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UNIVERSITY OF TECHNOLOGY SYDNEY

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CHERE SUBMISSION TO THE

SENATE COMMUNITY AFFAIRS COMMITTEE

Inquiry into Private Health Insurance Bill 2006 [provisions] and related Bills

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Submission to the Community Affairs Committee on the Private Health Insurance Bill 2006 [provisions] and related Bills

Introduction

The Private Health Insurance Bill 2006 [provisions] and related Bills signals the Government's intention to implement the next wave of reforms to Australia's health care system. Whilst the bill introduces a raft of new initiatives, this submission concentrates on what the Government calls 'broader health cover'. We agree with the Government that this measure is groundbreaking and by far the most significant part of the proposed reforms.

Around the world, there is a long and rich history of reform failure in the health care system. Some of these are political failures and don't even get to the stage of legislation, whereas others fail after implementation (see, for example, some case studies from the UK, USA, the Netherlands and New Zealand: (Cooper 1994; Oberlander 2002; Helderman, Schut *et al.* 2005; Maynard and Street 2006). Given the historic failure of many well-intentioned reforms and the groundbreaking nature of the legislation currently before the Senate, careful scrutiny is required.

In essence, the 'broader health cover' reforms will allow private health insurance (PHI) funds to cover services beyond the four walls of the hospital. The Government's proposed changes will mean that private health insurance companies can design and sell products that offer people more insurance products to suit individual health needs.

Currently, private hospital insurance can only cover those services that are performed inside the four walls of a hospital[1]. As a result, many patients seek in-hospital treatment in order to use their private health insurance when safe and suitable out-of-hospital services may exist at less cost for that particular treatment. The longstanding demarcation between what constitutes inpatient and outpatient care has, to some extent, prevented private hospital providers from introducing modern clinical practice care, for example, enabling a person with cancer to have chemotherapy in or out of hospital and still be covered by their private health insurance.

The government hopes that as a result of these reforms, the needs of Australians will be better met - and private health insurance can cover services that reflect current clinical practice. However, the proposed reforms also carry the risk of causing some fairly fundamental (unintended) consequences. In particular, the submission focuses on two potential risks that the broader health cover reforms pose:

- Diminished community rating and de-facto risk rating of private health insurance premiums;
- Extension of a two tier system.

Diminished community rating and de-facto risk-rating

One of the fundamental aspects underpinning the provision of private health insurance in Australia is the concept of community rating. By law, insurers must firstly provide cover to any person seeking

[1] Whilst ancillary insurance covers some outpatient services such as optical products, dental care and physiotherapy, they typically do not cover services that could be regarded as substitutes for in-hospital care such as dialysis and chemotherapy.

private health insurance, regardless of age, sex, health status or claims history. Secondly, insurers must offer the same type of cover at the same price to all their customers.

Community-rating has two important implications worth highlighting here. Firstly, on the positive side, it has an important social function because it limits the cost of private health insurance to high risk individuals. In the context of a system with universal public insurance and voluntary private health insurance, community rating can play an important role in ensuring that high-risk individuals do not drop private health insurance and rely solely on the public system.

Secondly, on the negative side, community rating can play an important role in what is often called *adverse selection*. *Adverse selection* refers to proposition where low risk individuals will regard the community rated premiums as bad value for money and therefore rationally decide to drop out of private health insurance. If low risk individuals drop out, the average risk profile of the insurance pool rises and therefore payouts (relative premium income) rises. This means that private health funds have to increase premiums and the whole cycle starts again (Australia. Industry Commission. and Australia. Productivity Commission. 1997).

