COTA
For older Australians

Submission to the Senate Community Affairs References Committee

Inquiry into the Value and Affordability of Private Health Insurance and Out-of-Pocket Costs

Prepared by
COTA Australia

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COTA Australia

COTA Australia is the national consumer peak body for older Australians. Its members are the State and Territory COTAs (Councils on the Ageing) in each of the eight States and Territories of Australia. The State and Territory COTAs have around 30,000 individual members and more than 1,000 seniors' organisation members, which jointly represent over 500,000 older Australians.

COTA Australia's focus is on national policy issues from the perspective of older people as citizens and consumers and we seek to promote, improve and protect the circumstances and wellbeing of older people in Australia. Information about, and the views of, our constituents and members are gathered through a wide variety of consultative and engagement mechanisms and processes.

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Introduction

COTA Australia appreciates the opportunity to provide brief comments to the Senate Community Affairs Reference Committee Inquiry into the Value and Affordability of Private Health Insurance and Out-of-Pocket Costs.

This Inquiry is significant for older Australians, who remain strong subscribers of PHI (with 52.6% of people over the age of 65 retaining coverage)[1] despite generally much lower incomes and greater difficulty meeting premium payments after retirement. However, it is also important to note that nearly as many older Australians do not have PHI as do, and there are strong variations in coverage amongst older people depending on factors such as marital status, cultural and linguistic background, incomes and where a person lives.

One example of the diversity in PHI take-up amongst older people can be seen in the 2014 figures in the Household, Income and Labour Dynamics in Australia (HILDA) Survey. It showed that 71.4% of 'elderly couple' households (both partners over the age of 60) had some form of PHI compared with 50.8% of single 'elderly person' households (over the age of 60).[2] The same source found that 'elderly couple' households were the second strongest growing group with PHI coverage between 2005 and 2014, outstripped only by 'lone person' households.[3]

Also important to COTA, at a broader policy level many of the current debates around PHI and the continuation of a mixed public/private healthcare model are conducted within the frame of a negative and alarmist concern about an ageing society placing heavier demands on the public health system. While it is true that the incidence of use of the health system does overall increase with age there are many ways in which the configuration of our health services system could be improved to deal with older people in more restorative, rehabilitative and enabling ways that would both increase health outcomes and decrease costs.

In December 2016 through our national magazine ONECOTA, we asked our members' views on the value of Private Health Insurance (PHI) and what they considered to be the main problems needing attention in the system. Most of those who responded had some level of PHI coverage.

Many questioned the value of PHI given the high cost of premiums compared to the benefits received in return. Out-of-pocket expenses were a great concern. Reinforcing these messages, a number of members reported having had very good recent experiences using the public hospital system, leading them to further skepticism about the value of PHI.

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1 Private Healthcare Australia, *Private Health Insurance Membership and Coverage – March 2016* http://www.privatehealthcareaustralia.org.au/private-health-insurance-membership-and-coverage-march-2016/

2 Roger Wilkins, *The Household, Income and Labour Dynamics in Australia Survey: Selected Findings from Waves 1 to 14*, (Melbourne Institute of Applied Economic and Social Research, The University of Melbourne. Commonwealth of Australia 2016) 95

3 Wilkins 96

Despite this, most said they maintained their PHI coverage to avoid lengthy waiting lists in the public health system and to have the doctor of their choice. Extras cover was valued by some as it allowed them to maintain optimal health by providing access to a range of allied health services, particularly optical and dental care. Others felt that Extras cover was of little value.

The cost of PHI and the rate of premium increases were the most commonly expressed concerns, particularly for those who are fully reliant on the Age Pension for income. Many members were concerned they may not be able to afford PHI in the future given the premium increases, especially if there is a reduction in the PHI Rebate. Some members noted that while using PHI "Preferred Providers" increased the benefits paid, the Preferred Provider was not necessarily the provider of the member's choice or preference.

The challenge of shopping around for PHI was also highlighted, as it is increasingly complex and difficult to compare the benefits of products offered. One member highlighted the importance of considering subtle differences in benefits, for example coverage for 'ambulance in emergencies only' does not include a range of situations where an ambulance may absolutely be required but which are not considered an emergency.

These responses late last year reflected the key concerns we have heard in feedback from our members and the older general public over a period of time. They are also consistent with earlier research findings by National Seniors Australia that identified the main reasons for purchase of PHI by people over 60 were: security or protection or peace of mind; shorter wait for treatment or concerned over public hospital waiting lists; choice of doctor; and allows treatment as a private patient in hospital.[4]

We will confine our brief contribution in this submission to a limited number of the Inquiry's Terms of Reference below. However, a key issue for COTA underlying our comments throughout is the need for a much more consumer-friendly PHI system, based on the fundamental principles of transparency, simplicity and comparability. PHI consumers require the right kind of information at the right time in order to reduce the risk of purchasing or maintaining the wrong product for their needs. Older consumers also tend to have specific requirements regarding the means of delivery of information. We view the industry as having a long way to go to improve on communicating fairly and effectively with policy holders and those wishing to purchase new (or review existing) PHI policies.

