DISCUSSION PAPER PROPOSED PRODUCTIVITY COMMISSION INQUIRY INTO THE PRIVATE HEALTH SECTOR

Labor

Introduction

On 4 February 2018, the Leader of the Opposition and Shadow Minister for Health and Medicare announced Labor's policy to cap private health insurance (PHI) premium increases at two per cent for two years and task the Productivity Commission with a comprehensive inquiry into the private health sector.

Labor is releasing this issues paper to undertake consultation with the private health sector, health care experts, consumers and others who have an interest in health care to inform the terms of reference and structure of the proposed Productivity Commission inquiry.
Labor invites submissions - in addition to specific recommendations on draft terms of reference - that will inform the design of the Productivity Commission's inquiry and assist with its first phase of consultation (call for submissions).

With the consent of their authors, responses to this issues paper will be provided to the Productivity Commission. Labor will also publish draft terms of reference for the inquiry before the next election, informed by submissions to this paper. Labor's intention is that the inquiry should start promptly on entering office with as much developed material as possible.

Background

In February 1997, the then Industry Commission finalised its report on Private Health Insurance in Australia. Subsequent legislative changes based on recommendations of that inquiry established some of the key policy settings that continue in place to this day.

Since that time there has only been one parliamentary inquiry, in 2017, focussed specifically on private health insurance and the private health sector. [1] Other parliamentary inquiries have considered related issues including:

- the pricing regulation associated with the Prostheses List;
- cancer patient journeys;
- out-of-pocket costs in Australian health care; and
- hospitals and health funding.

Since 1999, the Australian Competition and Consumer Commission (ACCC) has also been required to provide an annual report to the Senate that considers 'any anti-competitive practices by health insurers or providers, which reduce the extent of health cover for consumers and increase their out-of-pocket medical and other expenses'.

Notwithstanding these reviews, the policy settings for PHI have largely remained unchanged over this period, with the current Liberal Government making only modest reforms to PHI and the private health sector. This has included price reductions to the Prostheses List (PL) and the work of the Private Health Ministerial Advisory Committee (PHMAC). Most of these changes

[1] Senate Community Affairs References Committee, Value and Affordability of private health insurance and out-of-pocket medical costs, December 2017.

have been welcomed by Labor, including more competition and transparency regarding PL pricing and proposals to standardise definitions for medical procedures across all policies.

These attempts have been modest at best and do not begin to address the structural issues in the system. APRA data show that the proportion of the population with hospital insurance has fallen every quarter since June 2015 from 47.3 per cent to 45.1 per cent at June 2018. This represents an effective decline in participation of over half a million people as at June 2018. The average annual premium increase over the last five years has been 5.3 per cent - far in excess of general inflation and wages growth.

Labor's approach to reform

The key principles that will inform Labor's approach to any potential reform of the private health sector (following a Productivity Commission inquiry) include:

- A commitment to Medicare as a universal health insurance scheme that provides every Australian with the highest quality of health care regardless of where they live and their capacity to pay.
- A recognition that this commitment relies on the finely balanced public/private mix that exists within Australia's unique health care system.
- A commitment to retaining community rating as a matter of principle.
- A recognition of the role the PHI rebate plays in moderating the cost of PHI for consumers.
- A recognition of the challenges facing the private health sector, including from an ageing population whose health circumstances are increasingly complex.
- An intent to increase competition and choice in order to improve the value and affordability of private health insurance for consumers.

Labor also believes that no Australian should be forced to pay more than is fair and necessary when they turn to a private health provider for care. Given this, Labor believes that private health insurance will continue to play a key role in enabling working Australians to access the outstanding hospitals and medical services that are available in the private health sector.

This paper includes key questions on the broad areas for the proposed PC inquiry, arranged around the following topics:

- How can community rating be supported?
- Is the system of risk equalisation providing the right incentives to insurers?
- Should insurers cover all providers equally?
- Could competition in the private health insurance sector be improved?
- How should the private health insurance sector be regulated?
- What should private health insurance cover?
- How can the information available to consumers be improved?
- Could the pricing process for prostheses and related devices be improved?
- What role should private health insurance play in public hospitals?

Implicit in each of these is the overriding question for Labor's Productivity Commission inquiry: how can we improve affordability, value and quality for consumers?

Labor's intention is that the Productivity Commission would be provided with one year to conduct an inquiry. Submissions and feedback to this issues paper will assist with the scope of the inquiry and the timing of the PC's proposed work program.

How can community rating be supported?

Community rating is the requirement, imposed by law, for private health insurers to charge the same for each product to every customer irrespective of that person's age, health or other factors such as claiming history.

It is the opposite of the concept in insurance of "risk rating", where premiums are assessed having regard to the individual circumstances of the person seeking cover (people assessed as higher risk pay a higher premium).

