

23 March 2017

Mr. David Salisbury
General Manager
Consumer and Small Business Strategy Branch
Australian Competition and Consumer Commission
GPO Box 520
Melbourne VIC 3001

By email: phireport@acc.gov.au

Dear Mr. Salisbury,

Reference: ACCC report to the Senate on Private Health Insurance

A. Your letter dated 17 February 2017

The Australian Society of Anaesthetists (ASA) thanks you for the opportunity to make a submission to the Australian Competition and Consumer Commission (ACCC), prior to its report to the Australian Senate on private health insurance (PHI).

The ASA notes in your letter to stakeholders that the specific task of the ACCC is to report on “any anti-competitive or other practices by health funds or providers which reduce the extent of health cover for consumers and increase their out of pocket medical or other expenses”. As you note, the ACCC is already able to access a wide variety of publicly available information and data. The ASA will therefore largely limit its views on the issues at hand to general observations.

Firstly, it is essential to note the overall importance of the private health care sector in Australia, both in terms of the provision of patient care, and its funding (which ultimately all comes from the consumers of private health care). The most recent version of the Australian Institute of Health and Welfare (AIHW) report “Australia’s Hospitals at a Glance”, for the financial year 2014-15, released in July 2016¹, shows that healthcare in Australian private hospitals is extremely cost-effective. 50% of hospital separations were for public patients, funded by governments, and 42% were funded by PHI. This indicates that privately insured health consumers make a major contribution to the funding of healthcare in Australia. Furthermore, the private hospital sector clearly spends these funds wisely. According to this same AIHW report, private hospitals were able to provide care for around \$3000 per separation, compared to \$8100 per separation in the public sector.

It is therefore clear that the private healthcare sector must remain strong and viable. The Australian taxpayer cannot afford an increasing movement of consumers from the private sector to the public sector, for hospital-based care. Consumers must be encouraged to continue to fund their own health care, via maintaining their private health insurance policies.

¹ Australian Institute of Health and Welfare: “Australia’s Hospitals 2014-15 at a Glance”
<http://www.aihw.gov.au/publication-detail/?id=60129556023>

There are several factors which, currently, are creating an environment in which health consumers are increasingly questioning the value of their health insurance policies. In many cases, consumers are downgrading their level of cover or even dropping out of the PHI market altogether.

Health Insurance Premiums

Health insurance premiums have continued to rise year-by-year at a rate significantly greater than inflation. The federal government must approve these premium increases. While the ASA acknowledges that health costs overall have continued to outstrip inflation, for all of the reasons well known to government bodies and stakeholders, e.g. the changes in the demographics of the Australian population, there are other factors at play.

The large majority (over 70%) of Australian health consumers are now covered by insurers whose sole motive is financial profit. The industry has been extraordinarily successful in its endeavours in this regard, with overall PHI profits of over \$1.7 billion in 2016. This figure has been increasing rapidly in recent years; well beyond the rate of premium hikes. All for-profit PHI insurers' input into the issues at hand must have these facts at the forefront of consideration.

The ACCC, in its role of protecting the interests of the Australian health care consumer, must maintain a strong dialogue with government, aimed at minimising the degree and impact of PHI premium hikes.

Recent Developments in PHI

By way of example, certain actions of Australia's largest insurer, Medibank Private (a for-profit insurer), assist us to understand the motives of PHI companies, and the potential hazards to maintaining a large pool of privately insured health consumers. In 2015, Medibank Private introduced contracts with private hospitals which contained "no pay" clauses where a list of 165 so-called "preventable" adverse events occurred. 70% of Australia's private hospitals have entered into such agreements with Medibank Private. Apart from the fact that an adverse event's "preventability" can only be judged by clinical experts, the introduction of such schemes has a number of potential consequences. Importantly, it may result in providers and hospitals avoiding providing care for patients where they see these patients as being at higher risk. These patients would then have to rely on public hospital care. This would certainly be of financial benefit to the insurer, and would improve the private hospitals' outcome statistics. However, it would also place an increasing burden on the public system, and would clearly reduce the extent of health cover for PHI consumers. It would also limit consumers' choice of practitioner and hospital – a key benefit of having a PHI policy in the first place.

A number of insurers, both for-profit and not-for-profit, are also providing an increasing amount of online information about providers. This includes contact details for providers, which may well be useful, but the intentions behind providing the range of other information proposed, go well beyond this.

In particular, the intention is to provide information on providers' utilisation of PHI "no gap" schemes, and their level of out-of-pocket (OOP) expenses for their care. This is clearly aimed at having consumers (and referring practitioners) limit their choices to providers based purely on costs. Providers should be chosen on the basis of quality, not just cost. One possible outcome is that providers struggling to obtain referrals (for whatever reason) will utilise the situation to their advantage, by guaranteeing no-cost or low-cost services to consumers. Furthermore, the billing history of one particular provider gives the consumer no guarantee that their specific episode of care will be provided at the same cost.

PHI companies also propose to list patient feedback on their providers' performance. Such initiatives are already well underway, as demonstrated by the NIB-initiated "Whitecoat" website, which already provides such information on over 40,000 allied health providers, and which is proposed to be extended to medical practitioners. Again, this poses significant risks of adverse consequences. Practitioners may avoid higher

risk or more complex cases, with the risk that patients with significant co-existing medical problems will be limited in their choice of provider and hospital, or will have to seek care in the public sector.

