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HCCA Submission to the Senate Community Affairs References Committee Inquiry into the Value and Affordability of Private Health Insurance and Out-Of-Pocket Medical Costs

Submitted 28 July 2017

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Background

The **Health Care Consumers' Association (HCCA)** is a health promotion charity and the peak consumer advocacy organisation in the Canberra region. HCCA is a member based organisation, aiming to represent the voice of consumers across the ACT in local health issues, as well as providing opportunities for health care consumers to participate in all levels of health service planning, policy development and decision making.

HCCA involves consumers through:

- consumer representation and consumer and community consultations,
- training in health rights and navigating the health system,
- community forums and information sessions about health services, and
- research into consumers' experiences of health services.

We promote improvements to the health care system from the perspectives of consumers, with an emphasis on equity, as well as promoting and providing expertise on consumer participation in health. We support universal health care. It is through this lens that we are responding to the **Senate Community Affairs References Committee Inquiry into the Value and Affordability of Private Health Insurance and Out-Of-Pocket Medical Costs**.

In preparing our response, we sought input from our members and through our networks about consumer experiences in relation to the terms of reference for this Senate Inquiry[1]. Our consultation with consumers, their stories, comments and ideas, as well as HCCA's years of experience in advocating for consumers in health, have all helped to shape this submission.

[1] http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Privatehealthinsurance [Accessed 25/07/17]

Executive Summary

It's hard for consumers to know what is covered by their private health insurance. Policies are complex and hard to compare, both for value for money and to minimise out-of-pocket costs. HCCA members have had a variety of experiences with purchasing and/or using private health insurance. This reflects a range of factors including varied health needs, expectations of the systems in place, past experiences, health literacy and financial situations. We see the key issues for consumers for this **Senate Inquiry into the Value and Affordability of Private Health Insurance and Out-Of-Pocket Medical Costs** as follows:

- Consumers purchase private health insurance for many reasons – key among these are peace of mind, being able to avoid public waiting lists and the misconception that insurance is compulsory.
- Not everyone can afford private health insurance, and the costs of premiums have been rising rapidly in recent years. Consumers are reassessing the coverage of their policies, and whether they should maintain their coverage.
- Safety and quality is important to consumers, but without publically available outcomes reporting, consumers don't have data with which to make informed decisions about their health care.
- Private health insurance policies are very complex, and without being familiar with every detail it can be difficult for consumers to make informed decisions.
- Feedback from consumers indicates that health insurance extras 'cover' often leaves us with the majority of the expense to pay out-of-pocket. These costs are in addition to their policy premiums.
- The practice of being a private patient in a public hospital is not well understood by consumers, nor is it well explained by hospital staff. Consumers are sometimes asked to 'do the public system a favour' by using their private insurance in a public hospital, without being given sufficient information to make a fully informed decision about the personal cost.
- Using private health insurance for a hospital visit raises issues for consumers about informed financial consent. Consumers are not always fully advised about out-of-pocket expenses, time limits, or claim limits on particular services.
- Consumer 'bill shock' is not uncommon following the use of private health insurance for an inpatient stay. Our feedback from consumers demonstrates that patients using private health insurance know that their out-of-pocket costs could be high, and that they have little control over these charges.

We support universal health care and believe that both the public and private systems, and where they intertwine, need to deliver safe and high quality care. If the Australian Government is continuing to support private health insurance, the system needs to be achieving value for money at all levels.

General comments

Australia has a mixed public-private health care system. The main elements of the public health system are general practice, medical pharmaceuticals, and public hospitals. The first two are funded directly by the Commonwealth through Medicare and the Pharmaceutical Benefits Scheme (PBS), respectively. Public hospitals are managed by the states and territories, but publicly funded under the Medical Benefits Scheme (MBS). Private hospitals also receive payment for anything covered under the MBS, and so receive a lot of public moneys. Further complicating the picture is that the majority of Australian medical practitioners consider themselves to be private practitioners, even though their income is underwritten by public money through Medicare or the MBS. **It's no wonder that consumers have difficulty understanding what is covered (or not) by private health insurance.**

Australians purchase private health insurance for many reasons. Having peace of mind, being able to avoid public waiting lists and the misconception that insurance is compulsory are just a few. The Australian Government provides incentives for the purchase of private health insurance via the Private Health Insurance Rebate[2] and the Lifetime Health Cover (LHC) initiative[3]. These encourage consumers to purchase and maintain private hospital insurance cover earlier in life.