Community rating has been a feature of the Australian model of private health insurance since it was first regulated at a national level in the 1950s. It is an important fairness measure which ensures that people who have or are at risk of poor health are able to purchase health insurance, and are not discriminated against in the setting of premiums.

Apart from Ireland (which effectively adopted the Australian system of private health insurance regulation in the 1990s), Australia is the only country in the world with a system of voluntary community rated health insurance operating within the context of a government funded universal health system.

This is important because the model of community rating only works when there is a large pool of participants including many people who are in good health and who do not claim on a regular basis. This ensures that there are sufficient resources to meet the benefits payable to the smaller number of policy holders who require hospital care.

The Industry Commission inquiry in 1996-97 was established at a time when private health insurance premiums were increasing rapidly, driven by a rapid decline in participation in people aged under 65. It recommended a system of "Unfunded Lifetime Community Rating" to support community rating by ensuring that people either purchased insurance as young adults, or else paid a higher premium if they first bought insurance later in life.

The Howard Government implemented this recommendation as Lifetime Health Cover in 2001. It was successful in increasing the number of people covered by private health insurance by about fifty per cent. This initiative followed the introduction of the rebate and a tax penalty on higher income earners who did not hold private health insurance.

These measures maintained the insurance pool at a little under half of the population until 2015, since when a systemic decline has been evident.

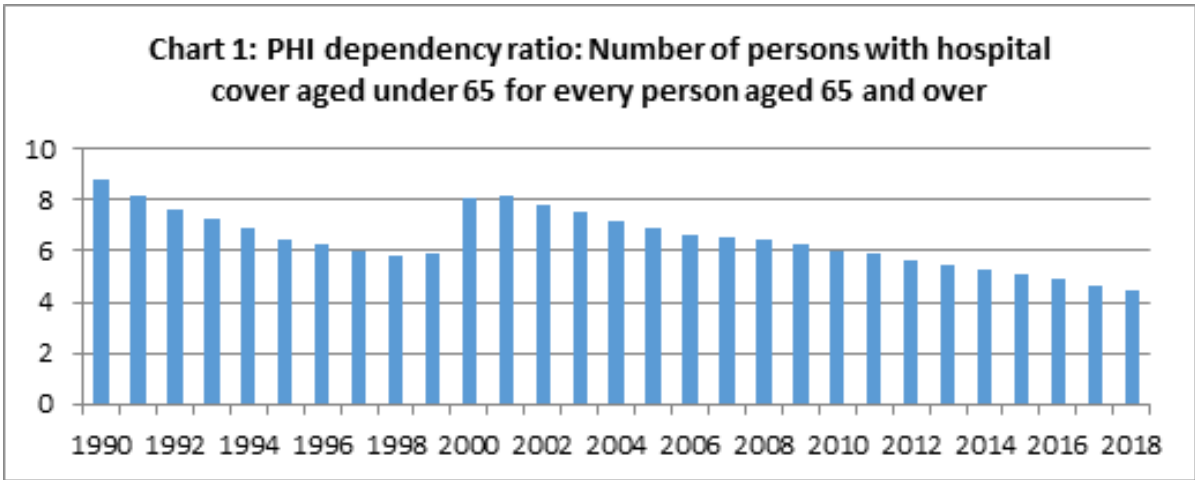
Even more Australians may withdraw from private health insurance if not for the tax penalty and the risk of facing Lifetime Health Cover premium loadings later in life.[2] Because of this effective compulsion, Labor acknowledges that there is a special and continuing obligation upon government to protect and assist consumers. This includes promoting and maintaining an acceptable level of consumer choice.

Since the introduction of these incentives following the then Industry Commission's review in the late [1990]s, there has not been a sector-wide analysis to determine their effectiveness. In particular there has not been a detailed review of their effectiveness in attracting younger people into insurance to improve the risk pool or support the long-term viability of the private health sector.

Accordingly, while Labor has no plans to make further changes to the rebate, a review of these incentives is appropriate to evaluate their long-term effectiveness in supporting participation in private health insurance.

Age profile

The age structure of the insured population has changed significantly since 2001, to the point that there are now fewer people aged under 65 per person aged over 65 than there were when Lifetime Health Cover was introduced (see Chart [1]). [3]



