any consumer, for that matter—to be sufficiently aware when being admitted to discuss whether their health fund has a contract with the hospital or not. The nature of mental illness mostly precludes planned hospitalisations—they are usually acute—and adds to the difficulties in fully grasping the implications of informed financial consent. It is not appropriate that a consumer is required to fund the differences and the gaps between the hospital and health fund by way of copayments—and I am not referring here to the excesses or front-end deductibles that relate to the product purchased from the health fund.

Clearly, our understanding of the highly complex nature of private health insurance is extremely rudimentary. We understand the need for a competitive marketplace in which to get best value for money, but we do not understand the inconsistencies in funding services, where a health fund can pay different hospitals different amounts of money for the same services, often in the same city. We are not talking here about the basic default or the second-tier benefits, but clear commercial negotiations. It could quite rightly be argued that it is not our business, but I think if it requires us to pay costly gap payments or copayments then I would say that it is our business. We certainly need to rely on the Australian government to act in our best interests.

We also understand that it is time that legislative and regulatory requirements for the provision of mental health care be reviewed as a matter of urgency. This is necessary to support health funds and to appropriate funding to private hospitals to enable them to offer services which can be delivered outside the hospital walls to support a true continuum of care. We do, however, hold concerns about reforms in private mental health funding. If the emphasis in funding and providing services swings from getting the best possible outcomes for consumers purely to cost containment or, indeed, cost reduction, then we become anxious about the introduction of these types of funding models. They really are not acceptable to us. We are grateful to have the opportunity of raising our concerns through our submission and also with you today.

CHAIR—As background, does anybody want to comment on the relationship between mental health in the private sector and the public sector?

Mr Taylor—The relationship between the SPGPPS and the public sector is mainly through the AHMAC National Mental Health Working Group in which we have an opportunity to work with the public sector on issues relevant to mental health with both the Commonwealth and state governments.

Mr Mackey—It is also worth mentioning that, probably more so than in any other part of health care, the two sectors provide treatments for different types of conditions. So they are complementary systems, really, very much in mental health. The public sector provides for some conditions and the private sector provides very much for other conditions.

CHAIR—Can you elaborate on that? I do not think we have the expertise to differentiate between the various conditions.

Mr Mackey—Sure. And I am sure there are others better qualified than I to do so.

CHAIR—I am coming in very much ignorant on this.

Mr Mackey—One thing we certainly can do is to give you on notice some of the data that shows the types of conditions that are treated in the different sectors. Bill, is there anything you want to say about the different conditions?

Dr Pring—Yes. We do have some information. It is not in colour, unfortunately which makes it a little less—

Ms HALL—Sorry to interrupt but, in giving that information, could you highlight for the committee the need for seamless movement between public and private and how that fits into the whole scenario of the different treatment within the different sectors?

Dr Pring—All right. I would quite like for Janne to also comment about this issue from a consumer and carer point of view. I think that might be different again. As a very rough guide, the public mental health sector, from what we understand from the information that is there in terms of diagnosis, treats a lot of people with psychoses, particularly schizophrenia and paranoid disorders. I think the figure is around 40 per cent. About 20 per cent of people treated have affective disorders, mood disorders: depression, mania and those sorts of things. Both sectors treat other conditions. In the private sector, we really have the bigger proportion of people with mood disorders. About 20 per cent of the people we treat have psychoses. So there is a difference that way.

Ms HALL—If a person had an acute episode, they would end up within the public psychiatric system in a normal response to that. Would that be fair to say? And people with private health insurance who are having more ongoing treatments would tend to—

Dr Pring—It depends how disturbed and how voluntary they can be. Obviously, if they are quite disturbed but okay with going into a private hospital and have private insurance, they are likely to be offered that early—possibly that would be the first thing they are offered if their GP knows that that is the case and they can be referred.

Ms HALL—And for nonvoluntary?

Dr Pring—If people are nonvoluntary, it varies between the states. In some states, it is possible for people to be admitted involuntarily into the private sector and in other states it is not.

Ms HALL—What percentage of people go into the private sector on an involuntary basis?

Dr Pring—I am not so sure about that.

Ms Gee—We could probably take that on notice. I think it was around 10 per cent.

Mr Mackey—It varied a bit. There are only a couple of states governed by state legislation for whether or not private hospitals can admit involuntary patients.

Ms Gee—So in Queensland and South Australia you are able to. But they are the only two states. In those states, I think it was around 10 per cent.

CHAIR—But they can be admitted to a public hospital involuntarily in other states?

Ms HALL—Yes, that is where most of them go.

Ms Gee—The difference with state legislation is that, if someone is made an involuntary patient, they cannot legally be admitted into a private hospital in any state other than South Australia or Queensland.

Mr Taylor—We, as the SPGPPS, have asked the National Mental Health Working Group, when the states are reviewing their legislation, to look at the issue of enabling involuntary patients to be admitted into the private sector in those states that are not doing it at present.

CHAIR—So you want that to happen?

Mr Taylor—Yes.

CHAIR—Why doesn't it?

Ms Gee—I think it comes back to the legislation of those individual states. I can only speak about Queensland, having worked in a hospital there. When the Mental Health Act was reviewed and there was discussion about making involuntary patients able to be treated only in the public sector, the consumer movement jumped on board and argued very strongly that it should not be limited to just the public sector and that, if patients were normally treated in the private sector and had private health insurance then if they became unwell in such a way that they had to be involuntarily detained, it would be preferable to do that in the private hospital that the patient would normally go to.

Ms HALL—That links in with the other information that you have in your submission. I am sorry for interrupting you.

Dr Pring—Obviously we are always trying to improve on overall seamlessness. We acknowledge that it is not always perfect. It comes down to communication a great deal of the time, and the quality of the GP, as the link between systems and treating people, is important. I think Janne might have a comment.

Ms McMahon—It is an interesting situation in the public sector. They certainly have good, intensive case management, particularly in the community, but they do not have continuity of treating psychiatrists. Patients see the hospital psychiatrist, who is usually a registrar on rotation every six months. It does not lend itself well to psychotherapy and that type of treatment. One would think that the best of both worlds would be to have a private psychiatrist who provides ongoing care and then reap the rewards of the public sector in terms of case management and community care, which is only undertaken in a small way in the private sector. Unfortunately, there is a lack of communication as a general rule between those public sector facilities and private psychiatrists. An example would be that medication regimes can be changed, treatments can be altered by the hospital registrar after a new patient episode and that information does not get back to the private psychiatrists. There are still lots of areas that are contained in either public or private. As much as we would like them not to be, that is the case.

CHAIR—In the event of such an episode, who refers the patient to the public hospital? Is it the psychiatrist or the GP? I know it would vary depending on the circumstances.

Dr Pring—It is usually the GP.

Ms McMahon—It is the GP, or if you had a private psychiatrist and they felt that in-patient care was necessary and someone was not privately insured then they would refer them to the public sector service.

Ms HALL—How can we get around the situation that exists at the moment? What recommendations do you have for the committee in relation to this matter?

Ms McMahon—I think that community care is essential. We see that in the public sector with their mobile community teams and crisis teams and their multidisciplinary approach—they have social workers, psych nurses, psychiatrists et cetera—which we do not have a lot of in the private sector. I would like to see more community based services in the private sector outside of the hospital walls.

CHAIR—Paid for by private health insurance?

Ms McMahon—Yes, it would be picked up by them. But my understanding is that at the moment that cannot be done because of legislation requiring people to be an admitted in-patient. In my view, and I think it is borne out by the hospitals and health funds in their submissions, that would broaden the services that can be carried out. You are also looking at preventative type programs that currently cannot be provided in the private sector. If we could get in early on in someone's episode then perhaps hospitalisation could be avoided altogether, but again we run into the legislation. So we, as consumers and carers, would like to see some real reviewing of those legislative predicaments that just preclude these services from being offered.

Ms HALL—I notice in the submission that one of the issues you raise is a better integration and partnership between the public and private sectors. How do you see that that could be done, and what steps or recommendations should this committee make in that area?

Ms Gee—Maybe I could just make a couple of points before answering that question. Looking at a comparison of the demographic and the diagnostic populations that are treated and admitted into the private sector and those admitted to the public sector, they are clearly very different, so it is probably the area where the private sector is generally treating a different group of people to the people that the public sector are treating.

Ms HALL—Would you expand on that for us?

Ms Gee—Just in terms of different diagnostic categories. So in the private sector, as Bill indicated, you are seeing more people with mood and affective disorders, and that is not to say that those conditions are any less acute than the ones going to the public services.

Ms HALL—So conditions like depression and anxiety?

Ms Gee—Major depression, anxiety, obsessive compulsive disorders, eating disorders and postnatal depression.

Ms HALL—So that type of thing.

Mr Mackey—Addictions.

Ms Gee—Yes, very much addictions. In fact the private sector provides about 92 per cent of same-day alcohol and drug treatment and rehabilitation services. So I think that is one of the differences—that the two sectors are treating quite different groups of people.

Ms HALL—What about the demographics?

Ms Gee—We actually have some information from both the Australian Institute of Health and Welfare and the SPG CDMS unit that we could provide to you.

Ms HALL—That would be very useful.

CHAIR—We will more than likely be going to Queensland. Could we visit your hospital and could you show us first-hand what happens?

Ms Gee—Certainly.

CHAIR—It is a sort of taboo subject that we do not ever get involved in.

Ms Gee—We would be very happy to show you around.

CHAIR—This is very, very novel.

Ms HALL—Would you like to continue with the answer?

Ms Gee—The two sectors are actually catering for different groups and some of that may well be to do with the patients with a mental health disorder who are able to continue with their private health insurance as well. Certainly the public sector seem to have homed in on what is largely a schizophrenic type population, although a number of schizophrenic episodes are treated in the private sector as well.

Ms HALL—Bipolar tends to be treated in the private sector a lot.

Ms Gee—I think it is treated across both sectors as well.

CHAIR—How many of the patients who receive this type of treatment are in the work force?

Ms Gee—In the private sector?

CHAIR—Yes. If they can afford private health insurance, I am just wondering how they can afford it. They must be in the work force.

Ms Gee—Or they may be with partners or families who have health insurance. Or they have grown up with a mental illness and their families keep private health insurance for them.

Ms McMahon—I think it is also important to note that a lot of children can be covered under their family health insurance until about the age of 23 with most health funds.

Mr Osborne—I could try and illustrate the question that you are asking. Back about seven years ago I attempted to access public services for some private patients. The situation was seemingly quite straightforward. The public sector that I was talking to in South Australia said they had a lack of access to private psychiatrists for their patients and in the private system patients do not have access to some of the very good community services that Janne had mentioned. So you would think that there would be a natural trade-off there. We are used to dealing with complex problems, but it actually hit a number of barriers that are probably illustrative of some of the problems. One is, as Janne said, the inability of funds through the legislation to pay for the doctor’s services outside of the hospital.

With no disrespect to the Public Service there also sometimes seems to be an attitude that private patients should get put down the bottom of the list and have less priority to access those services, which seems strange, as they still pay their Medicare levy, on top of their private health insurance. The other thing that came into it was the concept of the reinsurance clause, which I am sure you are all familiar with. It is a little bit perverse, I have to say, in that, if I pay for someone to go into a hospital for an acute episode and they are over 65 or spend more than 35 days in hospital, a large part of that—say, half of that—is claimable back through insurance but, if I pay for community programs, support programs, preventative programs or disease management type programs, it is not. So there is actually a perverse incentive to put them into hospital rather than not to. The only other barrier at the time was dealing with the South Australian government and the local area government, which was becoming very difficult—but that may well have improved now.