[4] Jeremy Temple and Tim Adair, *A Carrot and a Big Stick: Understanding Private Health Insurance and Older Australians*, (National Seniors Australia, Productive Ageing Centre, Research Monograph No1, October 2011)

Inquiry Terms of Reference – COTA Response

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

COTA was deeply concerned by the release of figures by the Australian Institute of Health and Welfare (AIHW) in May showing the growth in numbers of patients who used private health insurance to fund all or part of their admission to public hospitals and the simultaneous finding that

> Public patients had a median waiting time of 42 days for elective surgery in a public hospital, while it was 20 days for patients who used private health insurance to fund all or part of their admission.[5]

COTA joins with other stakeholders (such as the Consumers Health Forum[6] and Catholic Health Australia[7]) to call for immediate action by governments to ensure that private patients in public hospitals do not receive preferential treatment ahead of public patients. The patient's clinical need must be the only factor for prioritising treatment in public hospitals. We understand that this essential commitment was originally included in the Medicare Principles but was removed in an earlier revision. It should be reinstated immediately in the Medicare Principles and steps taken to adhere to it.

We are particularly concerned by reports that "inducements" are being offered to privately insured patients to use their insurance when admitted to a public hospital, and reports from the medical profession and patients confirming that patients in hospitals in at least several states are being told they will be treated more quickly if they opt to be private.[8]

COTA accepts that many older people legitimately maintain PHI as a way of avoiding lengthy waiting lists for elective surgery in the public system. We support the view that the place of treatment remains a choice for individual health consumers in a mixed private/public system, and recognise there are justifiable circumstances when privately insured patients have no choice but to use the public system – lack of access to an appropriate private facility (particularly important in regional, rural and remote Australia), the requirements of a particular clinical condition and the choice of doctor.

However, a key aim of publicly subsidised PHI is to encourage treatment in the private system,

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[5] AIHW. *Hospital admissions growing steadily, more Australians going private in hospitals* (17 May 2017), http://www.aihw.gov.au/media-release-detail/?id=60129559532

[6] Consumers Health Forum of Australia, *Patient need must be first priority in public hospitals* (Media Release, 21 June 2017), https://chf.org.au/media-releases/patient-need-must-be-first-priority-public-hospitals

[7] Catholic Health Australia, *Upsetting the Balance* (June 2017), http://cha.org.au/images/CAT2006_Report_v4_FA_Low_Res_Digital.pdf

[8] Catholic Health Australia, Ibid, iii and a number of verbal advices to COTA Australia

taking the pressure off the public wait lists and enabling public patients to be seen earlier. If the outcome of publicly subsidised PHI is that public patients have even poorer outcomes than would otherwise be the case, the mixed model of public and private health provision is failing to achieve its aims. Older Australians are heavily reliant on a strong, fair, universal healthcare system and COTA supports policy settings that are effective in achieving this primary aim.

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

A recurring story we hear at COTA is older people having maintained PHI for decades, only to find when they need to draw on it in later life they cannot realise the benefits because they cannot afford to meet the co-payments or other out-of-pocket costs associated with a procedure or treatment.

While a key driver for many older Australians to maintain PHI is a worry that they will not have their needs met in the public system, many find that they are not able to pay the out-of-pocket costs in the private system over which they have no control and therefore forego or postpone aspects of necessary treatment. Ironically, they could have received the full treatment at no cost in the public system (but opted for the private system because of the wait lists in public hospitals, particularly for joint replacements). This is increasingly a wake-up call for older people with PHI, who generally do not have financial reserves and are unable to go into debt to fund the gaps.

These comments are not a negative reflection on PHI policies that contain a planned excess in exchange for a lower premium, which are transparent to the policyholder. COTA has no objection to such products.

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

The same point applies here as in ***b)*** above, regarding product exclusions and benefit levels. Often the consumer will not understand that they have been carrying a policy with exclusions that apply to them, due to complexity of product information, or not having reviewed their policy for some time and picked up on changes to it. They maintain PHI in the misplaced belief that they will be covered for whatever treatments they need in hospital.

As Catholic Health Australia points out:

> Another key driver of the growth of private patients in public hospitals is the proliferation of private health insurance policies with exclusions and restrictions. A number of policies do not adequately cover patients for treatment in a private hospital (not 'fit for purpose'), and only cover public hospital treatment.[9]

The specific nature of many of these exclusions are particularly pernicious for older people.