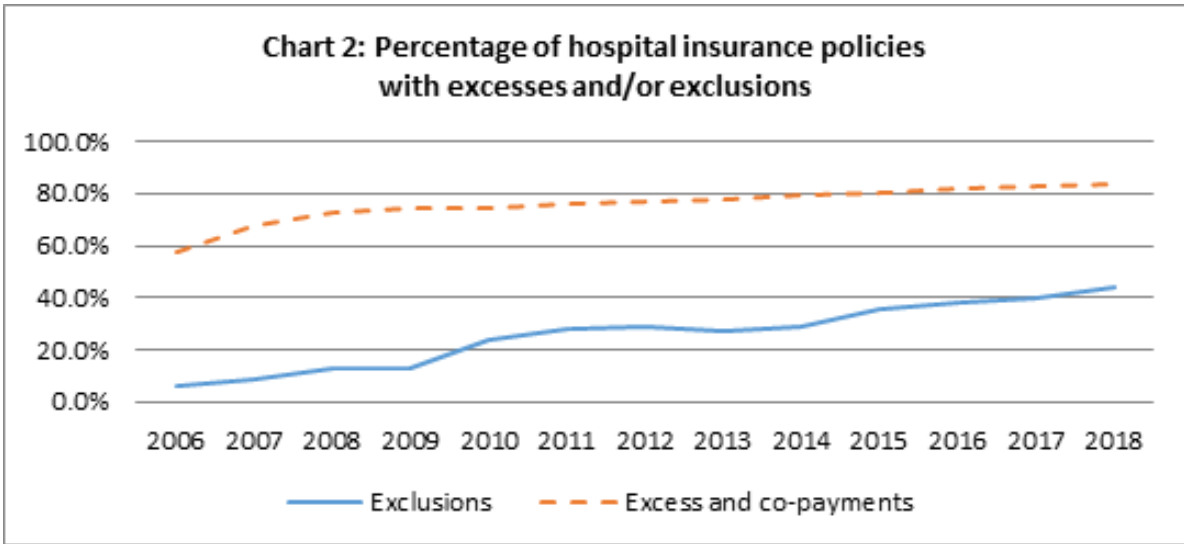
This change in age profile has been a factor contributing to premium increases far in excess of general inflation or wages growth.

Exclusions

Insurers have responded by making available an increasing range of products that exclude cover for particular kinds of hospital treatment – usually those associated with older age such as cataracts or joint replacement, but also including pregnancy and IVF. Since 2006 the proportion of policies with exclusions has increased six-fold, and if current trends continue more than half of all policies will have exclusions in the next few years (see Chart 2).

[2]See Consumer Private Health Insurance Report, Galaxy Research (commissioned by iSelect Ltd) 20 March 2018; ; S Parnell, "Private health insurance a hard sell to Medicare generation", The Australian, 30 June 2018.

[3]All data in charts is drawn from reports of the Private Health Insurance Administration Council or the Australian Prudential Regulatory Authority.



At the bottom of the market it is now possible to buy products with a gross premium of between $1100 and $1350 for a single person that:

- only cover treatment in public hospitals; or
- only offer cover for accidents (unlikely to be provided in the private sector); or
- cover accidents, wisdom tooth removal, tonsil and adenoid removal, appendectomy, minor day-only gynaecology, and joint reconstructions (not replacements), as well as minimum psychiatric, palliative or rehabilitation care.[4]

Some commentators argue that community rating is being undermined by the growth in insurance products with exclusions. These permit young and healthy people to select cover which provides minimal coverage, undermining the cross-subsidy from healthy people to sick people that is they key policy objective of community rating.

A further concern with these policies is that consumers may not understand the limited nature of the cover they have purchased, and find themselves uninsured at the point when they need hospital services.

Questions for discussion

1. Does the current system of incentives and penalties to purchase private health insurance provide sufficient support for the sustainable application of the community rating principle?

2. Would community rating be strengthened or eroded by raising the minimum standard for hospital insurance products?

3. Will the current growth in policies with exclusions continue or will it level out? What implications will there be for community rating?

4. What effect will the current Government's categorisation of products into Gold/Silver/Bronze/Basic tiers have?

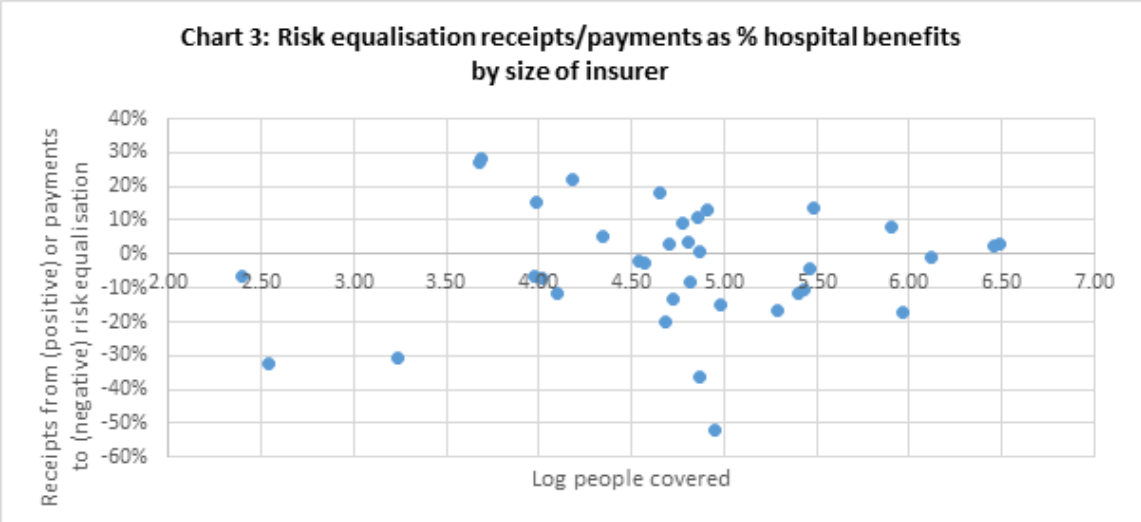
[4] See s72(2) of the Private Health Insurance Act 2007.