Ms HALL—In your submission you make what I think is a fairly valid point about the sharing of information about private consumers or patients who are in a public hospital and the fact that a different medication regime can be organised without consultation with the treating psychiatrist or whoever in the community. What recommendations would you make to the committee in that area? How can we address that?

Dr Pring—I think that a lot of that is about communication. One of the big advantages of this alliance group that we are in is that we are all talking to each other about problems within our sector—about communication and communication with GPs, for instance. GPs are around the table too in our alliance group. It has been a great opportunity to try to get much better communication in our own sector. In this group we have particularly focused on communication within our own sector. Now we are, in various ways, seeing how we can improve the communication with the public sector.

I would like to point out, though, something that may not be immediately apparent to you. As far as private psychiatrists are concerned, 10 per cent of their services are delivered in private hospitals and 90 per cent of their services are delivered in the community. To an extent, private psychiatrists can act as case managers for people with chronic conditions in the community. We actually get, and I personally have received, many referrals from the public sector when people are being discharged from their services. I wonder about that sometimes because these are people who we know are likely to have to go back into hospital. The public sector people say, ‘Oh well, we’ll admit them again if they need to come into hospital.’

But if they come to see me and I try to engage services from the public sector they are usually precluded because they are theoretically in the private sector—but they do not have private insurance. So these are key problems. Perhaps I should not be talking about it in great detail but I am just trying to give you a view of the complexity of the sector. There are people who do not have private insurance who are seen by private psychiatrists. It would be good if some of those community services were available for those people, but we are also trying to develop community type services for the private sector.

Ms HALL—So a scenario could be that a public hospital refers a patient or consumer to you, that person has an acute episode and goes back into hospital, there is no communication whatsoever with you and they can refer them back again—and this could keep going on?

Dr Pring—And, as Janne said, their treatment might have changed in a way that I might not think best for the long-term stability of the person. It is very frustrating sometimes.

Ms HALL—There is obviously a need for better communication there.

CHAIR—Is this a form of cost-shifting to the Commonwealth by the states? Obviously, they want to get rid of their public patients to private psychiatrists who are being funded by Medicare.

Dr Pring—There is an element of that in it, although I do not think it is necessarily highly conscious. But it is silly to be not providing services to people who do not have private hospital insurance but do have chronic conditions and are likely to come to attention at some stage. In a sense, it puts a burden on our sector, because when you have a patient like that you end up having to see them much more frequently. I see some of those people every two weeks, to try to maintain stability. That is my time occupied; I am not seeing other people. If there were more community facilities in the public sector for people with ongoing conditions it would probably free up psychiatrists in the private sector to do even better with people with private insurance who are not getting adequate private services.

Ms HALL—But the decision to discharge a person from a public hospital is not driven by the fact that they want to get them out of the state facility and have that person’s treatment covered by the Commonwealth. Rather, is it not driven by the fact that the person no longer needs that hospitalisation in the acute sector and should be treated in the community?

Dr Pring—I am sorry, I am not talking just about discharge from hospital after admission. I am talking about discharge out of the public mental health service when they are supposedly fixed but we know, both of us, that the person has got an ongoing condition—otherwise why would they need to come and see a psychiatrist? It is just another complexity to it all.

Ms HALL—What state are you in?

Dr Pring—Victoria.

Mr Mackey—In relation to people with chronic ongoing conditions, funding is an element though—how well funded either the public system or the private system is. Every national mental health report that comes out says that around 6½ per cent of outlays are spent on people with mental illness. It is even lower than that in the private sector, where only around four per cent of health fund benefits are spent on the hospitalisation and treatment of people with mental illness. So there are clearly issues around funding, and any move towards greater provision of services in the community needs to be considered against the background of inadequate funding to start with. If you are looking for a solution, the solution is more money. It is the key to more services being provided.

Ms HALL—No-one could argue with that.

CHAIR—If we were starting from scratch, how would you recommend that mental health be treated? I am not really familiar with the history of what has happened in mental health over the past few years. We do know that the states have passed on the responsibility for mental health. I saw the *Four Corners* program the other night, and I think everybody here would have. That sort of situation in a country like Australia is unbelievable to me. Where did we go wrong, and what should we do to fix it? Where do we start?

Dr Pring—I think where it starts off is actually in the community. I will let others say more about this, and I think Janne will have a comment about it too. I think it starts in the community with the lack of funding for mental health services. I think it is one of the last stigmatised conditions in the community, and I think the situation starts with that stigma and people not wanting to know about it. So, even though it is a big cause of morbidity and mortality in our society, it has not been given sufficient emphasis or funding appropriate to the level of the problem that we have in the community. In a sense it might simply come back to that—that in some ways we need the leadership of our politicians to try and correct that, so that people with mental illness are not looked after in Third World conditions when they can have heart conditions treated in First World conditions.

Mr GEORGANAS—Has there been a deterioration in the services that we are talking about or wasn’t it highlighted 20 or 25 years ago? As someone who has been in the area for a long time, you might be able to answer that.

Dr Pring—It is very hard to tell, because there has not been a lot of measurement of what has been going on. That is one of the things we are proud about as a group: that we actually have an outcome measurement database going of treatment in the private hospital sector. That was a major exercise that we managed to get going. We can now, if we change models of care, look at the outcomes before and afterwards. There is an impression overall in the community that the mental health service is faltering at the present time because not enough community services have been put in place, with deinstitutionalisation and the decrease in hostel care.

Mr GEORGANAS—If that is the problem, did we have more community services in those days 25 years ago when it did not seem to be a problem or was it again something that was not highlighted back then?

Dr Pring—The asylums were sold off and now they are housing estates and golf courses. But unfortunately when that happened there was a need for ongoing and much greater funding for community services. It costs more to provide diversified services in the community than it does to provide them in one great big asylum. That has not ever really been fully grappled with.

Mr GEORGANAS—That could have been the turning point.

Ms McMahon—When we talk about services in the community, we cannot underestimate their value. They are critical and crucial in maintaining someone in the community and at home in a functional state. That is irrespective of whether they are privately insured or not. We have in the public sector community support teams. Clearly, funding is a huge issue for that particular area. But it is something that I would like to see coming into the private sector and being accepted to a much greater extent.

Currently, there are 46 hospitals, or thereabouts, with psychiatric beds, but only 12 of those have in place an Australian government approved outreach service—which means that community care services can be delivered and funded by health funds. The alternative for people who are privately insured, if they cannot access that care because of legislation, is an acute inpatient admission. They have shown clearly that they are cost effective. They suit consumers. Consumers of community care have shorter length stays if hospitalised and hospital admissions have been prevented by more community support. That is something that we as consumers and carers would like to see embraced more in the private sector. It is something that is embraced in the public sector but we would like to see it more so in the private sector.

Mr Taylor—From the Commonwealth’s perspective, it is really making sure that the money that is allocated to mental health actually ends up in mental health once it reaches the states. You need to be able to know what you are getting for your money. Our CDMS came about very much from being able to demonstrate to health funds that they are getting value for money and that people are going into private hospitals quite sick and then coming out well.

Ms HALL—You mentioned health funds, and that is where I wanted to go. Some of the evidence we received this morning was that restrictions were being placed on consumers or members of private health insurance funds in relation to psychiatric services. Even in your submission you make a comparison between people who have ongoing dialysis and people who are receiving mental health services. Do you feel that currently some health funds are actively discriminating against people with psychiatric illnesses? Do you think that there needs to be some guidance from government to ensure that people with psychiatric illness are treated in the same way as somebody who has heart bypass surgery or has problems with ongoing dialysis or whatever? Janne seems really keen to answer this.

Ms McMahon—I guess that is because the submission that you are referring to is from the national network, rather than the SPGPPS, so I actually put this together with my colleagues. When you raise those issues, you are raising something that we have written about. Yes, we have drawn a parallel to renal dialysis. There are, through the commercial-in-confidence negotiations, hospital purchaser provider agreements. The health funds and the hospitals come together and decide on what benefits they will pay to someone for a service. There is increasing evidence of more copayments being required. If there is a breakdown in those negotiations—

Ms HALL—More copayments for people—

Ms McMahon—Yes, that is right.

Ms HALL—that are having psychiatric treatment?

Ms McMahon—Yes, and I think it is all around chronic illness. It is a difficult management sector.

Ms HALL—You are saying that one chronic illness is being treated differently to another chronic illness.

Ms McMahon—In our view, yes. It is our view that psychiatry, although we are told it is only four per cent of the whole of health funding, appears to be being targeted more and more to save money to pay for procedures and technologies like heart defibrillators and those sorts of things. It appears to us that, yes, we are in a difficult situation where they are taking from us, from psychiatry, to prop up the other areas of health funding. That is how it appears to us.

Ms HALL—Why do you think that is?

Ms McMahon—I do not think psychiatry is a good area to invest in, in that it is very often chronic and whole of life. It can be episodic: you can be relatively stable but then have an episode which requires acute inpatient care in a private hospital. Again, some of this could be reduced or avoided altogether if the health funds were able to be freed up enough to pay for those services. It is terribly complex and I cannot profess to know all the answers or even understand the issues around the funding of services, but it does appear to us that, yes, psychiatry is being targeted at other areas—like, perhaps, renal dialysis. The other thing is that if you do not have renal dialysis you are dead, essentially. It could be that, in psychiatry, if you do not get the proper treatment you are also dead, but you can categorically say that without renal dialysis you will be dead.

Ms HALL—So do you think it is the stigmatisation and stereotyping of people with mental illness that is the problem? You do not pick up your daily newspaper and read in it that a service station has been held up by a person who is currently receiving renal dialysis, whereas you might say that a service station is being held up by Joe Blow, who is suffering from schizophrenia.

Ms McMahon—Yes.

Ms HALL—Do you think that that sort of approach makes it easier for health funds and other organisations within the community to back away? This probably goes back to my discrimination question at the beginning.

Ms McMahon—I do not believe that the health funds would take notice of social discrimination in making and determining the benefits that they were going to pay. I think psychiatry can be a costly area because of the chronic nature of mental illness. For example, I have received ongoing care since the late eighties. I have had seven or eight acute in-patient admissions. Am I likely to again? One hopes not, but quite probably. I do not think that the health funds fund services based on discrimination in that sense.

Ms HALL—Maybe I did not say it as well as I could have. The simple fact that that community attitude exists towards people that are in receipt of psychiatric services and that those people—particularly when they are having an acute episode—are not as powerful and cannot argue as strongly for the services and the access to services that other groups can leads to a situation where there are these subtle forms of discrimination.

Dr Pring—That is true but, to give them credit, they are at our table and they are trying to work through a lot of those issues.

Ms Gee—I am going to pop a private hospitals hat firmly on in saying this. The National Health Act requires that any waiting period in relation to health insurance benefits for psychiatric products must not exceed two months. Of concern, definitely to private hospitals, is that that does not preclude health funds from putting in restricted benefit periods or benefit limitation periods whereby a fund would only be required to pay a patient who required treatment for a mental health condition the basic default benefit rather than a full benefit. Some of those benefit limitation periods can be up to three years.

Ms HALL—That is enormous, isn’t it?

Ms Gee—And some of them can be a lifetime in some products.

Ms HALL—That is treating one illness very differently to another illness, isn’t it?

Ms Gee—Very much. Probably of great concern—definitely to the psychiatric hospitals—are the health fund products that are targeted specifically at younger people but include restricted benefits for mental health services. I do not think that that is a fit purpose product when you see the increase in mental illness.

Ms HALL—Particularly in that age group.

Ms Gee—Particularly in that age group, definitely. The APHA provided a submission to the mental health inquiry. We detailed in that a number of things taken from health insurance fund web sites. The number of health fund products that have this health benefit limitation period is quite surprising.

CHAIR—How does this affect contracting?