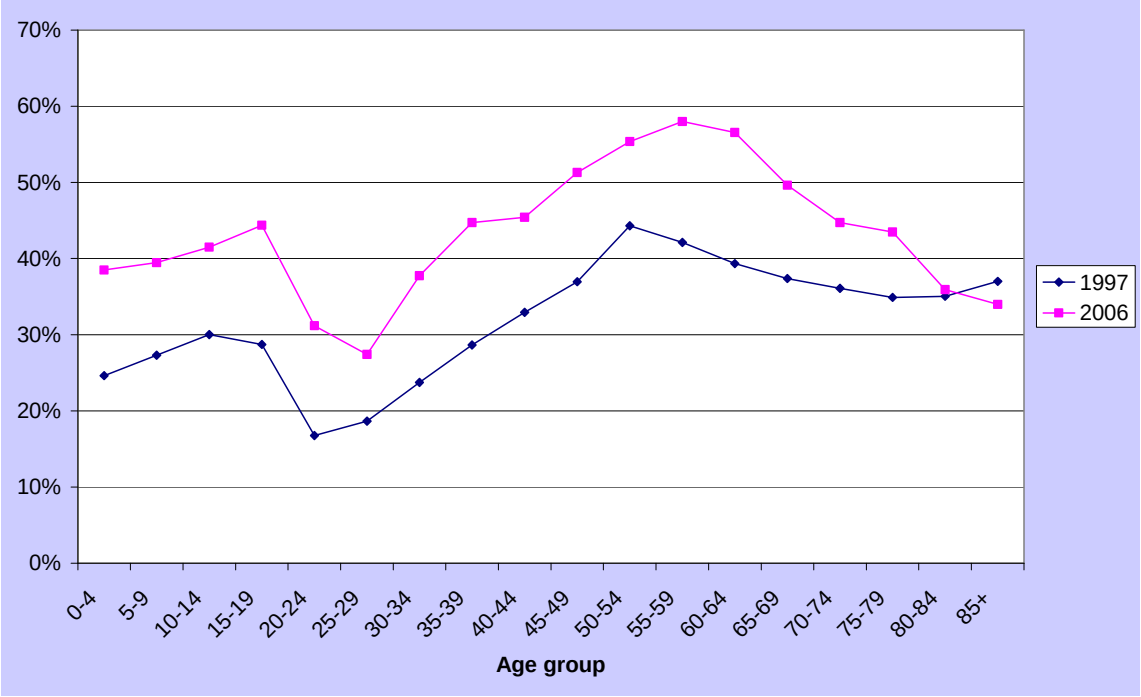
The decline in private health insurance membership evident in the 1980s and 1990s is often attributed to *adverse selection*. Indeed, many of the submissions presented to the Productivity Commission at their inquiry into private health insurance focused on this topic (Australia. Industry Commission. and Australia. Productivity Commission. 1997). However, empirical evidence is mixed. Using the 2001 ABS National Health Survey, Doiron et al found a strong positive association between self-assessed health and private health cover. This relationship persists even after the inclusion of controls for personal and socio-economic characteristics, risk-related behaviours, objective health measures and an index of mental health (Doiron, Jones et al. 2006). Moreover, this finding is consistent with the results of previous research (Schofield 1996). However, Doiron also found that people with private health insurance were more likely to have chronic health conditions and were higher users of the health care system. The Productivity Commission concluded in 1997 that health funds do not cater for the sicker individuals of the population — as adverse selection might predict (Australia. Industry Commission. and Australia. Productivity Commission. 1997). Figure 1 shows the proportion of people with private health insurance by age in 1997 and 2006. It shows that in both 1997 and 206 PHI membership amongst younger cohorts is relatively low then starts rises around ages 25 to 30 and then falls again around age 50 to 55. Figure 1 also shows that through the Governments previous initiatives, PHI funds have been able to attract a greater proportion of younger cohorts whereas insurance rates amongst the oldest age group did not alter substantially between 1997 and 2006.

The Government claims that in the seven years since the reforms were introduced private health insurance membership has stabilised at around 43% of the Australian population (Abbott 7 December 2006). The fact that the Government thinks that private health insurance membership has stabilised implies that it thinks the cycle of *adverse selection* is not a major issue in the current environment.

This means that insofar as *adverse selection* is concerned, past and current community rating arrangements have had limited impact on private health insurance membership. In fact, the opposite seems to be occurring; the insured appear to be healthier and wealthier than the uninsured.

The potential erosion of community rating and the ensuing move towards risk-rated premiums is therefore unlikely to have any significant impact on adverse selection (because there is very little of it in the first place). However, such a move may have important implications for the social function of community rating - relatively low premiums for high-risk individuals.