However, private insurance costs, and it's not a cost that everyone can afford. In recent years, private health insurance premiums have been rising rapidly. The increasing costs of private health insurance have meant that many consumers are frequently reassessing both the value of their policies and whether it is worth maintaining their cover[4].

The Medicare system provides universal coverage that overlaps with the private hospital system. The current arrangements mean that consumers with private insurance may weigh up the pros and cons of all the options available to them, not just through the private system. A consumer's decision to use or not use their private health insurance in an interaction with the health system can be based on multiple factors. These include: their individual circumstances; their level of health literacy and their previous experiences of the health care system, as well as the fine print of their private health insurance policy. The decision making process is complex – more than simply paying your premiums and being able to choose your doctor.

For example, some consumers with private health insurance may opt for cancer care in the public system, because they know others who've had a good experience, the health pathways in hospital and the community seem clear to them, and they can get

[2] Xx https://www.ato.gov.au/Individuals/Medicare-levy/Private-health-insurance-rebate/ [Accessed 25/07/17]
[3] Xx https://www.ato.gov.au/individuals/medicare-levy/private-health-insurance-rebate/lifetime-health-cover/ [Accessed 25/07/17]
[4] For example, see https://www.choice.com.au/money/insurance/health/articles/cost-of-health-insurance-forcing-people-to-downgrade-policies-accc-190717 [Accessed 25/07/17]

the care they need at a difficult time. The costs are covered by Medicare and they avoid the worry of 'bill shock' which can occur from the out-of-pocket payments in the private system.

Others with private health insurance will feel comfortable that they can elect to go ahead with a joint replacement in the private system. They can often skip the lengthy waiting lists of the public system. They believe that because they are able to choose the orthopaedic surgeon and use a private hospital, this will get them the best outcomes, and allow them to be on the road to recovery faster. However, this is a belief rather than an assured result, as there is little publicly available evidence upon which to base choice of doctor or hospital. Consumers holding private health insurance may have the capacity to pay the out-of-pocket costs in the private system, or they might struggle to do it but feel it is still worth it in the end. Others may choose to use their insurance coverage to be a private patient within the public hospital system.

The reasons for choosing to be uninsured are also complex. Cost is obviously an important factor: so while some people would like private health insurance they cannot afford the hefty premiums. Others are happy with their coverage under Medicare and the public system and see no need for private insurance. Still others support the concept of a universal health system and perceive that it is undermined by a private system, which receives considerable public moneys. Then there are those who choose not to have private health insurance, because they feel it offers them better value to pay the whole cost out-of-pocket in the private system when the occasional need arises.

Given that the government does financially support private health insurance through various mechanisms and incentives, it is important that private health insurance achieves **value for money** for both government and consumers. Private health insurance should also uphold the government principles of using public resources in an **efficient, effective, economic and ethical manner** that is not inconsistent with the policies of the Commonwealth.

Safety and quality are also important to consumers. One of the untested beliefs that leads consumers to hold private health cover is that people believe that the private system provides better care and outcomes for patients. While the "hotel services" of private hospitals may be better, when a patient is sick, what matters most to patients and families is the quality and nature of the care provided. The on-going absence of patient outcome reporting by doctor and by kind of hospital (public/private) means that consumers are left without any data to make significant decisions about their health care.