Ms Gee—It is above contracting. It is a limitation on the product, not on the contract. But certainly that is another way that funds can limit what they are going to pay in the way of psychiatric benefits. For example, a contract between a hospital and a health fund could provide another level of benefit limitation period, so it could be negotiated through a health fund contract that a patient could only receive 10 same-day episodes in a 12-month period—or however many days in a 12-month period.

CHAIR—How many private hospitals would provide mental health services?

Ms Gee—In Medsearch hospitals, there are 25 stand alone and 19 wards or units.

Ms HALL—Could you provide to this committee a copy of the submission that you made to the Senate inquiry? That would be very useful.

CHAIR—We can get it from the web site.

Ms HALL—But, if it was submitted to this committee, it would be then considered as part of the inquiry—as opposed to if we get it from the web site.

Ms Gee—There was a submission and a further submission.

Ms HALL—If you could do that, that would be wonderful.

Mr Osborne—That is an illustration of how complex this is. I am trying to remember my original train of thought before the comment; I think it was that I would like to try to dispel any idea that there is any active discrimination by funds towards people with mental health issues. We should be able to recognise that these people, as much as anybody else, are our members, our business and the hospitals' patients, and it does not serve us well to lose any member—they are our business.

Ms HALL—So why do you have a situation, similar to the one that Ms Gee identified to the committee, which to me looks like some form of discrimination against people with mental illness?

Mr Osborne—Are we talking about benefit limitation periods?

Ms HALL—Yes, specifically relating to mental illness, among other illnesses.

Mr Osborne—My answer to this is the same as the one I gave to the question about whether there is less funding. I have said in the SPG and in other forums that when money is in short supply—and I do not think anybody is suggesting that in the private or public sectors there is surplus money—any area of cost gets looked at, not just psychiatric care. I think the suggestion was that funding within funds generally for psychiatric care was in the order of four per cent—our figure is five per cent—of the budget for, in my particular fund, 2½ per cent of our members. It is a relatively costly area, but it is certainly not the only other area, as Janne pointed out before. Chronic physical diseases are much more important to us. In one fund I work with, members over 65 account for 14 per cent of our membership, but they account for 51 per cent of everything we pay, which amounts to some $300 million nationally.

There is an awful lot of work in this area of mental health—and maybe in other areas I am not aware of. That goes into trying to manage those patients better. I have been involved in a project that has taken three years of my life up until now. We have a lot of costs that go into prostheses; we have a lot of costs that go into cardiology; we have a lot of costs that go into rehabilitation; we have a lot of costs that go into a whole range of areas. What I have said is: do not feel that mental health gets picked on. I know it probably feels that way sometimes within the sector but, when the money is tight and the funding has to be looked at judiciously so that you get the best outcome you can, every area gets looked at.

I have no doubt that, if we were to agree that 10 per cent should be spent on mental health and I went to the cardiologists, nephrologists and every other discipline and asked how much more they wanted, we would end up spending 200 per cent of what we have. But we do not have 200 per cent, so we have to make the best use of the money that we have. That is one of the bonuses of the SPG—that we have been able to look at different ways of funding that give us more bang for our buck, more value for our dollar and a better use of the money that is available within the area.

Ms HALL—We have not been approached by cardiologists putting forward that sort of argument. It seems to be very much directed towards this area, and the evidence that we have received in relation to mental health and mental health services has been a lot stronger than in any other area.

Mr Osborne—I think it is an area that is becoming much more aware and has been, to a certain extent, a hidden problem in the public sector—and possibly in the private sector too. But I have no doubt that, if I were to go to cardiologists and ask whether we are spending enough on cardiology—preventative programs, cardiology generally, drugs awareness—they would probably say no. I imagine that most other clinicians would say that their area deserves more attention too.

Ms HALL—But these restrictions have been put in place.

Mr Osborne—I think the point was raised by the ombudsman this morning that there are only two funds with BLPs, as I understand it. I know that one of those funds is in the process of removing its BLPs to a simpler level of tables so it is more transparent to patients. I make the point that BLPs were put in there historically years ago to stop hit-and-run members signing up today, having their operation tomorrow and then dropping out of the private health sector.

Ms HALL—Ms Gee, would you like to comment on that?

Ms Gee—I think Paul was about to.

Mr Mackey—You will find there are some issues around the language and the way things have been described—as to whether it is a benefit limitation policy or a restricted benefit. You will see from the submission that we will provide you with that as it details down there are certainly a lot more than two who have limitations of some sort before full benefits are payable. As Christine said before, some are three years and some of them are for the life of the policy. It is true that there is one particular fund that has a restriction that only affects psychiatric and rehabilitation benefits.

I will make an additional point, following up on what Christine was talking about in terms of the limitations. The other issue related to that in funding is that there are gaps and differences for consumers, depending on which fund they might belong to. Janne mentioned the outreach programs before. There is a Commonwealth approved process that you go through. It is a very detailed process, where applications are assessed. You say, ‘This is the sort of program that we want to offer’, and it gets a tick at the end of it. There is no guarantee that any fund would then actually cover that. In some cases, one fund might, and, if you are lucky enough to belong to that one, you might be able to access that program. That program might be really good for someone else, but that fund has said, ‘No, we’re not going to cover that.’ That is another issue involving gaps across the system that is a considerable problem for consumers.

Mr GEORGANAS—Shopping around for prices et cetera would be very difficult for someone suffering from—

Mr Mackey—It would be. But the problem with the one I just mentioned is that you would not know, because the fund would not say, ‘We don’t cover X-type of outreach program.’ It would only be when you needed to access it that you would find whether it was actually covered or not. So there are two levels. At one level of the macro things, if you like, there is disclosure of what policies will cover—but, because other things occur within the contracting framework, that is never disclosed to consumers at the front end. It is only when they need to go and access the service that they discover it has a limitation or is not covered at all.

Ms HALL—So there are disclosure issues too.

Ms McMahon—There are probably five areas of major concern. One is the portability issue, which is now being resolved—or it will be, as I understand it, from 1 November. Another is the issue of limitations, which we are talking about now. For example, the health funds may only pay for 12 ECT treatments in a year, whereas a good clinical outcome may need 18. As Paul said, with some services you arrive at the hospital and you do not know whether you are covered, because a lot of this is in the commercial-in-confidence negotiations.

We are concerned about portability, limitations and copayments. Copayments can come out of limitations and they can be significant. You can look at a $50 copayment for a one-day program once a week. The program might run for eight weeks, so you are effectively looking at $400 out of your pocket. The copayment issue is a real problem for us. There is a particular health fund that will only pay, I think, 30 days admission for a period, one admission being 30 days. It is not unrealistic in mental health to be in hospital for an extended period of time—although, admittedly, the length of stay is reducing all the time. If you needed perhaps three admissions in that calendar year, or on that per annum basis, then you are looking at a lot of costs coming out of your pocket as well. So copayments and the limitations are a real issue for us—the exclusionary products. When you are 20, it is very hard to know what is going to befall you in the future. It is very difficult to comprehend the reasons for the exclusionary products.

There are disputes between hospitals, which we have seen publicly in South Australia and in Victoria, where those negotiations simply broke down. It was pretty much resolved in South Australia, but in Victoria consumers who would previously have used that hospital had to either find a different treating psychiatrist who had admission rights to that hospital or go elsewhere. It is a very difficult situation for us, knowing what we are covered for and what we are not—knowing, when we roll up to the hospital, whether we are covered or not and whether the hospital has a contract with our health fund or not. That comes into it. We do not know those things; they are not disclosed to us. There are a range of issues that in our view really need addressing.

CHAIR—What about regional Australia? Are there any problems specific to regional Australia?

Mr Mackey—Yes, regional Australia is a huge problem. Most psychiatric hospitals are city base—predominantly so. It means that people from the country need to travel to the city to obtain psychiatric care.

CHAIR—That is in the public sector?

Ms McMahon—No, that is in the private sector. You find that a lot of people in rural areas actually do not have private health insurance because they cannot access it. Nevertheless, a lot of people keep their private health insurance in the mental health area because they know how important it is, and they know it can be a whole-of-life situation.

There are huge problems there. Telepsychiatry is one way of overcoming some of those problems. I understand now that the psychiatrists are paid for under Medicare, but I do not believe the hospital receives any reimbursement from any source—either from the

Commonwealth or from health funds—for providing that service. That is certainly something that we would like to see expanded. I think it is something very useful and very worthwhile and is a very good service. But there are huge issues.

There are no resident practising psychiatrists in rural areas either. That is a huge problem. You find that, because of the closeness of the community in rural areas, people will not be seen entering a mental health office or community mental health facility, because of the stigma attached to mental illness. You run into them socially, perhaps work-wise—the local banker and that sort of thing. There are huge issues around that. What the answer is, I have no idea. I think it is something we all struggle with—and not just in mental health but generally.

Dr Pring—There are three things I, as a psychiatrist, would quite like to say. One is that the strengthening Medicare safety net is probably quite a useful thing for people with chronic illnesses that still are able to earn an income or have access to an income, and that includes people with psychiatric illness. It really has been a help to people who have large medical expenses through no fault of their own, especially with conditions that are chronic or repeating. It is quite a useful economic improvement in the situation under Medicare.

Secondly, I would like to draw attention to the fact that, really, we are very lucky in Australia to have roughly evenly balanced private and public systems. I think that gives the health care across the nation a lot of strength: if one is suffering a bit, the other can come in a little bit. As I was saying before, private psychiatrists are private in a way, but they are treating lots of people without any private hospital insurance. The two systems compete against each other in other areas, seeing how good they can be. I think we are very lucky. I think it would be very good for there to be some consideration, when the public sector is having some difficulties, of other ways that the private sector can be used—particularly for some of those issues about rural, remote and regional areas, because telepsychiatry rebates, for instance, are ridiculously low. We do have telepsychiatry rebates, but I would not support—

CHAIR—What is telepsychiatry?

Dr Pring—That is where you deliver services with a video conferencing link. The other thing is that standards—

CHAIR—Is that through another doctor or direct to the patient?

Dr Pring—It can be direct to the patient in some cases but, in terms of the rebates, it is with a linkage to the general practitioner as well, of course. The third thing, which you may or may not realise, is that private psychiatrists draw the lowest amount of rebates of any specialty, including general practice, from the CMBS. There has been a conscious government policy—and I address this to you because it is a federal government matter—to try to limit the amount of rebates that specialists other than GPs get. There has been a specific limitation. Psychiatrists see people who are often financially disadvantaged. A lot of people with mental illnesses are not able to work, so we are often rebating people to the same extent as GPs.

Politicians have said to me that people cannot get in to see private psychiatrists, but who, as a young doctor coming through, would want to go into psychiatry when it is very hard to run a practice of sufficient standard? It is not just about money in the pocket; it is about running a practice of a sufficient standard that you can be proud of. If the rebates are too low, you cannot do it. For the first time in 20 years, this year I have stopped taking referrals directly from the public mental health sector, and that is because I cannot afford to do that too much more. I will take them from GPs but not directly from the public sector. It is for that reason. Something could be done about that by the federal government.

CHAIR—We have quite a number of things to think about as a result of meeting with you. The committee appreciate you making the effort to come all this way and talk to us. If there is any other information you would like to give to the committee, we would welcome it. I was serious about that visit to Queensland. I have never been to a hospital that treats psychiatric patients.

Mr Mackey—We will liaise with the secretariat.

Ms Gee—We would love to have you.

CHAIR—All right. There are many more members of the committee, by the way, but in the first week after parliament it is a bit hard to get them down to Canberra because there are other things on the agenda. But I am sure that in Queensland we will have a bigger turnout. Thank you very much indeed.