Figure 1: Percentage of the population privately insured



Source: (PHIAC 2006)

In the Australian context of community rating, PHI funds have had an incentive to undertake, what often termed, *cream-skimming*. This refers to insurers' activities aimed at reducing the risk profile of the insured population. Such activities can take many different forms and guises including marketing strategies aimed at younger cohorts, designing products that typically appeal to more healthy individuals, or making insurance products for consumers with specific conditions more expensive. Under the Bill before parliament, private health funds can now offer separate products that cover what are termed 'general services' and 'hospital services'. This will give funds greater flexibility to design products targeted at specific populations – and importantly – set different prices for different products. This greater flexibility in product design would enhance insurers' ability to undertake cream-skimming activities.

If, following the enactment of this Bill, private health funds engage in such strategic behaviour, it may be feasible for them to set higher premiums for products targeted at high-risk individuals and lower premiums for low risk individuals. The extent to which such behaviour occurs will depend on how PHI companies design the new products for people with, for example, diabetes or cancer as well as the potential changes to existing insurance products for those people who do not take out the new insurance. That is, will the new products lead to changes to the basic insurance package? This is critical because currently services such as chemotherapy are covered by PHI (although patients may have fewer choices about where they can have chemotherapy administered). In 2003/04 there were 276,000 chemotherapy separations. Of these 52% occurred in private hospitals and 55% were covered by PHI. The implication of patients having to purchase additional insurance to be covered for such services is that a step has been taken towards setting PHI premiums through risk-rating – in other words, the institution of a de-facto form of risk-rating. In the Australian context, such activities may lead to high-risk individuals not taking up private health insurance and relying on the public system instead, resulting in public hospitals caring for a sicker population.

Extension of a two tier system

Before turning to this point in more detail, it is worthwhile pointing out that it has been necessary for us to take a specific interpretation of some of terms and definitions contained in the Bill. We believe our reading of the Bill is fair and reasonable but we acknowledge that there is some ambiguity and therefore there may be other interpretations. In particular, we believe that the definition for the terms *hospital treatment*, *general treatment* and *hospital substitute treatment* are open to interpretation. For example, according to the Bill, *hospital treatments* can be provided either at a hospital or with the involvement of a hospital (see section 121-5). This is a very broad definition and, in our opinion, diminishes the need to define *hospital substitute treatment*, unless the government intends to allow non-hospitals to provide *hospital substitute treatments*. If this is the case then there are potential further consequences that need to be considered and these are discussed below.

It can be argued that Australia already has a two tier health system. Patients with private health insurance are covered for private hospital services giving them greater choice of doctor and, importantly, significant reductions in potential waiting times for elective surgery than those who are not privately covered. In addition, consumers with ancillary insurance face lower out-of-pocket costs and hence have greater access to dental and a range of allied health services that are not covered by Medicare. However, the two tier system is negated to some extent by the role GPs play in the health system. GPs do not only provide medical care, they act as the gatekeepers to other health care services through their referrals to specialists' consultations as well as diagnostic services. Research shows that Australia has a pro-poor distribution of GP service use – indicating that people on lower incomes have a higher use of GPs even after taking into account health status (van Doorslaer, Masseria et al. 2004). However, in terms of specialists service use there are indications that such services are pro-rich (van Doorslaer, Masseria et al. 2004; van Gool, Savage et al. 2006). Following his analysis of inequality in 21 OECD countries, van Doorslaer et al conclude that there appears to be a universal pro-rich distribution of specialist care and that this phenomenon is reinforced in countries where there are private insurance or private care options (van Doorslaer, Masseria et al. 2006). Australia is no different; recent analysis shows that the distribution of specialist utilisation is pro-rich. That is, after adjusting for health need, people on higher incomes use more specialists' services. Furthermore, the authors warn that an expansion of the private sector in secondary care services may further compromise one Australia's primary health system objective the objective Australia's health system of equitable access (van Doorslaer, Clarke *et al.* 2006).