Is the system of risk equalisation providing the right incentives to insurers?

The system of risk equalisation acts to underpin community rating, and ensures that even policies with a very low scope of cover contribute to the costs of more comprehensive policies. It is intended to prevent the market instability that would arise from insurers covering young and healthy people disproportionately, and thus charging lower premiums which would attract other young and health people away from insurers with a worse risk profile, leading to those insurers raising their premiums.

The risk equalisation system shares the marginal costs of people aged over 54 across the industry as a whole through an effective levy on each policy of almost $800 (single) or $1600 (family). While the marginal costs of over 54 year olds make up about 45 per cent of total hospital benefits, total net transfers between insurers make up only about 3 per cent of total benefits. This implies that the system effectively mandates a cross-subsidy within each insurer between products which is far larger than the cross-subsidy between insurers.

However, as shown in Chart 3, under the current system a number of insurers pay more than 20 per cent of benefits in the form of contributions to the risk equalisation pool, while others have more than 20 per cent of benefits met by payments from the risk equalisation pool.



Labor recognises that risk equalisation is a contentious issue amongst participants in the private health industry.

The value of claims subject to risk equalisation processes has grown significantly in recent years, driven in part by the ageing of the insured population. This has become a source of frustration to some insurers who argue that risk equalisation payments erode the profit or market advantage they can gain from innovation.

Others insurers argue that risk equalisation is essential to ensure that they can continue to offer affordable policies covering a comprehensive range of hospital services which are likely to attract older and less healthy consumers, and that the principle of community rating requires these costs to be spread across the industry.

Some commentators have suggested that the system should be to compensate prospectively insurers for their underlying risk profile rather retrospectively for benefits actually paid.

Questions for discussion

5. How does the current system of risk equalisation affect competition and innovation?

6. Could it be improved?

Should insurers cover all providers equally?

Before Medicare began in 1984 private health insurers effectively had a universal access obligation, and paid benefits at the same rate for services provided by any hospital, doctor or other health professional.

Second tier default benefit

Changes to the National Health Act in 1995 removed this requirement for hospital treatment, and explicitly allowed insurers to contract with hospitals to determine the rate of benefits for patients treated in that hospital. To protect the interests of patients who might not attend a contracted hospital, the changes required insurers to pay a minimum default benefit.

In 1998 the government introduced the second tier default benefit, under which insurers are required to pay non-contracted private hospitals that meet certain eligibility requirements 85 per cent of the average amount that the relevant health insurer is paying similar contracted hospitals for similar services in that state or territory. The second tier default benefit was introduced as a form of protection for small hospital operators who were fearful that with limited market power, they would be financially damaged by powerful health insurers driving down the benefit levels for insured patients.

As the eligibility requirements are easy to meet, virtually all private hospitals are able to receive second tier benefits.

The second tier default benefit has been a contentious element of the regulatory system since it was introduced in 1998. The Howard Government decided to abolish it in 2002 and replace it with a similar arrangement applying only in regional and rural areas, but subsequently reversed that decision.

Insurers argue that:

- the difference between the full contracted rate and the 85 per cent benefit is too small and does not put sufficient pressure on hospitals to contract;
- the second-tier benefit has supported the establishment, especially in the day hospital sector, of hospitals that are not needed to meet the needs of the insured population;
- the requirement to pay benefits at 85 per cent of the contracted rate at every hospital prevents them from securing better contract rates based on guaranteed patient volumes; and
- consolidation of the private hospital market (with two groups now holding about 45 per cent of the market between them) means that larger groups do not need protection of the second-tier default benefit arrangements.

On the other hand, private hospitals argue that the second-tier default benefit should be retained, and that it is essential for the viability of hospitals in regional and rural areas and many day hospitals. Medical groups have also raised concerns that removing the requirement for insurers to pay a benefit at every hospital will result in insurers directing patients to particular hospitals, potentially limiting patient choice and medical freedom to decide on appropriate treatments.