Proceedings suspended from 2.11 pm to 2.16 pm

SCHNEIDER, Mr Russell John, Chief Executive Officer, Australian Health Insurance Association Ltd

CHAIR—Welcome. I am required to point out that the committee does not require you to speak under oath. You should understand that these hearings are formal proceedings of the Commonwealth parliament and that giving false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. Having said that, I invite you to make a brief introductory statement.

Mr Schneider—As you know, I have been before the committee before. At that time I made the point that I believed there should be greater information made public about the financial position of individual hospitals, not only to improve community understanding of the role that the private sector plays but also to assist policy makers such as you to more adequately assess the veracity and the credibility of claims that are made by the various parties about health care financing.

I have been in this position for 22 years and I have concluded one thing: although we hear so many claims about concerns for the patient, in many respects the patient happens to be nothing more than a conduit for the transfer of funds from one area—that is, the payers, whether they be governments, who are taxpayers, or health funds—to providers, whether they be doctors or hospitals. As one who represents about 10 million people who have private health insurance in one form or another, I think it is incumbent on all of us to be making sure that that transfer happens in the best interests of the patient and emphasises improved outcomes rather than improved incomes.

Private hospitals have of late attempted to argue that they are suffering because their share of private health insurance benefits is declining. They then contrast benefits paid per episode or per bed day to justify this claim. Unfortunately, their commercial behaviour is quite contrary to the submissions that they make. Direct private hospital incomes from health insurance have increased by 61 per cent between 1999 and 2005. Payments to private hospitals have gone up from $2.3 billion to $3.7 billion. So the pie has increased very dramatically and, with your indulgence, I would like to table a graph that shows the breakdown of benefits paid to private hospitals.

CHAIR—Is it the wish of the committee that that be made an exhibit? There being no objection, that is so ordered.

Mr Schneider—The reason for this is not just the growth in benefits, although benefits have increased over that period, but, as the ombudsman pointed out, there has also been a very significant growth in volume. Since 1999, overnight stays have risen by 36 per cent and same-day surgery, either in private hospitals or freestanding day surgery units, has increased by 88 per cent. When you multiply the increase in volume with the increase in benefits, you will then see that the total increase in private hospital incomes from health fund contributors has risen by at least 61 per cent in that period, and in that period premiums rose by only 37 per cent.

To put it another way, the increase in volume coupled with increases in benefits means that the benefits paid per private hospital bed, which you might term the unit of production, have increased by an average of 44 per cent for overnight accommodation—from $93,000 per bed in 1998 to $135,000 in 2004. Freestanding day surgeries have increased their income even more spectacularly—from $41,000 in 1998 per bed or lounge, or whatever they may call the thing that patients occupy while they are being treated, to $89,000, or by 117 per cent, per bed. Again, I would like to table graphs showing the increase in benefits per bed per private hospital.

CHAIR—Does the committee accept those as exhibits? There being no objection, that is so ordered.

Mr Schneider—The comments that are made in this place by private hospitals, with what I suggest is the direct intention of leveraging higher benefits which must be reflected in higher premiums, are in marked contrast to the comments made to the stock market and, indeed, their own investment activities. Money is going into consolidation in the private hospital sector. It may be a commercial decision to put the money into consolidation rather than investment in capital equipment, but investment in capital has increased over the last few years compared to the previous years. As a result of recent consolidations in the industry, you can now put a value on a private hospital bed of somewhere between $263,000 and $288,000, depending on which purchase you regard as being the most accurate reflection of this.

We heard a lot about the problems of the psychiatric sector a few moments ago, but that is not reflected in investment behaviour in the psychiatric sector. In 2001 there were 24 freestanding psychiatric hospitals with 1,369 beds. Last year there were 25 psychiatric hospitals with 1,441 beds. If the private health insurance system was so mean, one would expect a reduction in services rather than growth, but obviously entrepreneurialism is suggesting that it is a worthwhile investment. If health fund benefits are not keeping pace with investment expectations that is a commercial matter, but not one that should affect public policy.

Ms HALL—Do you think that could have a relationship to the increase in psychiatric illness in the community as well as to the commercial issues you have raised?

Mr Schneider—With the greatest respect, you would not invest in those facilities if you did not expect to get a reasonable return. Regardless of the demand, you are not going to invest in purchasing something if you are not going to make money from it, unless you are a very bad investor.

Ms HALL—With equal respect, some of the evidence that we have heard tends to indicate that it is the actual consumers that bear the costs as opposed to the hospitals.

Mr Schneider—It is true, whether it be medical gaps or hospital copayments, that the gap is a distance between two points and you can bring the gap down if you bring the price down, as well as reducing the gap if you increase the benefit paid. So it is a two-way street. I think you have to take into account, when considering what policy measures to put in place, whether you are meeting the genuine needs of consumers or simply meeting the income expectations of the providers. I think it is incumbent on the parliament to ensure that the consumer is protected. As I said, we should be putting our emphasis on outcomes, not incomes.

I do not ask the committee to determine which set of facts are accurate. But, given the demands for policy intervention, I think it is in the public interest as well as the public purse interest for the committee to recommend greater disclosure of individual financial performance of hospitals to assist rational debate and policy conclusions on these issues. I do not make a comment one way or the other about who is right; I simply say that you cannot make a judgment in ignorance of all the facts.

The chief executive officer from PHIAC was here earlier. She could have—and no doubt will if you ask—provided you with the PHIAC annual report, but I will if you wish me to. It provides you with intimate detail of the financial position of all health funds, and would suggest the same report be made in respect of private hospitals. In addition, I believe there is an equally strong argument for much greater information and public disclosure on outcomes and clinical performance as between hospitals and medical providers. ‘Dr Death’ may be a state issue but private hospitals are a federal issue, because the federal government issues provider numbers and therefore carries ultimate responsibility for private sector performance.

I have already said that the second-tier benefit criteria—outlined as appendix C to our submission—should be the baseline for the issue of provider numbers. I invite the committee to review those criteria and ask themselves whether that should not be the minimum standard required. Indeed, I find it quite strange that any hospital that did not meet those criteria could be allowed to operate.

Secondly, I point out that at the moment it is extremely difficult for anyone to collect and aggregate data. Earlier the committee was seeking information about medical gaps. I can provide you with some, but not complete, information about that, the reason being that privacy requirements make it very difficult to aggregate data related to charging or performance in relation to medical providers. The Privacy Act should be amended—and I ask you to recommend this—to clarify that the collection and aggregation of data which would enable comparisons of the performance and charging practices by medical practitioners should be possible.

Ms HALL—So that is a recommendation that you think we as a committee should be making?

Mr Schneider—I strongly urge you to make it, in the public interest and in the interest of public safety. I would also like to briefly refer to one of the propositions put to you—

CHAIR—Is that information available in public hospitals at the moment?

Mr Schneider—Some states do attempt to do it, but it is done far more in relation to hospitals than medical providers. Not very long ago, in the state of Western Australia, the performance of cardiac surgeons was evaluated. The doctors agreed to participate in the study. But because of privacy, the Director-General of Health in that state was unable to find out, let alone name, which doctor was having the worst outcomes. And it may not have been the worst outcomes. It may well have been that that doctor was the best doctor, who was being given the most difficult cases. But because of privacy, no-one knew and no-one knows today what the real story is. That is grossly contrary to the public interest and it does not help to improve quality and safety in our health care system, which I believe is where we should be putting all our emphasis.

At the last committee meeting hospitals were suggesting that perhaps one solution to some of the public sector problems might be for the Commonwealth to purchase beds in the private sector. I would urge extreme caution in relation to that. One of the big difficulties in health care is that, particularly in the public sector, people try to come up with solutions for queuing which end up having very perverse outcomes. The National Health Service in the UK is a classic example where, for—without being unkind—political considerations, promises are made about how the incoming government will solve waiting problems in the NHS. And what they do is compound them. They say, for example: ‘We will make sure no-one waits for more than two years for a bed,’ ignoring the fact that people who have waiting for two years for a bed have already been triaged by doctors who have decided that other cases are more urgent than theirs. In one period, people with minor bumps and lumps were being treated ahead of people who needed urgent lifesaving cardiac surgery because the people with bumps and lumps had been on the list for more than two years. So we have to be very careful about what we do.

But there are some very perverse problems that could come from the proposal I mentioned to purchase beds. One would obviously expect the Commonwealth government to demand a better financial deal than insurance organisations would be able to achieve, and the hospitals would undoubtedly, given their past behaviour, expect higher health fund benefits to compensate for any reduced margins they got from treating public patients. So premiums would go up. Also, if uninsured persons are guaranteed access to private hospitals without paying for insurance, the majority will see no need for insurance. While some might see this as a good thing, the economic fact is that if everyone abandoned their private health insurance—and there is no reason why they would not—the national health budget would actually be reduced by $5.5 billion: the money that contributors currently pay for health care services net of the rebate. The problem there is that if that money was to be raised again, you would have to raise it from people who today are not insured. So you would totally shift the payer burden from those who are paying for health insurance today to those who are not paying for health insurance.

Finally, I would like to express some disappointment—considerable disappointment, in fact—that an industry-agreed reinsurance system, which is outlined in our paper, which aims at encouraging funds to provide services for hospitalisation and which could well reduce the ongoing rate of increase of premiums has not yet been adopted by the government. Instead, it appears to have been put off for at least a year and is subject to further delay and further review when in fact there is an industry agreed proposal which, for the first time, has brought together virtually all funds with a solution. It is a shame that that has not been adopted. I am more than happy to answer questions.

Ms HALL—Thanks, Russell. During the inquiries, when we have had you and the private hospitals appearing, the one thing that has made the biggest impression on me is that you seem to be having a barney between yourselves and that the consumer is secondary. Don’t you think it is about time you sat down together and tried to resolve this issue—not being so focused on this dispute that is taking place but getting down to the basic issue of trying to provide affordable health care? Is there any way through this that you guys can—

CHAIR—We want you to focus on outcomes too.

Ms HALL—get over it and look at the outcomes? You make some great suggestions along the way, but somehow I think that the whole purpose of both of you is to win over each other.

Mr Schneider—In fact, in forums outside this room, you may find that there is far more constructive dialogue than appears in public. The practical reality, though, is that the concern of the insurer is twofold. Firstly, it is to try to make sure that its members receive the most appropriate and best care resulting in the best possible outcome, for a very logical reason—if you get a good outcome, the patient is not likely or is less likely to go back into hospital, so you save money. That leads to the second interest: to reduce the rate of growth of premiums.

Some health funds are commercial organisations, most of them are not-for-profit organisations but all of them have one principal concern—that is, to hold down their costs, whether it be for competitive purposes or, indeed, because many of the boards of health funds actually consider themselves to be representatives of their consumers. That is particularly true in the smaller funds but is not untrue of the larger funds either. There is a psyche within the health insurance industry that is both patient focused and premium focused because the consumers are your members. Most health funds grew out, one way or another, form the friendly society movement—the mutual cooperative movement.

Providers of health care, on the other hand, quite understandably have their focus on making sure that patients are provided with care but their driving impetus has to be income. A little while ago we heard a medical provider suggest that it was not possible to provide treatment to certain patients because she could not afford to do it. I commented, as an aside, that in the 22 years I have been in this business it has always amazed me how money becomes the determinant of whether a person receives treatment or not by such altruistic people as those who provide care.

That is the reason that there is this conflict. We have an interest which is focused on reducing the price of care and the providers have a natural interest in maximising their incomes. If you can find a way of bringing those two things together, it would be very good. I have to say that that is not just true of the private sector. It tends to be more obvious in the private sector because we are operating in a marketplace. I think, and I am sure you know, that were you to discuss these issues with the people who are responsible for paying for services in the public sector, you would find exactly the same tensions and problems exist and arise, more frequently than we would like to actually see.

CHAIR—So it is all Treasury’s fault?