Even at an Australia-wide level, the AIHW hospital statistics[8] states that the differences in frequency of adverse events was most likely simply the result of different case mixes[9] and patient populations. 97% of emergency services are provided by public hospital[10] and 87% of emergency admissions involving surgery occurred in public hospitals[11]. Private hospitals conduct around two-thirds of elective surgery[12] and patients of private hospitals were from a higher socio-economic demographic.[13] In the *My Hospital* website, very limited outcome data on golden staph infections and hand hygiene data is provided at an institution level[14]. However, private hospitals are not obliged to provide their data and in the case of Canberra private hospitals, this ranges from no data to both sets of data.

No hospitals in the ACT provide broader patient outcome data to allow potential patients to make proper choices on the basis of performance or quality of care. There is certainly no practitioner level data to base choice of doctor upon and few doctors would be able to provide it, even on request.

8 The most recently available data relates to 2014-15 and was published in 2016: Australian Institute of Health and Welfare (AIHW). *Australia's hospitals 2014–15 at a glance*. Health services series no 70. Cat . no. HSE 175 . 2016 Canberra, AIHW. [Australia's hospital 2014-15]

9 The AIHW noted that "about 6 .7% of hospitalisations in public hospitals and 4.1% in private hospitals had an adverse event recorded; the differences may reflect the different casemixes of public and private hospitals". Australia's Hospitals 2014-15, see note 8 – see page 29

10 Australia's Hospitals 2014-15, see note 8 – see page 31.

11 Australia's Hospitals 2014-15, see note 8 – see page 12.

12 Australian Institute of Health and Welfare*. Admitted patient care 2014–15: Australian hospital statistic*s. Health services series no. 68. Cat. no. HSE 172. 2016 Canberra, AIHW: Table 6.27, page 177.

13 Australia's Hospitals 2014-15, see note 8 – see Figure 23, at page 20.

14 http://www.myhospitals.gov.au [Accessed 27/07/17]

Responses to the Terms of Reference

We have chosen to make a response a select number of the terms of reference only, which are (a), (b), (c) and (e) . Our responses are detailed below.

(a) Private and public hospital costs and the interaction between the private and public hospital systems including private patients in public hospital and any impact on waiting lists

Our feedback in consultation with consumers suggests that the practice of being a private patient in a public hospital, at least in the ACT, is not well understood by consumers, nor is it well explained by hospital staff. As a result, consumers who may already feel vulnerable in the health system, feel even more so when they are asked to 'do the public health system a favour' by using their private insurance, without sufficient information being provided to make a fully informed decision. For example, a consumer gave us the following story:

> *"My experience was being approached, while still in ED, by a young.. training doctor in the early hours of… [the] morning. He had taken a medical history from me. I think he had been sent down to enquire by his boss…I was just given the line about how using my private health insurance would help the hospital. That was when I agreed. Subsequently, when I was in the.. ward I was given appointments for a further test and consultation in the private rooms of the [specialist]. No information about costs was provided.*
>
> *What troubles me about this is a question about whether Specialists are able to use the system to recruit vulnerable private patients. Although I am normally on the ball, in the early hours of the morning after a sleepless and rather scary night, I was very vulnerable and unable to make a proper informed financial consent. I know nothing about the cardiologist, and I still do not know anything about the fees and out of pocket costs (though I will enquire) or what the further downstream costs will be.*
>
> *In the case of my friend who will need ongoing public aged care services, the implications of using their insurance were certainly not explained.*
>
> *It all seems to me to be a highly questionable practice – both by the hospital and the specialists. Where is the focus on informed consent (both financial and other)? What are the ethics of this practice?"*

HCCA was provided a copy of the information sheet given to consumers at The Canberra Hospital (see Attachment A) with details about the ACT Health 'No Out Of Pocket Expenses' (NOOPEX) scheme. We feel that the NOOPEX information sheet creates great uncertainty for consumers about how bills and charges will be processed, as well as whether consumers will have to grapple with Medicare, cheques and invoices after being discharged from hospital.

We note that NSW Health has developed information for consumers on being a private patient in a public hospital[15]. The information is presented more clearly and gives much greater confidence to the consumer that the hospital will deal with the health fund and all accounts, without out-of-pocket expenses. It also states that "you will help our hospital if you choose to use your private health insurance". If this is the approach supported by government to in turn benefit the public and support our public system[16], then this message needs to be made clear to all consumers.