It is clear that insurers are trying to gain more control over the system, in order to decrease their outlays. We cannot allow the private healthcare industry to follow the lead of the USA, where “managed care” is a major issue. Allowing insurers to decide which care will and will not be funded is a major risk to health care. It would essentially mean that insurers are given the power to decide which care will or will not be provided, as the vast majority of consumers would not be able to afford care in the private sector if insurance coverage is denied.

Various commentators, clearly supportive of the best interests of insurance companies rather than of patients, have lauded the USA “managed care” system as the best way forward. They point to the fact that a fee-for-service system is open to manipulation by the vested interests of providers, who will be motivated to provide as many services as possible. The extremely negative term “perverse incentives” is often bandied about, as are veiled accusations that Australian doctors are deliberately providing unnecessary services in order to generate income. These commentators fail to point out, however, that giving control of funding decisions to insurers creates a potentially even bigger problem.

Many private health insurers, especially the “for profit” funds now covering over 70% of privately insured consumers, are highly profitable, large companies with enormous resources, and far more market power than the medical profession. Their motives are not to provide care to patients, as is the case for the medical practitioners at the coalface. Their motive is to maximise income from premiums, and minimise outlays on the funding of health care. The insurers have a vested interest in denying funding in order to maintain profitability. Yet it is suggested they be given the role of gatekeepers of access to care. Who has the greater “perverse incentive” here?

The other fact that these commentators fail to highlight is that healthcare in the USA, under the “managed care” system, consumes enormously more resources than does the current Australian system, with, as best as can be told, less satisfactory overall patient outcomes (or certainly with no better health outcomes than the current Australian system provides).

Consumer Information

Over the years, in virtually every report of the ACCC to the Senate on the issues at hand, it has been made clear that many privately insured consumers do not fully understand their health insurance products. This has led to repeated instances of problems such as last-minute cancellation of admissions/operations, or cases of “bill shock” where consumers experience unexpected OOP costs due to not being covered to the extent they believed they were.

Private health insurance products are complex. They are also expensive. It is therefore not surprising that many consumers choose to exclude certain services and procedures from their cover. However, due to the complexity of the products on offer, it is still the case that many consumers do not understand the consequences of altering their policies in this way.

Some consumers make their decisions based on online information, made available by groups such as iSelect and Choosi. However, while such websites may allow consumers to compare the different policies available, they are not completely reliable. The ASA is aware of a number of instances of patients experiencing higher-than-expected OOP costs for their medical bills, as the website had not disclosed the insurer’s terms and conditions relating to medical expenses.

The round-table forum held by the ACCC in June 2016 was a welcome development, as was the formation of the Private Health Ministerial Advisory Committee (PHMAC) which has been given the task of recommending changes to the government, such that PHI products become easier to understand.

Fees for Medical Services

The issue of doctors' fees, and the fact that these are a source of OOP costs to some consumers, has generated a great deal of publicity in recent times. Almost invariably, the publicity in the media is slanted heavily against doctors, with little or no mention of the reasons for the existence of such costs. Quotes from figures within the PHI industry have given the impression that OOP costs for doctors' fees are a major problem, and a major disincentive to taking out PHI policies.

Extensive publicity has been given to the fees and charges of a very small number of "outliers". The consumer would be forgiven for believing that the very large fees of these very few doctors, actually represent the norm. While it is entirely factual that such OOP expenses exist, their incidence (and actual dollar cost) is not as high as the media and PHI industry would like the consumer to think. Certainly, these OOP costs pale in comparison to the annual hikes in PHI premiums, and the exponential rise in the profitability of the for-profit insurers in recent times.

What is hardly ever mentioned, and then only in passing, is the actual cause of the "problem" of OOP costs for medical fees. The increasing incidence and amount of OOP costs is of course entirely due to the fact that Medicare and PHI rebates have not kept pace with the rising costs of medical practice. Every year for over three decades, since the introduction of the Medicare system, the indexation of rebates has been well below inflation. In some cases, indexation has been zero, or even negative (i.e. a decrease in the available rebate). And, of course, we are now in the middle of an eight-year freeze on Medicare rebates (Nov 2012 – July 2020). A number of PHI companies have likewise frozen their rebates, while others have provided small indexations, which remain well below inflation.

Despite this, the vast majority of medical services in the private sector continue to be provided at zero OOP costs to consumers. The general public is almost certainly unaware of this, due to the publicity discussed above. Australian Prudential Regulation Authority (APRA) data² (and until its recent discontinuation as a body, data from the Private Health Insurance Administration Council – PHIAC) indicate that close to 90% of all inpatient medical services in the private sector are provided at no OOP expense to the patients.

It is essential that the ACCC, as an independent body, highlight all of these facts in their annual report to the Senate. The continuing distraction from the performance, motivation and profitability of the PHI industry, by painting providers as the source of all problems, cannot be allowed to continue. It would be shameful if consumers were to decrease or drop their insurance cover, based on inaccurate, biased media coverage which does not give the whole story.

Australian health consumers deserve full access to all of the facts.

Yours sincerely,

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² Available online:
<http://www.apra.gov.au/PHI/Publications/Pages/Industry-Statistics.aspx>