Ms HALL—Following on from that, one of the issues that has been quite contentious has been the contracting issue. In my local area I have seen where it has had the enormous potential to disadvantage a significant number of consumers who have purchased product from a health insurance fund. Could you address the issue of contracting from your perspective and how it is impacting on people’s ability to access the health service, particularly in regional areas where there may only be one private hospital providing that service and if the contracts are not allocated then you have a whole group of people who are basically disenfranchised?

Mr Schneider—I guess it comes back to the point the chairman made early this morning: whenever health fund prices go up, members of parliament get criticism, the ombudsman noted that he had complaints and, rest assured, I get some too, although most of mine come from dealing with the media so I guess it is not so much criticism; it is more dealing with phone calls at six o’clock in the morning.

Ms HALL—But they are not people who cannot get health services. The media is there to assess performance and to comment on it. What I am interested in is people who cannot get services that they are paying for.

Mr Schneider—The question is: how much should they be paying in their premiums? The reason that you would have a problem with a contract dispute is that there is a disagreement between the fund and the hospital over the price—over what is being paid. I do not think I would be in favour of submitting that sort of thing to arbitration. One of the very positive measures that you could take to solve some of these contracting issues would be greater transparency of hospital financing.

Ms HALL—That is what I was going to ask you.

Mr Schneider—You could then make a judgment about whether the fund is the one being mean or the hospital is the one being mean. I am not suggesting that that is going to solve the problem of a consumer who might be left in the middle for a period of time, but I think it would go some way to reducing some of the misinformation that might be put out—by both sides. I am not claiming purity on one side or the other; I am simply saying that there is an information vacuum that you have in respect to one side that makes it very hard for you to make a judgment.

Secondly, one of the most unfortunate things that happens in health care is that there is a tendency on the part of providers to play the patient. I would like to refer to that in relation to medical gaps and some solutions to that, too, later, if I may. It is very easy to leverage higher payments from a health fund or even a government if you can hold patients to ransom. One of the things that needs to be done is to look seriously at what constraints you can impose to diminish the incentive for providers to play that game. We had the same thing before. In 1985 in New South Wales when the procedural specialists had some strong objections to Medicare, they played the patient and they did that to leverage more money out of the state government. So it is not just a private sector problem.

It would be easy to say that the solution to the problem is not to have contracting at all. That will not solve the problem. What you would have is health funds setting their schedules, as they used to do before contracting came in, and they would say, ‘For this particular day in hospital, we will pay this much,’ but there is no constraint on what the hospital would charge. While the hospital is free to impose a charge above the health fund benefit, you are still going to have that sort of difficulty. You will have a different difficulty with the patient—the patient will then face a large copayment rather than for a period of time being concerned about this sort of dispute.

There are some things that we do believe—and we have actually agreed; at least I hope the hospitals have agreed with us—can minimise that problem. The first is in relation to how you deal with the patient at the cessation of a contract to ensure that people are given adequate notice that the contract is going to cease. The second is that people who have been prebooked continue to be treated by both sides as though the contract continued in force for a reasonable period after cessation. If you prebooked, the fund would pay what it was paying beforehand and the hospital would accept that in-full payment, so there would be no charge to the patient. For emergencies you would have a similar arrangement, and for people who are in an ongoing course of care you would have a similar deal, so those patients who could reasonably be expected to need the services are able to access them at no cost. That would, I think, go some way to solving the problem.

Ms HALL—The other issue is the transmission of information to consumers about the existence of contracts and the impact that will have on them if they have a service in a hospital.

Mr Schneider—That it is not contracted?

Ms HALL—Yes.

Mr Schneider—We try very hard to make sure that people know about that. One difficulty we have today is a generational one. That information can change from week to week. It is very difficult to produce brochures or written material that people can hold onto for any length of time, because you have to update it all the time. We do put it on web sites, but so many people—

Ms HALL—The people are usually elderly and do not even know how to push the button to turn the computer on.

CHAIR—If they have got one!

Mr Schneider—That is what I was about to say. It is a generational issue. So often people see web based information as the solution to all their problems. In fact, it is a solution for people under 50, who have enough income to have access to the web, but it is not a solution for people over 50, whether or not they can afford access to the web, because most of them just are not into that sort of technology. There is the same problem with banking and electronic funds transfer. All I can say is that the insurers do their best to advise people about these things. The one message that we believe should always be out there is that people should check with their fund before committing themselves to hospitalisation or to courses of treatment that are likely to effect hospitalisation. They should find out the level of coverage under their contract arrangements so that if they have exclusions they know about them in advance. They should also know which doctors are likely to charge gap fees and which are not.

We have invested a lot of effort, time and resources into trying to provide that data. One of the things that is not often known about is that we have produced lists of no-gap doctors—or doctors who consistently do not charge gaps or with whom the funds have contracts—in GP software. So, theoretically, you can go to your GP and ask them to refer you to a specialist who will not charge you a gap. We are not having the same success in getting GPs to use the software. It has been difficult to communicate the message to members that they should ask that at the point of the GP consultation.

CHAIR—It is possible that when a patient goes in for surgery his GP will refer him to a surgeon, the surgeon puts together the operating team and the patient does not have the choice of doctor; he cannot go shopping for an anaesthetist or whatever. That just does not hold water. The patient does not have the option of shopping around for a no-gap doctor when someone has to put a surgical team together.

Mr Schneider—That is true, but—

Ms HALL—That is to do with bringing in informed financial consent, which is what I was going to ask about next.

Mr Schneider—You are absolutely right, but with this exception. One of our strategies has been to try and get the information into the GPs' rooms, because that is the point at which the patient is least vulnerable; they are dealing with a doctor who should know which specialists are best for them. Our concept was that the patient would say, 'Can you refer me to a doctor who is not going to charge a gap,' and the GP would have that information at their fingertips. At that point the GP, in consultation with the patient, could recommend a specialist who did not charge a gap. The second problem is that you cannot choose your anaesthetist—if you do, you are likely to find that your specialist will suggest that you go to another specialist.

Mr GEORGANAS—Why is that?

Mr Schneider—Specialists invariably choose their anaesthetist.

Ms HALL—There is a relationship.

Mr Schneider—In some cases they might have two or three anaesthetists they work with. That might be for a number of reasons. One anaesthetist might be particularly good if the patient needs to be under an anaesthetic for two hours, and another might be good if it is only for five minutes.

One possible solution, which I am quite sure would be difficult to implement but not illogical, would be to 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 been able to put that into health care, and it seems to me rather illogical. I would have to say, though, that that would be a very courageous decision—to use a *Yes, Minister* expression—on the part of a government.

The solution, as I see it, comes back to taking away the capacity of the specialists, the anaesthetists and the other doctors to play the patient. We have looked at this for quite some time. We have looked at what we may be able to do, as health funds, to ensure that there is no gap. We can do a lot of things: we can vary the amount of money that we pay specialists, so that we pay them this much if there is no gap and this much if there is a gap, and we can put incentives in place. But, at the last resort, the doctor can always go to the patient—bypass the health fund and bill you or me—and that is the end of the issue as far as we are concerned. Your health fund can do nothing to protect you there. The solution, I think, to this problem is a pragmatic one, and that is to say that if there is a gap, and that gap has not been agreed on in advance, you cannot be pursued through the courts for legal recovery of the debt.

Ms HALL—Do you think that should be legislated?

Mr Schneider—I think so, and I believe that the Commonwealth can use its corporations powers to enforce it, because most doctors are incorporated—for tax purposes, if nothing else.

Mr GEORGANAS—I will go back a couple of steps. You have partially answered this question. Earlier on we had the pleasure of having the regulator here. We asked some questions, and she was telling us that, when you put your fees or your premium up, they have actuaries that look at it and make sure it is all bona fide and everything else. I suppose we have these regulations to keep the lid on escalating premiums, therefore keeping people in health funds and not being a burden on the government. But it seems to me that, if there is an escalation of the prices that you pay, we are chasing our tails. Is that what you were trying to get through previously?

Mr Schneider—Yes, it is.

Mr GEORGANAS—How would you sort that out? How would you suggest we keep a tab on what is happening in that area? Which mechanism would you propose to use to do that? I mean, could we legislatively keep a tab on it?

Mr Schneider—There are a couple of things that you could do. I think you have put your finger on the issue. The process we have at the moment is a very rigorous process but, in fact, it does nothing more than assure those involved—and, one would hope, those outside—that a price rise is justified by costs, and that there is no profiteering or impropriety in the way that the health fund has done it. I would like to send you information about the details that a health fund must submit, because they are very rigorous and they are checked off by about 25 people. So we are getting to the issue of justification, but we are not getting down to the issue of how you get to grips with the costs. We have a number of suggestions in the submission. I really do believe that one of the principles needed here, to get to grips with costs, is a massive improvement in quality and safety. It seems logical to me that a safe system is going to be an efficient system and will be a lower cost system.

Ms HALL—What do you base that on? As was earlier pointed out, the most efficient system is the one that has not got anyone in it!

Mr Schneider—I guess we have to accept that you are going to get people through it, and if you get large volumes of people through it, you should have more efficiencies. Indeed, most of the evidence suggests that you will have much, much more efficiency if you are getting a throughput through an organisation that is dealing with it all the time.

We recently did some work—which I think is probably not going to be finished—with the Australian Patient Safety Foundation, which commenced a study about the cost of indemnity payments in respect of obstetrics, to find out what the magic bullet to solve this was. It appears that the magic bullet is volume. If you have a maternity hospital that is doing a lot of deliveries, you will find that in that hospital there will always be some experts like midwives, doctors, gynaecologists or whatever they might be. If something goes wrong, you have the manpower—or the person power—at hand to deal with it very quickly. If, on the other hand, you are only doing one a year, the likelihood is that everyone is inexperienced. Childbirth is a natural thing, so normally nothing goes wrong, but if something goes wrong it goes wrong catastrophically. That results in more money, one way or another—either more health-care costs or more indemnity payments. There have been studies done about cardiac surgery, about virtually everything, and the same thing is true: the more experience you have, the better you are going to be.

Ms HALL—So that would be an argument that you only have extremely large teaching hospitals and you get rid of all small, local, district hospitals?

Mr Schneider—No. What you need to do, though, is to encourage more horses for courses, centres of excellence—areas where you can put expertise together. The second thing, though, is to put an emphasis on safety and reduce the rate of infection and readmissions. There was an article on that only the other day in the *Medical Journal of Australia*, and in fact we refer to it in our submission. We cannot say today that our hospitals are safer places than they were 10 years ago in either the public or the private sector. We do know that we have to pay, at times, for readmissions, unplanned admissions and unplanned returns for further and hospital related infections, all of which add to the cost that you, the contributor or the taxpayer have to pay for. We have to get to grips with that. One of the ways of getting to grips with it, I fear, is to allow better comparison and benchmarking of how individual hospitals and providers perform.

The thing about health care is that demand is always going to increase. We are always going to have people who will get sick. We are always going to have people who need to go to hospital. And technology is going to blow that out enormously. So we have to try and put into our overall system every check and balance we can to extract every possible dollar’s worth of efficiency so that, in either the public sector or the private sector, the cost remains payable. The danger is not that we are going to double the cost of health care; the danger is that we could end up getting to the point where the cost of health care is double GDP, because that is the capacity for demand in the system.

So I think safety is the primary thing that we must emphasise, and we will only get that by benchmarking. We have to look at why there are variations. Why should it cost more in one hospital to provide a service than in another hospital? There may be many reasons for it, but it might be that one is much more efficient than another one, and the efficient hospital is the one that should be rewarded.