Medical benefits

From 1986 to 1995 insurers were required to pay the difference between the Medicare benefit for in-hospital medical services and the MBS schedule fee, and were forbidden from paying more. Changes to the law in 1995 allowed insurers to pay amounts above the schedule fee if doctors agreed to take part in schemes under which they either charged no fee on top of the combined MBS and insurer benefit, or else a known fee. Further changes in 2007 allowed insurers to pay amounts above the schedule fee on whatever basis the chose, but maintained the requirement to pay the difference between the Medicare benefit for any in-hospital medical services provided to an insured patient.

In relation to doctors, insurers are required to pay a minimum benefit for any medical service provided to an admitted insured patient (as long as the admission is within the patient's scope of cover) of the difference between the 75 per cent MBS benefit and the schedule fee. Insurers generally offer open-ended agreements to doctors under which doctors agree to charge either no gap or a known gap above the insurer's benefit, in return for the insurer paying a benefit above the schedule fee. This amounts to an insurer paying differential benefits depending on whether a doctor will enter into an agreement in respect of a particular patient at a particular time. Patients receive a lower benefit and usually pay a much larger gap if their doctor proposes to charge a gap beyond what the insurer considers reasonable.

Preferred provider arrangements

Benefit levels for general treatment were not regulated in the same way as benefits for hospital treatment, and starting in the late 1990s insurers began to offer preferred provider arrangements under which benefits were higher (or lower or no gaps were guaranteed) if policy holders obtained treatment from participating providers. Some insurers had established dental or optometry services many years before that (the first HCF dental centre was opened in 1987) offering reduced or zero gaps for services.

The issue of preferred provider arrangements for dentists and other general treatment providers was raised in about two thirds of the submissions to the Senate Community Affairs inquiry into the value and affordability of private health insurance and out-of-pocket medical costs.[5] These submissions were generally from dentists who were not preferred providers, and who argued that preferred provider arrangements involving payment of higher benefits for services provided by preferred providers were unfair, anti-competitive, and led to reduced quality of services.

[5] Senate Community Affairs References Committee, Value and Affordability of private health insurance and out-of-pocket medical costs, December 2017.

However, most insurers believe that preferred provider arrangements or the provision of services by in-house providers offer good value for policyholders, and certainty over out-of-pocket costs. A smaller number of insurers have decided not to participate in preferred provider networks.

A related structural issue is the way in which private health insurers interact with providers in the system. At present, insurers are often unaware what medical and hospital choices their policy holders are making until the care has been delivered and the bill has to be paid. Some suggest that considering the scope of the current laws to increase insurer awareness, while protecting clinical decision-making, could assist consumers to make better informed decisions before they incur substantial medical and hospital bills.

Questions for discussion

7. Should insurers be required to pay benefits for services provided by all providers, or should selective contracting and benefit differentiation continue?

8. Are any changes to the second tier default benefit warranted?

9. What is the impact of preferred provider networks?10. What is the impact of preferred provider networks?

10. Should private health insurers be better able to assist their policy holders to make choices about their care? If so, how would clinical decision-making be protected?

Could competition in the private health insurance sector be improved?

There are currently 37 private health insurers, with the two largest having a market share of over 25 per cent each. At the other end of the scale (not counting very recent entrants to the sector) there are five insurers with less than 0.1 per cent of the market.

There are a number of features of the current regulatory system – including risk equalisation and the minimum benefit requirements for hospitals – which arguably make competition more difficult. Insurers may have responded by seeking to compete through product design, offering products with different included and excluded conditions in an attempt to attract particular demographics.

While there has been some market consolidation overt the last 25 years (in 1993 there were 49 insurers), a number of new insurers have been established in the last several years. This suggests that the barriers to market entry are not insuperable.

Questions for discussion

11. What measures can be taken to improve competition in the private health sector?

How should the private health insurance sector be regulated?

The private health insurance sector is currently subject to regulation and oversight by a number of different bodies, including several outside the Health portfolio.

Under a 2014-15 Budget decision the Australian Prudential Regulation Authority assumed responsibility for fiduciary regulation of the sector in 2015, taking over the role performed by the former Private Health Insurance Administration Council (PHIAC) for over 25 years. Under section 264-5 of the *Private Health Insurance Act 2007* PHIAC was required, in performing its functions and exercising its powers, to

> "take all reasonable steps to achieve an appropriate balance between the following objectives:
>
> (a) fostering an efficient and competitive health insurance industry;
> (b) protecting the interests of consumers;
> (c) ensuring the prudential safety of individual private health insurers"

However, the *Australian Prudential Regulation* Authority Act 1998 requires APRA, in performing and exercising its functions and powers,

> "to balance the objectives of financial safety and efficiency, competition, contestability and competitive neutrality and, in balancing these objectives, … to promote financial system stability in Australia" (subsection 8(2)).