Currently, no private health insurance can be purchased for GP services or any other Medicare outpatient service. The proposed Private Health Insurance Bill 2006 appears to safeguard this aspect of the Australian health system. However, as we understand it, the new products (termed *broader health cover*) that private health insurance can offer fall into two categories; *general treatment* and *hospital substitute treatment*. Broadly, general treatment refers to the provision of goods and services that are intended to manage or prevent a disease, injury or condition, is not a hospital treatment and for which no Medicare benefit is payable. *Hospital substitute treatment* is the provision of goods and services that are intended to manage or prevent a disease, injury or condition that substitutes for an episode of hospital treatment and is eligible for Medicare benefits, provided it is not claimed as an outpatient (ambulatory care) service. One of the most important differences between the two categories is that for *general treatment* services there can be no Medicare item (see section 121-10 of the Bill), whereas for *hospital substitute treatments* there must be a Medicare item and must be billed as an inpatient service (see Schedule 1 of the Bill and Section 72-1 of the bill) (2006).

We believe that the intent of the Bill is for Medicare to remain the sole insurance option for services such as GP, pathology, diagnostic imaging and specialists' consultations in the ambulatory care setting. However, we also believe that the Bill will create greater complexities in terms of the boundaries of what constitutes inpatient and outpatient care, and as a consequence between the public and private systems. Under the current system, the boundary may be arbitrary and in some cases may not make much sense in clinical terms, but nevertheless it is fairly clear. If the potential scope of private coverage is expanded, the line will become less clear. Providers are adept at figuring out the incentives of a financing system and are likely to respond accordingly. In Australia, such activity could typically entail shifting costs from parts of the health system that have capped budgets to parts that have continuous funding. This may result in increases in public and/or total health spending. Some possible scenarios are:

- Create disincentives on the part of private health insurers to develop products that attract consumers with complex needs.
- Create incentives for private hospitals and providers to set up clinics – not deemed to be hospitals - and bill patients on an outpatient basis. This is facilitated by the Bill through the blurring of inpatient/outpatient boundary. Such a scenario could be advantageous for hospitals/providers because it releases them from the contractual arrangements they have with PHI funds. Furthermore, changing the billing from inpatient to outpatient setting may be advantageous to those patients who have qualified for the Medicare Safety Net because it covers 80% of all Medicare outpatient fees, and insurance coverage is not restricted by the Medicare Schedule Fee.
    - Create more incentives for vertical integration of medical practice from primary care to hospital and outpatient care. This may lead to greater notions of corporatised medicine and diminish the role of GPs as gatekeepers and coordinators of the health system, Instead, putting greater emphasis on the hospital and specialists providers to provide the continuum of care for some sections of the community; or
- With the advent of new technologies and with the Bill allowing coverage of out-of-hospital services it is feasible that some services that were previously deemed inpatient type services may in the future be routinely provided in the outpatient setting. This may have to further consequences:
    - We may see greater pressure from providers/hospitals to add new technologies/services onto the Medicare Schedule and enable these to be provided in an outpatient setting.
    - It may invoke public hospitals to redefine the type of services that they provide. Public hospitals could decide to stop providing services that are now routinely provided in an outpatient setting; or severely limit the number of services resulting in extensive queues for uninsured patients.
    - The blurring of the boundaries creates a fundamentally volatile system of health care financing. It is not to too hard to imagine a situation in the near future where identical medical services may attract various rates of government subsides and private health fund coverage depending on type of health care product and the supposed setting of the service. This may create enormous complexity and confusion over financing responsibilities and entitlements. Such a situation could lead to wider dissatisfaction with Australia's health care financing system and calls for further reform. If this were to occur, then one possible consequence of this Bill is the extension of private health insurance into what is now the exclusive domain of Medicare: ambulatory care. One of the fundamental dangers of this is that we create a system where people can opt out of public insurance (through reduced taxes, levies) and rely more on private finance. This would create a more segregated

health care system for the privately insured, where the entire system (not just hospital) is differentiated for those with private insurance and for those without. More importantly such a system could endanger Australia's equitable financing arrangements.

Conclusion

The Government's intention to allow private health insurers to cover a broader set of services that are not necessarily bound by the four walls of a hospital are laudable. However, the Bill before parliament also carries serious risk of unintended consequences. This submission has highlighted some of the more obvious consequences as well as some of the more uncertain potential consequences. We believe the implications of this Bill are far reaching and therefore need to be carefully thought through before implementation as well as monitored and, where necessary, corrected. This justifies putting in place monitoring systems with public accessibility of data to enable independent scrutiny.

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