The third thing that we need to do—coming back to what I guess is my pet hobbyhorse—is breaking down the hospital walls so that, in those areas where we can fund services that are substitutable or would shorten the length of stay without compromising the patient’s outcome, we should be able to do that, because that is another way of reducing cost. At the moment, health funds are locked into the highest cost part of the health-care system, without any capacity to encourage, fund or reward treatments that stop people going into hospital. That is not in the interests of the community, it is not in the interests of Medicare and it is certainly not in the interests of the privately insured.

CHAIR—Russell, do you want to address some of the mental health issues that you heard earlier on?

Ms HALL—In your submission, following on from your comments about infection and avoidable readmission, you say:

> Our health care system, and those who pay for it, need very positive support measures to encourage and reward safety and quality. Unfortunately whenever such measures are proposed they are opposed on the basis that they may compromise the freedom of providers who hide behind the slogan “US style health care.”

Whereabouts do the consumers fit into this? I hear those sorts of comments from consumers, who are very concerned about the direction that our health services and our health system are going in in Australia. They are very concerned that some of the requirements, some of the things that we heard about in relation to mental health and the restricting of benefits are driving our health system in the American direction.

Mr Schneider—What we need to do in that sense is to ask, ‘What is the American direction?’ There are lots of directions in America and there is a lot of good managed care in America.

Ms HALL—So managed care is something you support?

Mr Schneider—I am on the record—

Ms HALL—Yes, I know—saying you do not.

Mr Schneider—There are aspects of managed care which I think we would all support. In the United States, GPs who make sure that their diabetic patients have their retinas examined at least once a year so that they do not go blind are rewarded. The payment system provides a reward for them and a financial penalty to those who do not—they do not get paid as much. That is managed care. I reckon that is very good.

Ms HALL—So it is like the saying ‘a little bit pregnant’?

Mr Schneider—No, managed care breaks down into all sorts of different forms. To be quite honest, there are some forms of managed care that are pretty terrible and that I would not want to see here. There are other ones: there is another very interesting one that I would love to see here but I cannot convince my members about it. It is to survey consumers six months after they have had an orthopaedic procedure to find out whether they feel better. If they do feel better, the doctor gets an extra payment. If they do not, then over a period of time they look at whether they should be providing the same level of payment to that particular doctor as they do to others.

Ms HALL—There are a lot of variables involved in that.

CHAIR—Deferred payment for six months?

Mr Schneider—No, they still pay the base rate but at least the consumer influences whether the payment is made or not. In fact, in hospital contracting a lot of the contracting is based on consumer satisfaction surveys. If consumers express concerns about the sort of care they have had—and particularly if they express concerns about hospital related infections that they might have picked up—that will be taken up by the funds when they renegotiate a contract with the hospital. There are things that are done in the interests of consumers that you do not always see or hear about.

To deal with the question you asked, I think it is a reflection of the environment that we have got at the moment, where the funds are locked inside hospitals and, therefore, they have to try to make the best use of the consumer dollar. As the regulator said today, there is no suggestion that any of that money is being wasted. It is the age-old question: is the price being sought by the supplier of the services reasonable or excessive and is the price being paid for those services reasonable, or inappropriate or miserly? I come back to my original point: we need the numbers to know.

CHAIR—We are 15 minutes over time. We will have to wind up. Thank you very much for appearing before us. I would like you to address some of those questions that were asked on the mental health aspects of health insurance funds. Could you perhaps give us a note on that a little bit later?

Mr Schneider—Yes.

CHAIR—Thank you very much.

[3.04 pm]

HARVEY, Associate Professor Donald Roy, Health Policy Adviser, Australian Council of Social Service

MACFIE, Mr Gregor, Policy Officer, Australian Council of Social Service

CHAIR—I welcome the representatives of ACOSS. Although the committee does not require you to speak under oath, you should understand that these hearings are formal proceedings of the Commonwealth parliament. Giving false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. We are very happy to see you here today, because we have been a bit light on as far as submissions from consumers of health services are concerned. After all, the basis of all health care is the patient, and you are representatives of the very group that we are concerned about. Please proceed with a brief introductory statement.

Mr Macfie—We would like to make one small change to the submission. The last sentence in the fourth paragraph on the first page says:

> This has occurred at the same time as increases in expenditure coming directly from consumers and a decline in the contribution from private health insurance funds.

It should read ‘relative contribution from private health insurance funds’. ACOSS would like to thank the committee for the opportunity to appear before it today. I would like to introduce my colleague Associate Professor Roy Harvey from the Centre for Health Service Development at the University of Wollongong. The Australian Council of Social Service, ACOSS, is the peak council of the community and welfare sector and the national voice for the needs of people affected by poverty and inequality. ACOSS has a longstanding interest in ensuring access to good quality health services for people living on low incomes, including Indigenous people, people with disabilities and chronic illness, sole parent families, young people, people who are unemployed or jobless and people living in areas with poor economic opportunities and inadequate services, including parts of rural, remote and regional Australia.

Health, of course, is determined only partly by access to health services. People who are poor are socially disadvantaged in other ways, live shorter lives and suffer more illness than those who are well off. This is due to a wide range of factors including low income, poor education, unemployment, inadequate housing and working in an unrewarding or menial job. Alone or in combination and over time, these stressful economic and social circumstances have an adverse impact on health and the health costs to the community.

It is uncontroversial that health services should be provided according to need but it is also the case that not all needs can be met. The real resources required to run a health system and in particular the health work force are in limited supply. Running an efficient, effective and equitable health system is therefore about setting priorities. At the last election, the Prime Minister committed the government to protecting and strengthening Medicare and delivering high-quality, affordable health care to all Australians. This is a position which ACOSS supports but there are a number of government policies which are producing outcomes that are in conflict with this objective.

The most serious of these in terms of both the equity and sustainability of the health system, in our view, are the key policies on private health insurance. Aside from the inequity inherent in the public subsidy for private health insurance, ACOSS's primary concern is that private health insurance policy is dragging scarce resources and doctors, nurses and other health professionals into private hospitals, thereby reducing the capacity of public hospitals to provide services according to population health need. We believe that there is a strong case for bringing the activities of private hospitals into closer alignment with population health need and that there are ways of doing this while maintaining a role for private health insurance.

The first thing we want to say is that, having private health insurance is strongly correlated with income and where you live. The lower your income, the less likely you are to have private health insurance. If you live outside the major capital cities you are also less likely to have private health insurance because of the lower incomes in regional—as opposed to urban—areas, and the fact that there is a limited supply of private facilities outside the major cities.

The second thing we want to say is that private health insurance is affecting fair access to health services. We are increasingly concerned that uninsured people and people living in socioeconomically disadvantaged areas are not getting equal access to elective procedures. In New South Wales, for example, patients with private insurance have twice the per capital level of service provision for elective procedures than those without insurance. Studies have shown that uninsured older people are not getting the same access to needed procedures, such as hip and knee replacements and cataract surgery, as insured people.

The third thing we want to say is that private health insurance policy is leading to uncontrolled charging in private hospitals, which draws resources out of the public sector. The major concern here is that private health insurance policies are encouraging the use of scarce resources in a setting where resources are not tied to priority community health needs and where costs are not controlled. The flow of money into the private hospital system encourages health professionals into private hospitals. With a shortage of real resources, particularly professional staff, throughout the health system, it is only to be expected that the flight of medical staff to the private sector will put additional pressures on the public system. As a result, there is an undue reliance on overseas-trained doctors in the public sector, as the recent case in relation to Patel shows.

It is also important in this context to recognise that the treatment in private hospitals has been skewed strongly towards elective treatments, to surgery rather than other treatments, and with a very high level of simple day-only procedures. Public hospitals, on the other hand, have been left to deal with the far more complex cases, including the emergency admissions and everything that just will not wait: a suicide attempt, a heart or cancer operation that has to be done now or a seriously injured accident victim. These people must be treated by a system that asks what the patient needs rather than what they can pay. There is also evidence that privately insured people can and do use public hospital as public patients and that some private funds do not insure against high-cost services, such as those provided in public hospitals.

At the moment, we see publicly funded inequity in the health system through private health insurance policy. As the OECD has pointed out, tax advantages for private health insurance have redistributive implications for the overall health system. They represent tax resources contributed by the entire community which benefit only the purchasers of private coverage. The proportion of higher income individuals buying private health insurance is higher than the proportion of lower income groups with such coverage; hence, people on higher incomes receive the highest proportion of tax rebates.

We believe it is time that we see community-wide returns on the $2.5 billion public subsidy for private health insurance. As we have outlined in our submission, we think that there needs to be a charter of Medicare entitlements that sets out the principles which underpin a healthy universal health insurance system in which the private system has a major role, which also sets out Medicare entitlements to services—the services the Commonwealth will fund for Australians, whether publicly or privately insured—and the maximum time that they should have to wait for major procedures, regardless of whether publicly or privately insured, as well as outlining the additional benefits, entitlements or privileges that are available to privately insured persons.

The second thing that we believe needs to happen is a full inquiry into the actual use and costs of public and private hospitals, including a review of the impact on cost of uncapped fees in the private sector on public sector employment and service provision.

Mr GEORGANAS—Would you like to quickly outline the charter that you spoke about?

CHAIR—It is in the submission, but would you like to speak more about the philosophy behind it and elaborate on part 1?

Mr Macfie—We can go into some more detail on how you might implement it later on. We support a system where the entire population is covered for a defined set of medical and other health services that are agreed to.

CHAIR—How is that different from now?

Mr Macfie—I think that one of the problems at the moment is that, although Medicare is badged as a universal health care system, in fact, we know that some groups miss out. We know that some Indigenous communities miss out; we know that there are patient copayments in the system that dissuade some people from using health services. There are a whole lot of holes in terms of, say, access to dental care which in some other countries is covered universally. We cannot fund everything, whether through the public system or the private system, but there needs to be some kind of community level agreement and agreement between the Commonwealth and the states as to what package of services will be universally covered for the entire population. Roy, you might want to elaborate a bit more on that.

Ass. Prof. Harvey—The Australian Health Care Agreements between the Commonwealth and the states actually have a requirement in them that the states provide care according to need—in other words, it is a clear health priority resource allocation decision—whereas the other part and the growing part of the acute care sector, which is funded through private health insurance, is essentially on a user-pays principle.

Though people are insured, as I am sure Russell Schneider pointed out, the out-of-pocket expenses and the over-the-Medicare-benefit expenses are actually growing despite the safety net and the increasing subsidies. Even within the system there is a growing rate of payments for people who are privately insured, which we are aware is one of the reasons that people with private insurance do go to public hospitals. The Australian health care agreements require the public hospitals to provide people with public care whether or not they are privately insured. So the Commonwealth is running two systems: one is health care according to need and the other one is health care still based on ability to pay—but first you have to be able to buy the private insurance. As the principal submission showed, this is highly skewed by income, and then we have the growing program which even the Health Insurance Association are talking about. Two or three of their recommendations are basically indirectly calling for cost control of private doctors' fees.

CHAIR—We do not have a constitutional power to do that.

Prof. Harvey—No, but the terms of reference for this look at the Commonwealth and states working together, and the states do. There are certainly models of funding and things like that whereby, by agreements with the states, you could flick the hard things to the states to do and hopefully improve access to the particular groups that were interested, including the people in rural areas and people with low incomes and disadvantage. So within the federal structure there are the powers to do that. It is a matter of whether you are going to maintain two principles: funding according to need in one sector and funding according to ability to pay.

It is leading to a bleeding of resources out of the public sector. We do not have enough evidence to show that there is declining access to some of the essential services, like hip replacements and cataract operations, but I think we can say reasonably confidently that people who do not have private insurance get less than their age characteristic would suggest. That is certainly one of the areas in which we ask that you initiate some sort of detailed research into. Unfortunately, there is a lot of partisan research, but it would be good to try and get some real facts on the table about the impact of private insurance on providing an opportunity for doctors to move out of the public sector and into the private, thereby reducing the access to services for the public.