There is no reference to protecting the interests of consumers in the APRA Act or in the Private *Health Insurance (Prudential Supervision) Act 2015.*

The 2014-15 Budget also included a decision to transfer the Private Health Insurance Ombudsman's responsibilities to investigate and mediate complaints about private health insurance to the Commonwealth Ombudsman. The Commonwealth Ombudsman now exercises the Private Health Insurance Ombudsman's powers and functions under Part IID of the Ombudsman Act 1976.

The Minister and the Department of Health are responsible for ensuring compliance with the Private Health Insurance Act 2007 and its community rating, benefits, and information requirements. This regulation appears to be carried out with a very "light touch", as there is no public record of any enforcement action since the Act was introduced.

A particular form of regulation applies to changes in premiums. The Minister is personally responsible for approving proposed premium increases (and decreases) under section 66-10 of the Act, which requires him or her to approve a proposed change "unless the Minister is satisfied that a change that would increase the amount or amounts would be contrary to the public interest". This power cannot be delegated.

The administrative process which sits behind this legislative function has varied over the years, but at the present time requests for increases in premiums from the insurers are received by the Department and assessed from a variety of perspectives including prudential risk, where APRA advice is taken into account, and broader public interest considerations. The result of the application process is normally announced by the Minister between December and February, with the increases coming into effect on 1 April.

Labor has announced that, on coming to office, it will cap increases in premiums to a maximum of 2 per cent for two years. Given the important part that not-for-profit, member-owned and community-based insurers play in ensuring competition and choice in the private health insurance market, Labor has committed to working with these insurers and the Australian Prudential Regulation Authority to ensure that not-for-profit insurers remain strong.

Questions for discussion

12. What has been the effect of the transfer of functions from PHIO to the Commonwealth Ombudsman and PHIAC to APRA? Have these transfers improved efficiency or reduced costs?

13. Has the sector benefited from prudential oversight by a regulator with a wider perspective?

14. How has the Commonwealth Ombudsman responded to an increasing number of inquiries and complaints?

15. Could the model for PHI premium increases be improved?

16. Is there a case for a "one stop shop" to combine the various regulatory and oversight functions?

What should private health insurance cover?

Hospital cover

At present, private health insurance is confined to supporting costs associated with hospital admissions and services provided in the community by non-medical health providers such as dentists or physiotherapists. This restriction has had a particular impact on categories of patients that have vital care needs, but who are not required to be admitted to hospital on a regular basis. One such group are patients receiving outpatient cancer treatments such as radiotherapy.

This group of Australians have clear and ongoing cost challenges, but the current system is designed in a way which largely prevents insurers from assisting them.

From Labor's perspective, Medicare will always be the principal source of funding for primary care, and the Commonwealth will retain the responsibility for the funding of primary care services. Labor understands that any change in this area could significantly impact the costs of Medicare and its continuation as a universal health insurance scheme.

Equally Labor acknowledges that the inability of insurers to cover outpatient services may be leading to unnecessary hospitalisations and overall increased costs for insurers. Any move to allow insurers a greater role in paying for outpatient services would need to be designed so as not to disadvantage people without insurance or drive up costs.

General cover

'General treatment', 'extras' or 'ancillary' insurance covers health services that are provided outside hospitals but that Medicare was not designed to cover. These include dental, optical, physiotherapy, ambulance and other services.

As of December 2017, over 13.5 million Australians were covered by general treatment policies. General health insurance coverage is higher than hospital coverage, at 54.6 per cent of Australians compared with 45.1 per cent.

Many Australians feel that general treatment insurance plays an important role in filling 'gaps' in Australia's universal public health care system, with over 92 million services funded in 2017. However, average benefits for these services are around half of fees charged and are subject to annual limits, meaning that patients often face out-of-pocket costs of hundreds of dollars for more complicated dental procedures or a sustained course of physiotherapy. Consumer group CHOICE describes general cover as "basically a collection of discount vouchers for various treatments", rather than rebates for the actual costs of services used.

While general treatment insurance does cover many unexpected events (crowns for broken teeth, or physiotherapy following injury), many of the services it covers (such as routine preventive dental care or replacement of glasses or hearing aids) are foreseeable and discretionary. The Australian Dental Association has suggested that government should support a system of health savings accounts to allow people to save their own money to cover such costs, rather than engage in cost-sharing through an insurance product.

General treatment insurance is important to the overall financial position of the private health insurance sector, with APRA data showing that gross margins are much higher for general treatment products (25 per cent) than hospital products (11 per cent).

Questions for discussion

17. Should private health insurance have a greater role in paying for outpatient services such as radiotherapy? What impact would this have on overall costs? What impact might it have on uninsured patients?

18. Should private health insurance be allowed to play a bigger role in funding the management of chronic conditions at home, in community settings and out-of-hospital? What would the impacts be on other parts of the health care system were this to be the case, including costs to government of the provision of out-of-hospital Medicare services? How could the universality and sustainability of Medicare be protected?

