Pharmacy and Insurance Branch
Department of Health
MDP 853, GPO Box 9848
CANBERRA ACT 2601
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Re: Options to reduce pressure on private health insurance premiums by addressing the growth of private patients in public hospitals

Thank you for the opportunity to put forward a consumer view on this options paper, we have considered the issues as they pertain to those accessing health care in the ACT.

The Health Care Consumers' Association (HCCA) was incorporated in 1978 and is both a health promotion agency and the peak consumer advocacy organisation in the Canberra region. HCCA provides a voice for consumers on health issues and provides 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 consumer experience of human services.

HCCA is a member based organisation. We consulted with a targeted group of members on this options paper from the Department of Health. The consultation group included members of HCCA's Health Policy Advisory Committee. The consumer comments we received have shaped this submission.

Yours sincerely

Darlene Cox
Executive Director

15 September 2017

HCCA Submission on

Options to reduce pressure on private health insurance premiums by addressing the growth of private patients in public hospitals

Submitted 15 September 2017

Contact: Darlene Cox
Executive Director
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Consumer Consultation and General Comments

We felt that this feedback from one of our consumers summarised our comments well:

> *"I do not see the problem this paper is trying to address. We have a hybrid system in Australia, a product of Government policy over time. There are public patients treated in private hospitals just as there are private patients treated in public hospitals. This is a result of availability of services, issues of access as well as financial imperatives or funders (both governments and private health insurance) as well as services (public and private). In the ACT all public primary joint replacements happen in a private hospital, Calvary John James. And there is a regular flow of patients between the public and private sectors, for example National Capital Private Hospital and Canberra Hospital. And the new private hospital at Bruce will have all women birthing in the public hospital and then transferred to the private hospital for accommodation and follow up care.*
> *The amount of money being looked at for saving is a small proportion of the total. The real value lies with careful scrutiny of ancillary services (extra's cover) and in providing adequate support for those people with significant health issues requiring regular access to medical care, including hospitalisation".*

Specific Comments

Page 1 – Recent growth in private health insurance premiums

- The opening paragraph talks about Australia spending less than the OECD average healthcare but that it '*achieves better than average health outcomes'.* We think that if this statement forms a basis for the arguments of this paper, the evidence should be referenced.
- The last sentence in the opening paragraph states *'A healthy and stable private health insurance system used by 13.5 million Australian is essential for the stability of Australia's overall health care system'.* Is it essential? The options paper doesn't give any details about why the Australian Government considers the private health insurance system to be essential.
- The second paragraph explains that premium increases for private health insurance in Australia have totalled 46% between 2011 and 2017. There is no comment made about the impact on consumers. These significant increases mean that the cost of health insurance has grown at a much higher rate than income, and such rises mean that private health insurance is now unaffordable for many Australians.
- The table at the bottom of page 1 contrasts insured hospital benefits in 2010-11 and 2015-16. We note that the public hospital proportion of the total insured hospital episodes goes from 15% (2010-11) to 17.5% (2015-16), showing a 2.5% increase in episodes over the five year period. Also, the public hospital proportion of the total insurance benefits goes from 11.9% (2010-11) to 12.8% (2015-16), which shows less than 1% increase in total insurance benefits in the public sector. We suggest that without further explanation and analysis, the table about insured

hospital episodes and benefits fails to make a strong argument for either the policy problem suggested or the options that are presented later in this paper.

Page 2

- There is mention here that health insurers are returning around 90 cents in the premium dollar back to consumers as benefits and that opportunities to identify savings through the internal operation of health insurers is limited. We know from the APRA Private Health Insurance Quarterly Statistics (June 2017) that net profit has increased from $1.2billion (2015-16) to $1.4billion (2016-17), so while premium costs are going up, health insurers are still returning a significant profit, which makes us question whether there is a policy issue that needs to be addressed.
- Given APRA data (APRA Private Health Insurance Quarterly Statistics June 2017) shows that the average bed day costs for insurers is three times greater in a private hospital than a public hospital, it would seem economically more sensible to encourage privately insured patients to use public hospitals for their medical care, if the policy aim is actually to reduce cost pressures on premiums.

Page 2 – Private patients in public hospitals

- We question the first statement in this section: '*The rapid growth in privately insurance episodes in public hospitals is a concern for private health insurance costs*'. Is it a concern? Why is it a concern? As one of our consumers said: "*The paper doesn't explain this issue!*"
- The second paragraph says that there does not appear to be any reason for the rapid growth of private admissions in the public sector. We do not accept that the growth has been rapid and there are different reasons why consumers are using private health insurance in the public sector. For example, a consumer shared this story with us:

> *"In 2012 my father had carotid artery surgery to restore proper blood flow to his brain. He was admitted to Concord Hospital as a private patient. His cardiologist encouraged this as he felt it was urgent surgery and there was inadequate facilities at the local private hospital. He was concerned my father may need a higher level ICU rather than a HDU post-operatively. The decision to go private expedited admission. He was able to have the operation that week rather than wait four weeks in the public system. The point is that sometimes public hospitals are the only facilities that have the equipment and/or resources required".*

And other consumer shared this story, where the public hospital pressured use of private health insurance in the interests of the local community:

> *"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 [specialist], 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".