Ms HALL—And increasing their incomes.

Prof. Harvey—Yes. You just need to look at table 7 in the PHIAC report to see the significant amount of billing in private hospitals which is done at twice the Medicare schedule, three times the Medicare schedule and things like that. That is bad enough to some extent, but with the sessional payments adopted some years ago—I do not know what the figures are now—specialists were being paid $150 or $200 an hour to do sessions in public hospitals.

Ms HALL—VMOs.

Prof. Harvey—Yes. The ophthalmologists could make something like $900 an hour in the private sector. If you had a choice of which sector you were going to work in, I am afraid there are not that many humanitarians to say, 'I'll work in the public sector.'

CHAIR—We approved the submission earlier today from a group, and there is a quote in it from former Premier Bob Carr: ‘As fast as we hurled money at the hospitals, there was a further abandonment of private health cover and a further rise in demands on the public system.’ So this is a ‘chicken and the egg’ argument, isn’t it?

Mr Macfie—What was the date of that quote?

Ms HALL—The document that the chair is quoting from is the Australian Doctors Fund’s submission.

CHAIR—There is no date on that.

Mr Macfie—These comments are usually made in the context of the five-yearly Australian health care agreements where the states are trying to find reasons to get more money from the Commonwealth for the public hospitals. At that stage they may well have looked at and tried to argue that because there had been a decline in private health insurance in the past there should therefore be more money for the public hospitals.

The reverse was the case when the Commonwealth was arguing that they would not give as much money to the states under the current agreement because private health insurance coverage had gone up. We see it in the context of the argy-bargy that occurs with these negotiations around the five-yearly health care agreements. There is certainly evidence that the type of services provided in public hospitals are different to those provided in private hospitals and that you cannot necessarily make that type of comparison. One of the issues that we are concerned about is that, with the increasing opportunities to make more money in the private system, you are dragging a limited resource from public hospitals into the private sector, so that is putting pressure there.

CHAIR—In Queensland, my state, the funding model for public hospitals is based on achieving elective surgery targets. If you do not achieve your target you get a cut in funding, which I do not think is very bright. If you do not achieve your targets you should get an increase in funding, shouldn’t you? You finish up with a quantity based health system churning through numbers and not quality. Henceforth we get the problems that we have had in Bundaberg.

Prof. Harvey—I think you can split the health care costs into three elements: the quality of services provided, the cost per unit of service and who gets them. We know from a variety of studies that the cost of providing any type of service is basically more expensive when it is done through a private hospital. I did work some years ago—Professor Stephen Duckett in Victoria has also done work—showing that when you look at private hospital costs, adjusting for the difference in case mix to the extent we can, private hospitals were running about eight or 10 per cent dearer than the equivalent public hospital, including the Medicare payments and the private payments for fees and things like that.

One of the difficulties is that there are not the cost-control mechanisms in the private sector that currently exist within the public sector. That is why you have the Australian Health Insurance Association calling, directly or indirectly, for price control within it. From another point of view, I am on APAC, the Australian Pharmaceutical Advisory Council, and one of the things that has come up through that is that private hospitals are setting up processes similar to the public. Years ago, private doctors could write scripts for anything they liked in private hospitals and it would be up to the patient or the hospital to pay for it. This was also the case with prostheses. Again, the Health Insurance Association said that somebody ought to control the cost of prostheses. I have certainly heard Russell saying, in public forums on health insurance in Sydney, that he does not really believe in regulation but that he thinks there is a good case for the government to regulate the cost. So you have the cost per unit of service. There is virtually unequivocal evidence that in hospital service it is more expensive to treat any comparable case in a private hospital.

Then there is the issue of who gets the services. Without wishing to attack the priorities of the government, the abandonment of the pensioner dental care and then the subsidy of private insurance in fact resulted in almost an equal amount of going from a high priority group, in terms of pensioner aged care, to a lot of work that is essentially cosmetic through private insurance. So, the total amount of money did not change a lot, but the priorities—the ‘who gets’—varied quite considerably. So there are issues around the processes in the public sector—as you said, giving public sectors the incentive to increase throughput does not sound real bright. Certainly, in some other state systems, they do not do it like that. But clearly maximising throughput and maximising price is almost a fundamental objective in the private sector because they are commercial and do not have a public obligation role. As you know, our longer and initial submission called for some sort of code of mutual obligation or something for the private sector.

The issues you may wish to consider are: how much does Australia want to spend, allowing for some discretionary spending around the edges; is it going to be spent in a way that is efficient; are we producing a certain type of service at a minimum cost consistent with good quality; and then, who in the population actually gets those services? We know from looking at the United States that they spend 14 or 15 per cent of their gross domestic product on health and have worse health outcomes than Malaysia. Malaysia has a better infant mortality rate than the United States. That is amazing but appalling. Malaysia’s gross domestic product is actually lower than the amount of money they spend on health in the US. So the issues of who gets the services and how they are delivered are crucial for determining the benefits that the community gets from health spending. The sorts of issues that you will hopefully be looking at are: what are the mechanisms that lead to efficient production of services—whether it is in the public or private sector; are there processes that ensure that the services that the Commonwealth is going to directly or indirectly subsidise are going to the people the Commonwealth believe are most in need of health care? That is partly what we were trying to address through a couple of our earlier recommendations.

CHAIR—Do you see a need for a realignment of responsibilities between state and federal in delivering health services? That is part of our terms of reference.

Prof. Harvey—The fact that we have the states running the high-cost end, the hospitals, and then picking up the community based services, with the Commonwealth paying for the private doctor services and some of the private hospitals, is a recipe for disaster. The sorts of things that Russell was talking about before about trying to improve continuity of care and getting better management of patients across whole episodes of illness is an issue which neither sector can do particularly well because, despite trying to work through the Australian health care agreements in getting better cooperation, we really have not done it. I think there is a case to be made for there to be a single manager in an area. It does not mean that all the health professionals have to be employees of the state. There are all sorts of contracting ways of involving private sector providers so that you can do it. But having different priorities at the Commonwealth and state levels and having them manage different parts of care—it is a different continuum of care from basic prevention care through to primary care to rehabilitation at the other end—because it is all split up, it really is a recipe for disaster.

CHAIR—There is a huge amount of wastage.

Prof. Harvey—Yes.

Ms HALL—In your submission you set out a model of Commonwealth funding and how states and territories are responsible for identifying the needs and designing the delivery of appropriate services but are then accountable to the Commonwealth.

Prof. Harvey—It does not even have to be at the state level. The director of the centre I worked at in Wollongong and I put out a paper a couple of years ago saying that there was no reason why the performance criteria for these areas could not be jointly defined by the Commonwealth and the state with agreed total funding and given considerable flexibility for management within those areas—a bit like with the area health service model, and I think Queensland has a basic area model as well. It does not actually have to be state management. Most of the states are too big to manage it efficiently; they have to devolve anyway. There is no reason why the Commonwealth could not agree with some of the states on what are reasonable management areas.

CHAIR—Have you heard Tony Abbott floating the idea that the states would give the Commonwealth the responsibility for hospitals?

Prof. Harvey—Yes.

CHAIR—What is your view on that? Everything I ask is from the point of view of the patient.

Prof. Harvey—I think the issue has to be seen in terms of whether the Commonwealth currently have the management capacity to do it. The Commonwealth Department of Health and Ageing is, to some extent, fully strapped juggling the balls that it has in the air at the moment. It is not a department that is a model of close cooperation. I do not know if you are experienced in talking to people from different areas. On the issue of having a single level, I do not think the state is the right level either. On the idea of having a joint funding, outcome performance standard for access, quality and things like that, I think it is probably essential that we get some formula, but I think it is a bit dangerous putting it in terms of Commonwealth or state because that unfortunately tends to be Labor versus Liberal.

Ms HALL—So you think it should probably be more of a collaborative approach, do you?

Prof. Harvey—Constitutionally, the states have the prime responsibility for delivering health care. We would have to suddenly change the Constitution; I guess we could go to a referendum. The Commonwealth and the states have shown great flexibility when they have agreed that there are problems. I do not see why it is beyond the wit of a person to come up with some joint funding arrangement with single management, instead of this silo sort of financing that we have at the moment.

Ms HALL—Do you see the silo mentality as being a problem in delivering the best possible health services to the Australian people?

Prof. Harvey—Absolutely.

Mr Macfie—I think the thinking behind the Commonwealth being the major resource is because it is able to raise the most money. It is a sensible alignment of roles and responsibilities for the Commonwealth to have responsibility for setting minimum standards and entitlements and to hold the states accountable. Of course, there are other areas in which the Commonwealth tries to do that—through joint agreements and the like. Our position is basically a pragmatic one in that it is unlikely that, unless the states cede it to the Commonwealth in terms of the running of hospitals, there is going to need to be some collaborative process, but, within that, some defined roles. That was really just an attempt to devise—

CHAIR—I think it was the Productivity Commission that estimated that 20c in the dollar gets through to the patient. The rest of the health dollar is lost along the way. I think that refers to both the private and public sectors.

Mr Macfie—One of the things that we are interested in, though, is that, if you are looking at the redesign of the system and the losses and the efficiencies, that is a very important part of the system. But part of the reason for looking at the charter of Medicare entitlements is to try and clarify some of the objectives of the health system so that whatever reorganisation is done it is done with the aim of reaching certain communally agreed outcomes and targets for the health system.

CHAIR—Absolutely—and for the patient.

Mr Macfie—That is right. For the patient and for the broader community you are looking at how to respond to population health needs whether someone has come into hospital with a critical illness or whether it is about reducing infant mortality in Aboriginal communities—it is the whole spectrum of health.

Ms HALL—In your submission you emphasise that public expenditure, particularly at the Commonwealth level, has been increasingly directed at supporting the health care of the most advantaged people in the community. You go on to say that the relative costs contributed by consumers have increased whilst the contributions from private health insurance have declined. Could you outline your concerns in the area relating to that statement about the most advantaged people in the community? Could you then highlight how the contributions have increased for consumers? In commenting on that, you might like to refer to informed consent in relation to services provided by doctors within private hospitals—the fact that people find they have large bills that they are unaware of—and how you think this should be addressed.

Mr Macfie—There are a number of concerns that we have about patient out-of-pocket costs. We were not specifically making a comment about private health insurance. We know there are enough problems there.

Ms HALL—Be expansive in your answer.

Mr Macfie—I am talking about things like gap payments when you have been paying for private health insurance, on top of the difficulty of affording the premiums if you are on low to lowish incomes. That is enough to put low-income people off wanting to go down that path. It comes back to that comment about a universal health care system. We see that, in a system where there are patient copayments and very little research or data on what impact that is having on people choosing not to use a health service when they need one, there is as a real lack of research. We allowed it to happen. We are not looking at what really is the role, if any, with patient copayments and that sort of thing. The broader point was that we have had for some while a 30 per cent rebate for private health insurance premiums.

Ms HALL—Do you think that is good health policy?

Mr Macfie—If you look at our materials we certainly have grave reservations about the 30 per cent rebate in that it is publicly funded money and we just do not see the value for money that we are getting from it, and at the same time the government has put in a lot of money to support private health insurance funds. We are seeing OECD figures that show that the relative proportion that the funds have been putting in, at least up until 2000-01, has declined over the last five or so years, and at the same time patient copayments are increasing. So that is the mix of issues we are concerned about. But the primary concern is that, particularly for low-income people, that kind of structure is likely to mean that if you are paying out of your own pocket it is not progressive; it is not looking at whether they can actually afford it. We certainly have anecdotal evidence that people are not using the services they need. So that, as it stacks up, is not positive in terms of health outcomes.