(b) The effect of co-payments and medical gaps on financial and health outcomes

Using extras cover

This is a story we received from one of our consumer members:

> *"I read part of the CHOICE report on PHI and they said that one of the motivators to join PHI is for extras cover, ie, services other than inpatient care. My story is a demonstration of some of the deficiencies of the extras cover. Our family pays almost $3800 annually for a policy that covered inpatient care and some extras – optical, dental and allied health services such as physio. We do not have a policy that covers maternity or mental health care (community based psychology services).*
>
> *I sustained a serious injury to my ankle that required regular (weekly) rehabilitation with a physiotherapist for 12 weeks, with follow up after that point for up to 12 months. The way the coverage is structure by my private health insurance provider is such that I am penalised financially for a long term need for rehabilitation.*
>
> *The cost of the physiotherapist was $105 for the initial assessment and consultation and then $90 for each appointment after that.*
>
> - *Initial assessment - my private insurance covered $28, leaving me $77 out of pocket*
> - *Follow up appointments - my private health insurance covered $26, leaving me $64 out of pocket.*

[15] Xx http://www.health.nsw.gov.au/Hospitals/Going_To_hospital/Documents/what-means-private-patient.pdf and http://www.health.nsw.gov.au/Hospitals/Going_To_hospital/Documents/your-choices.pdf [Accessed 25/07/17]

[16] Xx https://croakey.org/behind-the-headlines-on-hospital-waiting-times-lies-a-murky-story-about-lack-of-structural-accountability/ [Accessed 25/07/17]

- *After four follow up sessions the coverage reduced to $21 per session, leading to an increase in my out of pocket costs to $69.*

This does not make sense. Consumers should not be penalised for long term rehabilitation. We need to access these services so that we can regain full function and not live with pain. I do not understand why the coverage is reduced over time. If the insurers are concerned about over servicing then they need processes in place to monitor the registered health professionals and not shift this to the cost for consumers. It is a disincentive".

This story largely speaks for itself, and we believe reflects the experience of many other consumers using private health insurance. Feedback from consumers indicates that extras 'cover' provided through health insurance for services such as dental, optometry and physiotherapy **often leaves consumers with the majority of the expense to pay out-of-pocket**. This is **in addition to the premiums that consumers are already paying for their policy**. We believe such poor coverage would not be accepted on comprehensive insurance claims in other sectors, so it is not surprising that consumers are questioning the value of their health insurance policies.

The story also speaks to the disregard for consumer health outcomes under private health insurance. In this case, the terms of the policy mean that the consumer is penalised by their insurance provider for services that their health professional recommended in order to make a full recovery. We suggest that this does not encourage best practice care, and the disincentive to consumers does not support good health outcomes.

Using insurance as an inpatient

The affordability of co-payments is a major issues for consumers, as demonstrated in the story below:

"Co-payments are very expensive in Canberra while at [a Sydney private hospital] my treating doctors had agreements with my health fund for no-gap payments. It's better and cheaper for me to go to hospital in Sydney.

I live on a pension but will always stay in a health fund to choose my medical care because it gives me better more specialised treatment in a timely manner. I really do notice the difference, for example when I have a colonoscopy I am given a copy of the medical report and images to keep track of any developments in my condition as well as it being sent to the GP. This never happened when I was a public patient."

This consumer has had to use a hospital interstate in order to reduce the co-payment burden often associated with inpatient care under private health insurance. On a limited income, this consumer's experience is that the private system better meets their health care needs, despite the sacrifices necessary. It is concerning that public and sometimes private patients may not be given copies of their test results and reports, if requested, as would be expected under the current law in the ACT. Patients and their families are often the main source of continuity of care information, when patients move from public and private places of care.