The information provided to consumers in the ACT at the Canberra Hospital about using their private health insurance in a public hospital is poor (see Attachment A). We believe that if consumers are asked to consider using their private health insurance in a public hospital, that supporting information should be of sufficient quality as to give the consumer some assurance and confidence about the process and clear statements about out of pocket costs involved.

- The next paragraph states that there is a '*wealth of public material*' suggesting that growth in private patients is being driven by public hospitals making extensive efforts to persuade patients to elect to be treated privately. While the story we have included above does demonstrate this issue, we would like to see some references or links to the *'wealth of public material'* here in order to ascertain that this is indeed a significant issue across all jurisdictions.
- The table on page 2 shows the percentage of public hospitals separations funded by private health insurance by state and territory. While QLD has had the highest growth, from 5.7% to 12.1%, the growth in percentage points is still only 6.4%. We consider the growth across all jurisdictions to be a small proportion of total benefits paid, on the basis that consumers with private health insurance can choose to use it in a public hospital, should they wish to do so.

Page 3

- The third paragraph mentions AIHW health expenditure data that shows that private health insurance payments to public hospitals are an increasingly important revenue source, but again, there are no references or links cited here to better understand the evidence behind this statement. A comparison of 4.9% (2010-11) to 5.8% (2014-15) of state and territory own source revenue contributions still seems like a relatively small proportion and does not make a particularly strong argument for these payments being an increasingly important revenue source.
- The final paragraph and dot points outline some AIHW data showing the difference in admissions of private patients in public hospitals and wait times. We recognise that the Australian health system is a hybrid system that has been designed by government policy over time. The data here demonstrates that the

system has two tiers – where public patients have longer waiting times than those using private health insurance. It is no surprise that those who have private health insurance would use it in the public system if it facilitates faster access to care.

Page 4 – Impact of private patients in public hospitals on private health insurance premiums

- This section claims that private health insurance premiums would have been about 2.5% lower than they actually were if the number of private patients in the public sector had grown at the same rate as private patients in private hospitals over the 5 year period examined in this paper. This may be so, although no references or evidence are provided here, but it would be of little comfort to consumers with private health insurance who still would have paid out over 40% increase in premiums since 2010-11. And what if people with complex conditions had not been readmitted to hospital within 90 days?[1] The savings would be considerably greater and result in better health outcomes! There is a more pressing case to look at the quality and safety of services and focus on a reduction in unplanned readmissions and other clinical incidents (including falls, medication errors and hospital acquired infections) that may lengthen the period of hospitalisation.

Page 5 – Implications for the National Health Reform Agreement

- The options for reform are presented with a claim that these could reduce pressure on private health insurance premiums arising from benefits paid for private patients in public hospitals, thereby delivering greater system stability and addressing implications for the National Health Reform Agreement. We do not see that any of these options are provided with sufficient evidence and explanation to meet these aims.
- Therefore, we do not support any of the options presented, and further highlight that all options go some way to reducing the value of private health insurance for consumers and/or potentially further penalising consumers holding private health insurance with increased out of pocket costs. This seems to be at odds with other Australian Government policy that is trying to incentivise consumers to maintain their private health insurance policies, despite, as this paper states, the 46% increase in premiums over the past 5 years.

Final Remarks

This options paper fails to fully articulate the policy problem it is trying to address. The arguments, data and analysis presented are poor, and there is a severe lack of evidence and referencing presented about many claims made. This in the face of a range of

[1] HCCA is aware from recent data presented by Medibank Private that more than 27,000 members were readmitted to hospital within 90 days at a cost of $70million, and that a significant percentage of these readmissions could have been avoided. Around 2.2% of patients account for 1/3 of expenditure on hospital and medical expenses. According to APRA's Private Health Insurance Quarterly Statistics June 2017, the age group for these patients is most likely 6079, the age group for which most hospital benefits are paid.

options that seem to only serve to further penalise consumers who are encouraged by the Australian Government to purchase private health insurance. To what aim? The paper needs to explain exactly **why** the growth in privately insured episodes in public hospital is such a concern for private health insurance costs, before deciding on possible interventions. Then the options presented need to explain exactly how it has been determined that each intervention will work to address the policy problem presented. As it stands, this options paper is a far cry from evidence based policy and we do not support any of the five options presented.

Attachment A

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

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