Ms HALL—That goes to the point you made about equity of access to health services by all people within the community. You referred to the MedicarePlus safety net. Earlier today sitting next to you, Professor Harvey, we had a psychiatrist who pointed out to us that that was probably one of the government’s best policies because it enabled the people that he sees to access his services for a longer period of time, and he is able to offer more services to people and at the same time to preserve his income. Would you like to comment on that?

Prof. Harvey—Mental health is a particularly difficult area. To an extent the Commonwealth, through the national mental health program, has been trying to address real problems but unfortunately, as the direct payments tend to be through the Medicare Benefits Schedule, payments basically go for psychiatric services. There are various analyses done of who goes to psychiatrists and who is really sick and, unfortunately, there is not a big overlap between those two groups. A lot of the serious medical conditions are essentially managed by psychologists in the public sector dealing with bipolar and schizophrenia and things like this. I know psychiatrists hate the term ‘worried well’ but there is some evidence to suggest that a lot of psychiatric work tends to be dealing with the ‘worried well’.

There have been initiatives and attempts through the national mental health program to try and get collaboration in particular areas. My university, or the centre that I work with, has been involved in trying to structure ways whereby the public and private sector could work well together. Again, it comes back to the priorities issue. Do you want the money for mental health to go to the people with serious mental conditions who may suicide, who may be violent and who create enormous family stress, or do you want it to go to a group of people who, by most standards of psychiatric need, have much lower levels of need? Getting that balance right is where I really want the states and the Commonwealth to have a common priority instead of one pushing this way and the other pushing that way. The national mental health policy has been a good attempt but it waxes and wanes, unfortunately, in its success.

Ms HALL—Feel free to expand your comments on the MedicarePlus safety net to more than just mental health.

Mr Macfie—ACOSS is on the record as having been critical of that. We have concerns about the Medicare safety net in that it became an open-ended way of doctors charging above the Medicare schedule fee. Obviously there is a schedule fee and doctors can charge anywhere beyond the 85 per cent that it is set at, or beyond 100 per cent of the schedule fee—

Prof. Harvey—Or below it.

Mr Macfie—Or below it; that is right. And we know that some services and some doctors do that—and there is no need, therefore, for the safety net. But, accepting that we have a system where patient copayments are a feature of the system, we have argued—instead of the open-ended 80 per cent rebate under MedicarePlus—for combining the safety nets for the Pharmaceutical Benefits Scheme and the Medical Benefits Scheme and for that to be at a set level, backed up by research about the impacts of those copayments so they are set at a level that will not dissuade people at various income levels from still using the service, but if they are using the service heavily then they get the rebate. It is about the government really setting what it says publicly—that is, this is an acceptable price to be paying for a given service—rather than allowing it, in an open-ended way, to cause health inflation.

Prof. Harvey—The safety net also partly undermines the government's objectives—through former Minister Wooldridge—of trying to get private insurance to offer guaranteed cover. I think he was trying to ensure that patients did not have any out-of-pocket costs if they went through the private sector. But, if you look at table 7 in the PHIAC report, because the safety net now offers 80 per cent cover there is absolutely no reason why doctors who currently will not agree to a contract would agree, because they know that, for anything they charge that goes to the patient, the patient is going to be able to recover 80 per cent. Given that we are talking about people with high medical costs, if you are talking about some of the high-cost surgery and things like that then people are going to hit the thing on a single episode, so it partly undermines the objectives of trying to get private insurance to give people the sort of certainty that they want. Again, we want to go that way, but we are putting money the other way. There are several areas in the current funding where you say that is the way you want to go, but the money is pushing things the other way.

Mr Macfie—The other thing to add there is that we know that, in fact, where doctors happen to be located and people are using the service, a lot more money is going into those areas which happen to be the higher income areas, so that the benefits from the 80 per cent rebate above the threshold are flowing into higher income areas and not into the lower income areas. So there is an inequity there, especially if you consider that the health needs of the lower income or more disadvantaged areas are generally higher. Again, in that respect, there are inequities and we are not really meeting the health needs of the community.

Ms HALL—I noticed that, in the evidence you have given, you talked about the fact that private hospital treatment tends to be elective surgery, day-only surgery; that there is a lack of control in charging in private hospitals; and that funds do not provide coverage of high-cost service. You also mentioned uncapped fees. Firstly, do you think that the private sector is creaming? Secondly, what strategies do you think government can put in place to address the issues that you identified in those areas?

Prof. Harvey—Some of the areas like emergency departments are not in fact a doctor thing; they are a hospital thing. Emergency departments—and that is clearly emergency and outpatient departments in some of the big teaching hospitals—can make up to 25 per cent of the total cost of a hospital operation, so they are obviously high-cost activities. To some extent, there is also advantage in having some of these concentrated, so I am not too sure that you would want every hospital to have an arrangement like that. Having said that, there is no reason that, if there are no public hospitals in areas, you could not contract with a private hospital to do some of those services, but you would certainly want very careful cost analysis.

CHAIR—There seems to be a trend to co-locate public hospitals and private hospitals. When we were at the North Shore Private Hospital we found they actually have rooms in the public hospital next door. They lease them. Then you have Prince Charles Hospital with the Holy Spirit next door. Do you see this as some sort of a trend that could develop in the Australian model, where they deliberately co-locate?

Prof. Harvey—It was very fashionable 10 or so years ago. I think at that stage it was partly because medical benefits schedules were not keeping up with doctors’ expectations. Now it is totally out of whack. But for a while there the fees, even the AMA schedule, were almost in line with the Commonwealth medical benefits schedule. But then I think it fell back and this move started. It was partly a cost-shifting exercise by the states—if they can get people to go to the private hospital, they are not in fact providing services through the public hospitals. It was very fashionable for the states to co-locate because it shifted money from the Commonwealth to the states.

There are a lot of factors that went into it. But in the long run, because you are essentially moving from a highly-cost-controlled environment into a largely non-cost-controlled environment, as it was and still is, to some extent you are increasing the cost of providing pretty much the same volume of services. It did not help patient access. At least if the private hospitals were located away from the public hospitals, there may be some convenience—people could get some convenience by going to different hospitals. It seems to me that, on that ground, other than being of some benefit to the state and allowing doctors to earn a bit on the side at Commonwealth expense, in terms of public policy it actually had very little going for it.

Mr Macfie—On the premium question, it certainly looks like that might be the case, but we are not saying that the people who are getting elective surgery in the private hospitals should not necessarily be getting that. It is just that we think we should look at what everybody needs and what the joint roles of public and private hospitals are in providing a certain guaranteed level of care. That is something we think has to be in a sense negotiated in an informed way with the Australian community to see what it thinks the standards are.

CHAIR—We know what everybody needs—that is what the waiting list is.

Mr Macfie—Well, in a sense, the waiting list—

CHAIR—It is a ration.

Mr Macfie—I think we all acknowledge that there has to be some rationing. The issue is how you ration in a fair and efficient manner.

Prof. Harvey—And do you ration across the board too. Private insurance has long been understood as a queue-jumping exercise to the extent that, for a lot of issues, you can actually get treatment much quicker—

CHAIR—If you can afford it or you can self-insure.

Prof. Harvey—Yes.

CHAIR—Rich people do.

Mr GEORGANAS—In your opening statement, you mentioned the Commonwealth dental scheme. What are the effects of not having a Commonwealth dental scheme in place?

CHAIR—You need to go to the history of it. That was a four-year program introduced by I think the Keating government to help the states get rid of a backlog. When that four years was up, we happened to be in government then and we ended the program. It was a four-year program.

Mr GEORGANAS—But I think in your opening statement you mentioned that funding for other areas means that people who, for instance, are on that waiting list are missing out. For example, if you take out private health insurance and you take out dental care with it as well, you get the 30 per cent subsidy—

Mr Macfie—The ancillary—yes, that is right.

Mr GEORGANAS—So you have people who are in real need without funding going into that area—it is going into different areas.

CHAIR—That is a point.

Mr Macfie—With the dental, it comes down again to the Commonwealth-state issue. States do have a responsibility for dental care and so does the Commonwealth, actually, under the Constitution.

Mr GEORGANAS—Yes, it is in section 51 of the Constitution.

Mr Macfie—But the issue is: how is it resolved? It is a difficult question to answer. Nationally there is no doubt that access to dental care for about one-third of Australians is absolutely appalling. In some states it is worse than others. Some states like Queensland did a better job of investing some of the Commonwealth money. Instead of necessarily providing services through the money they got from the Commonwealth, they built up capital infrastructure and other things to provide dental care and therefore found it, I guess, a little bit easier to keep providing the service once the Commonwealth program was withdrawn.

The Australian research committee for oral health, I think it is—I have forgotten the name of it—in Adelaide have shown that access to dental services did worsen after the withdrawal of the Commonwealth Dental Program. That is true. The issue, then, is: how do the Commonwealth and states work together? What should the Commonwealth set out and what are its obligations and what does it expect in return from the states in terms of the funding of dental care.

The fact is—and Roy was talking about this—there was about $100 million in the old dental health program. Work done by John Spencer for the Australian Health Policy Institute at the University of Sydney showed that there is a great deal of support through private health insurance for private dental care, which then goes towards cosmetic dental care when we have pensioners and people in nursing homes who have dreadful oral health.

Mr GEORGANAS—Which leads on to other problems.

Mr Macfie—That is absolutely right. The figures are here. Later on I can certainly provide the information.

Mr GEORGANAS—That would be great.

Prof. Harvey—To pick up on that very quickly, I think the Medicare charter of entitlements coupled with a level of management that was not Commonwealth and state to some extent might get away from this buck-passing and cost-shifting that that goes on. If you had a very clear agreement on what the population expected and there was agreement by the Commonwealth and the states on the sorts of outcomes in terms of access to services, and it was then managed by a third party, you would be less likely to get this sort of finger-pointing that goes on now between the Commonwealth and the states. With modern information technology you can get really exquisite information about characteristics and needs of patients and you can look across areas to do priorities. Having something like that would enable you to first take out the ‘It’s your fault; it’s not my fault’ sort of thing, which I think is extremely destructive at the moment.

CHAIR—We are getting the message very clearly from the people of Australia. You are getting it.

Mr GEORGANAS—I am getting, too.

CHAIR—I am getting it on my side that they are sick and tired of the blame game. We have to get our act together, together with the states, somehow. The purpose of this inquiry is to work at some sort of rational behaviour between the different levels of government in delivering health services. Hopefully we will get there.

Prof. Harvey—I thought at least one of the state governments had said that they were happy to hand it across.

Mr GEORGANAS—That was Queensland.

CHAIR—Tony Abbott was in Queensland.

Prof. Harvey—Yes, I remember. I thought South Australia had said it at some stage, didn’t they?

CHAIR—I think Bob Carr at one stage had offered to talk on that issue. We have very much paralleled the terms of reference of the COAG process, which is on at the moment, to give people like you a chance to have a say. The COAG committee is a committee of officials looking at reform of the health sector, but we thought that everybody should get a say and not just the senior officials and the top levels of government. Hopefully the results of this inquiry will become part of the COAG reform process. That is what we are aiming at.

Prof. Harvey—Best of luck.

Mr Macfie—ACOSS has been working with the Australian Health Care Reform Alliance, of which John Dwyer is the chair. That has been pushing for an open health reform process so that consumer groups and the general community have a real and active role in articulating the values and shaping the priorities for the health system. It is our view that a sustainable and legitimate system will only be achieved with the support of the public, and that includes support for the ways in which health care will be rationed and what the priorities will be.

CHAIR—Unfortunately we have run out of time. I thank you sincerely for your attendance.

Resolved (on motion by **Mr Georganas**):

That this committee authorises publication of the transcript of the evidence given before it at public hearing this day.

Committee adjourned at 3.55 pm