19. Is general treatment or extras cover the most efficient way to fill gaps in Medicare?

How can the information available to consumers be improved?

Private health insurance is a complicated product to understand, purchase and use. Insurers have used different words to mean the same thing (cardiac services, heart treatments, cardiothoracic surgery, heart and lung services), or the same words but with different meanings ("major eye surgery"). While many insurers have used expressions such as "top cover" or "top hospital" appropriately, others have used "gold" in the names of policies which offer relatively limited cover.

The current Government is attempting to reduce some of this complexity by developing standard clinical definitions to underpin Gold/Silver/Bronze/Basic hospital insurance product categories. While sound in concept, implementation of this system poses significant challenges and risks – as reflected by the Government's decision to allow insurers to delay implementation by up to a year. Millions of Australians are likely to lose some coverage or pay more for their existing coverage. And while consumers will be able to compare, for example, a Bronze policy with all other Bronze policies, they will still be faced with a potentially confusing choice of Basic plus, Bronze plus or Silver plus policies.

Many consumers have little idea how to navigate the maze of complexity that constitutes many aspects of PHI. They generally are unaware of reputable non-commercial sources of information such as www.privatehealth.gov.au which provides reliable information about all the products in all insurers. Indeed, evidence presented to the Senate inquiry suggested that as few as one in six or one in eight consumers were aware of the website[6] and instead rely on commercial transactional companies which do not necessarily cover all insurers.

A further issue is that the portability system established under the Private Health Insurance Act 2007 is not widely understood. Consumers are often unaware that instead of remaining with an insurer which is not meeting their needs or has provided poor service they can easily switch insurers to get a better deal (without serving new waiting periods).

While the issue facing consumers purchasing insurance is making sense of the available information, the problem facing consumers approaching hospitalisation is a lack of information, especially about likely out-of-pocket costs for medical services.

The recent Senate inquiry received numerous submissions highlighting unexpected and large out-of-pocket costs despite holding a high level of cover and the complexity of medical bills.

Groups such as the Consumers Health Forum of Australia (CHF), National Rural Health Alliance, Australian Health Care Reform Alliance and others have consistently drawn attention to the issues around out-of-pocket costs. A recent CHF survey identified high out of-pocket costs for cancer treatment, hidden costs including engagement or booking fees, and unexpected and multiple complex bills as being of high concern to consumers.

Labor notes the existing body of work under way to address increasing and unexpected out of-pocket costs, including:

- the Ministerial Advisory Committee on Out-of-Pocket Costs and its focus on assisting consumers to make informed decisions on the costs of their medical care, through improving transparency;

- the Royal Australasian College of Surgeons' activity in informing patients about surgical fees and addressing extortionate and or manifestly excessive fees, and its support for the public release of risk-stratified patient outcomes data on surgical performance; and

- the Australian Medical Association's Private Health Insurance Report Card, which has contributed to the discussion on variable rebates paid by insurers and its contribution to out-of-pocket costs[7].

Labor supports and encourages the continuation of these processes and invites comment on

Questions for discussion

20. Is the information consumers need to make good choices about their interaction with the private health system (both at the point of entry and subsequently, including when they need care) adequate and easily available? What improvements could be made?

21. How can knowledge and use of the Private Health Insurance Ombudsman's comparison website be improved? How can consumers be made aware of the portability protections available to them?

22 What are the legislative and other barriers to improving transparency of out-of-pocket costs and how could these be addressed?

23. Should informed financial consent arrangements be formalised? How could current arrangements be improved? Could bills for in-hospital treatment be simplified?

[6] Senate Committee inquiry into Value and affordability of private health insurance and out-of-pocket medical costs, Hansard, 5 July 2017, page 1 https://parlinfo.aph.gov.au/parlInfo/download/committees/commsen/4a3249a5-6323-4872-bcc3-e4f1fc60b04a/toc_pdf/Community%20Affairs%20References%20Committee_2017_07_05_5245_Official.pdf;fileType=application%2Fpdf#search=%22committees/commsen/4a3249a5-6323-4872-bcc3-e4f1fc60b04a/0000%22

Could the pricing process for prostheses and related devices be improved?

Unlike other services and goods in the private health system, the Commonwealth regulates the benefits insurers must pay for surgically implanted prostheses, human tissue items and other medical devices via the Prostheses List made under the Private Health Insurance Act 2007. This regulation begin in 1985 at a time when insurers and hospitals did not have contractual relationships, and originally extended to a relatively limited range of orthopaedic items.

The List now includes almost 11,000 items.

In 2016-17, the Senate Community Affairs Committee conducted a major inquiry into Price regulation associated with the Prostheses List Framework. Many submissions and witnesses to the inquiry suggested that the Prostheses List required insurers – and hence policy holders – to pay more for listed devices than public hospitals or funders in other countries. The Senate inquiry heard that hospitals purchase prostheses from suppliers at a price lower than the Prostheses List benefit, but then receive the full benefit from insurers.