Consumer 'bill shock' is not uncommon following the use of private health insurance for an inpatient stay. Our feedback from consumers demonstrates that patients using private health insurance know that their out-of-pocket costs could be high, and that they have little control over these charges. For example:

> *"I have had several experiences as a private patient in a public hospital, and there is not difference in the level of care provided. Unless you negotiate to be a private patient without a gap in a public hospital, there will be out of pocket expenses which could be very high.*
>
> *In relation to surgery and other procedures in hospital, patients generally don't have a choice of who their doctor is and don't choose based on the cost charged. Patients, if they can, choose the best person in the field and therefore have to pay whatever price that doctor charges. It is not like other 'consumer purchases' where you can shop around and find the cheapest provider."*

Other consumers commented on out of pocket costs for inpatient care:

> *"Where you really get surprised by the cost is a private hospital visit, even though the hospital stay itself is normally covered by insurance. In particular, the cost of anaesthetics is often quite a shock. In my experience, it's not like you get any choice about which anaesthetist you use, and you're lucky to get an indication of the cost beforehand. Also, if you've been put on medication in hospital, they don't give you any on discharge, just the prescription/s. You have to organise to get the medications yourself. In the public system you would be given at least some medication to keep you going".*

Another consumer shared a story about a friend's experience:

> *"Her health fund… gap payments for her operation was $8000 for the premier surgeon. The second surgeon gap was $1500 and the anaesthetist gap was approximately $900 that she wasn't told about and didn't realise that it would be so big… She has had to put her house on the market... Her only income is the age pension."*

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

Private health insurance policies are so complex, it can be difficult for consumers to be familiar with every detail of their policies and make informed decisions. For some policy benefits, you may get to know more of the details for those aspects you use more frequently, such as dental, physiotherapy or optical. Even then, you could still have a health issue arise unexpectedly, for which you may have to refer to policy documents or call the health fund to check the coverage.

The Standard Information Statements[17] produced by health funds for each policy give a good summary, but the finer details can vary so much between policies that any sort of comparison becomes incredibly difficult. There is a lot of variation in rebates, exclusions and benefits, and in the detailed term and conditions that apply to each of these across an often wide range of services.

Using private health insurance for a hospital visit raises issues for consumers about informed financial consent. We are aware that consumers are not always fully advised about the costs involved for them that will be an out-of-pocket expense, or where there might be a limitation of time or a claim limit on a particular service. We suggest these aspects of private cover could at least be better managed through improved communication with consumers.

(e) The take-up rates of private health insurance, including as they relate to the Medicare levy surcharge and Lifetime Health Cover loading

The introduction of the Lifetime Health Cover policy by government in July 2000 clearly motivated some consumers to take up private health insurance. However, the continually rising premiums and poor coverage for services by health funds have led to consumers dropping their cover altogether, when it doesn't appear to offer them value for money.

> *She took up private health insurance (PHI) in July 2000 when the government introduced Lifetime Health Cover. She was employed and earning well at the time. Things changed when she retired. The prices for coverage kept increasing. Then she received a letter telling her several items were no longer covered. She was already feeling "ripped off", so took the opportunity to cancel her comprehensive coverage.*

[17] See http://www.privatehealth.gov.au/faq/sisguide.htm [Accessed 26/07/17]

She stated that rather than the government subsidising private insurers it would be "better having a very good universal health service. And here I am participating in it."

It turns out she was 3 months off having been insured for 10 years [the point at which Lifetime Health Cover loading would have been dropped from the price of the premium]. In 2010 she went to drop out and she wasn't told about the 10 year rule by staff. Instead she was persuaded by clerks "whose job it is to keep members" to take out extras only coverage. She makes sure she uses her coverage with massage, dental, etc. When she did the numbers on money paid to insurance and the difference paid to service providers, there was little difference from paying service providers directly. "Is this worth it? Propping up a system I don't approve of?". Her credit card details changed and she didn't reinstate regular payment, receiving "please re-join letters" for six months.

"It's a difficult choice. Extras are not a problem", but hip replacements and cataract removals are".