Following the inquiry, the Medical Technology Association of Australia (MTAA) agreed to a range of prostheses benefit reductions. Labor welcomes these reductions and industry's constructive engagement.

Questions for discussion

24. Is there a need for the government to set prostheses benefits, or could the supply of prostheses be dealt with in another way?

25. If the Prostheses List is to continue, what further consideration could be given to the transparency of pricing for listed medical devices and other items?

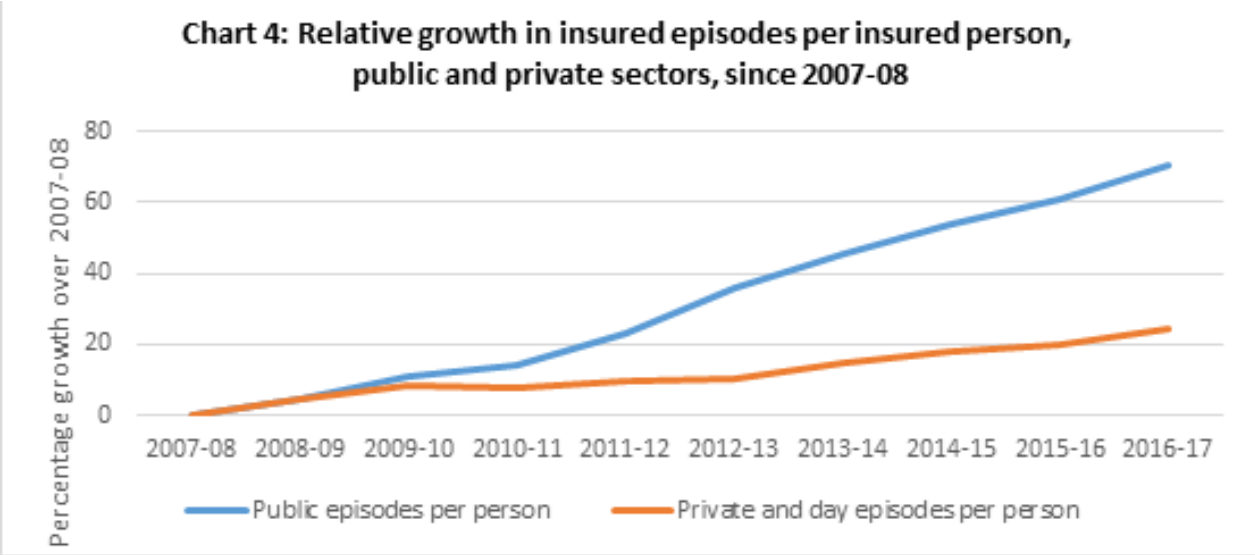
What role should private health insurance play in public hospitals?

Since the inception of Medicare, private health insurance has been required to pay benefits for insured patients electing to be treated as private patients in a public hospital. However, insurers are only required to pay the minimum accommodation benefit set in the Rules, which has been indexed by CPI since 1994 and arguably does not represent anything like the full cost of treatment for private patients. The balance of the cost is met jointly by the states and the Commonwealth under the National Health Reform Agreement.

Insurers argue that as those patients would be accommodated in a public hospital regardless of election, insurers should not pay a hospital benefit and should only be required to pay medical benefits of patients choosing a private doctor. Insurers also point to the rapid growth in private patient elections (see Chart 4) compared with growth in private hospital admissions as suggesting that hospitals are placing inappropriate pressure on patients in emergency department to elect to be treated privately.

[7]AMA Private Health Insurance Report Card 2018, ama.com.au/article/ama-private-health-insurance-reportcard-2018.

Public hospitals and states respond by citing the budget pressure they are under in the context of rising presentations, growing acuity and Commonwealth funding cuts under the current Government. They also argue that current arrangements encourage specialists to practice in public hospitals and provide value to privately insured patients in regional and rural areas where private hospitals are not available. Meanwhile, some private patients have been encouraged to use the public system by substantial capital investments under the last federal Labor Government and some state governments.



Questions for discussion

26. What changes, if any, should the Commonwealth consider in relation to private patients in public hospitals?

Conclusion

Labor is committed to a process of reform that preserves Medicare as Australia's universal health insurance scheme, while delivering better value and affordability for consumers with private health insurance.

A continuation of the present policy settings will likely see private health insurance participation continue to decrease while more Australians question the cost of their product and what value it offers. Accordingly, the proposed Productivity Commission inquiry provides an opportunity for providers, industry and consumers to provide input on both short and long-term solutions to realise meaningful improvements to the private health care system.

Submissions are invited from all interested individuals and organisations and should be made to privatehealthfeedback@australianlabor.com.au along with any specific suggested draft terms of reference.

Labor thanks organisations and individuals for their constructive participation.