She recognises that Australia's universal health insurance system isn't perfect. She will need cataract surgery in the next five years and is planning to get a referral from her GP soon, so she will be near the top of the public list by the time she needs it.

Making a decision takes a lot of juggling and guess work. "I'm not poor. If I needed to go private I could probably make it work." But a lot of others don't have reserves. "There's a back-up for me" but not for others.

Over the years she feels that she "clearly paid a lot of money and got nothing." Now that she is on a quarter of her previous income, her capacity to pay for private cover, if she wanted it, is severely limited.

This consumer's experience was that her health fund did not explain that she was close to the end of paying her Lifetime Health Cover loading (capped at 10 years where cover is maintained), on top of her premium, at the point at which she went to cancel her policy. This could potentially have changed her decision to drop her cover at that point, and the loading she would have to pay for private cover now, years later, makes it unaffordable.

We also note that consumers who can plan for upcoming elective surgeries years in advance may be able to have their surgery when they need it in the public system Not everyone on a public hospital waiting list will be so fortunate with receiving timely health care.

Concluding remarks

Australia's health system is complex - it's not surprising that consumers have difficulty understanding what is covered (or not) by private health insurance. The range of policies and their varying terms and conditions contributes further to the complexity of the system. The current system for private health insurance has consumers paying out considerable premiums, which continue to increase, whilst still often leaving consumers with large out-of-pocket expenses. For hospital stays using private health insurance, the coverage is often unclear, and the out-of-pocket expenses undetermined until the bills are received.

Consumers have varied health care needs, and this submission demonstrates that decisions often reflect the health experience of each individual and/or family; existing knowledge of the health system; family income and ability to pay the premiums; and belief that having private insurance will guarantee a 'better outcome', or at least a streamlined service.

How should consumers weigh up the government incentives for private health insurance vs consumer costs, in both premiums and out-of-pocket expenses? With such uncertainty, consumers are questioning what value their private health insurance holds, its affordability now and into the future, and whether coverage under the public Medicare system might need to be sufficient.

We hope the comments and stories from our membership will assist the Senate Community Affairs References Committee with their Inquiry into the value and affordability of private health insurance and out-of-pocket medical costs in Australia.

Please do not hesitate to contact us if you wish to discuss our submission further. We would be happy to clarify any aspect of our response.

Attachment A – ACT Health NOOPEX Information Sheet

ACT Government
Health

NOOPEX PRIVATE PATIENT – INFORMATION SHEET

If you elect to be admitted as a Private Patient under the No Out of Pocket Expenses (NOOPEX) scheme and hold hospital Private Health Insurance:-

- You will not incur any medical fees. This means your Medical Treatment will be fully covered by Medicare and your Private Health Fund.
- The Canberra Hospital will cover any hospital excess payable to your Private Health Insurer.
- You will not incur any personal expense for hospital accommodation, Imaging or Pathology.
- You should not receive any accounts for your treatment, as the hospital will bill Medicare and your Health Insurer directly, through our Simplified Billing System. NIB patients may receive an account for pathology services; however they will not be out of pocket.
- If you do receive any invoices please submit to medicare and your health fund, cheques will be sent to you to be forwarded to the provider. If any concerns with these invoices please contact the Patient Liaison Officer.
- The Canberra Hospital is a teaching hospital and the care given to you will be provided by a 'team' under the direction of Clinical Consultants. This team may consist of Consultant, Medical Registrar, Residents, Medical Specialists or Visiting Medical Officers and Allied Health (Physiotherapists, Social Workers etc.)
- If your Private Health Insurance covers you for a single room, every effort will be made to find single room accommodation for you. However single rooms are allocated according to clinical need.
- If your circumstances change e.g. you require surgery, please advise the ward clerk who will contact the Patient Liaison Officer.

If you have any queries you can contact the Patient Liaison Officer on
Phone number : 62443336 or 62443670 or
Email : plochhs@act.gov.au

GPO Box 825 Canberra ACT 2601 | phone: 6205 0825 | www.act.gov.au