[9] Catholic Health Australia, iv

The Private Health Insurance Council reported that in 2013–14 around 30% of policies had exclusions for services such as joint replacement or cardiac treatment – procedures that are largely required by older consumers – whereas, 10 years before, just 4.6% of policies had exclusionary clauses. Many people buying cheaper, exclusionary policies may then face gap payments when they need surgery which is not covered, or once again, end up in the public system.[10] They may have chosen this policy unwittingly in return for paying a lower premium – all they could afford.

The increasing use of exclusions in policies presents another assault on the PHI value proposition for older Australians. The practice itself needs to be reined in and older consumers need much better information available to them to understand the nature of policies they are taking out.

d) the use and sharing of membership and related health data

COTA believes that private health insurers should be excluded from accessing individuals' person health record data and denied the ability to share membership and related health data. Insurers are not health providers and we do not see any benefit flowing to the consumer from allowing information sharing within and between financial commercial entities. Conversely, we see the potential for significant consumer detriment, for example, introducing conditions or limitation into individual PHI policies based on access to data about an individual consumer.

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

COTA relies on data and analysis from other sources as evidence on this issue, but our sense is that the levy and loading do create an incentive to maintain PHI, and that this is important in the overall sustainability of the system.

However, these public policy "sticks" have contributed to the increase in the availability and take up of minimalist policies which focus only on private treatment in public hospitals. COTA recognises that those policies are legitimate for some consumers, particularly in regional and rural communities where private hospitals do not exist (and populations tend to be older). Nonetheless, this is one example of an increasing trend in tailoring policies that dilutes the integrity of community rating. Robust community rating arrangements are critical in underpinning a viable health insurance system across the life course.

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[10] Amanda Briggs, *Consumer issues driving current private health insurance debate* (Parliament of Australia Parliamentary Library, Posted 23/11/2015) http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/FlagPost/2015/November/consumer_issues

f) the relevance and consistency of standards, including those relating to informed financial consent for medical practitioners, private health insurance providers and private hospitals

The main point we make here is that all medical practitioners and practices, insurers and private hospitals ought to adhere to best practice standards regarding informed financial consent. We hear stories repeatedly from older health consumers that they did not know of, or understand, the exclusions or refund gaps they were facing when they took out a PHI policy, or when they booked in for a procedure.

There are significant issues about consumers not being advised in advance about the full costs of a medical procedure, especially but not only in relation to a hospital based operation involving surgeon, anesthetist and hospital costs and potentially three gaps of unknown size. This is a problem for PHI funds as well as it creates reputational damage for them with their members, but they have no control over health professionals not pre-advising charges.

This is an aspect of the PHI system in which all players must improve performance. From the point of view of older Australians, this means much clearer, targeted, appropriate information and engagement.

g) medical services delivery methods, including health care in homes and other models

COTA does not support the use of PHI for coverage of GPs. We see no evidence that it would improve health outcomes and have a deep concern that it would undermine universal health care through Medicare, leading to a two-tier primary system with public patients receiving poorer care. The recent experience, discussed above, in which people with PHI are receiving priority treatment in public hospitals is all the evidence required that expanding PHI into the core of primary health care would not be advantageous to public patients.

Older Australians repeatedly confirm with us their support for strong public health care and Medicare and are vigilant regarding any government action that will undermine these systems.

h) the role and function of:

- ***i. medical pricing schedules, including the Medicare Benefits Schedule, the Australian Medical Association fee schedule and private health insurers' fee schedules,***
- ***ii. the Australian Prudential Regulation Authority (APRA) in regulating private health insurers, and***
- ***iii. the Department of Health and the Private Health Insurance Ombudsman in regulating private health insurers and private hospital operators***

Re (i): Obviously these schedules provide an important aspect of transparency within the health system and give information to consumers about how far above the recommended prices individual medical providers are charging. However consumers regard these schedules with a

degree of cynicism. The MBS represents what the government is willing to pay for a medical item but not necessarily what it costs to produce and deliver it. The AMA schedule is not regarded as objective as it is essentially the "union price". Often neither have any obvious relationship to what many health consumers pay for medical treatment outside of concessionary and bulk billing arrangements. The gaps between the schedules and actual payment seem to consumers to continue to widen.

Re (ii) & (iii): A robust regulatory system and complaints mechanism are essential features of the PHI system. They can play an important role in improving the performance of the system in a number ways, including on the issue of informed financial consent (discussed above). However, there is significant scope to increase consumer awareness of these bodies and their roles, the rights that consumers have in the system and the role that these bodies can play in protecting those rights.

i) the current government incentives for private health

Refer to our comments in ***a)*** above. COTA supports the overall principle that government incentives for private health should result in a stronger public health system and if they are not achieving that outcome they are wasted.

Nonetheless, we make brief comments here on two specific incentives under existing arrangements: the extended Private Health Insurance Rebate for older Australians; and the Risk Equalisation Trust.

COTA believes that higher private health insurance rebates for over-65s encourage older people to retain their insurance even though they are generally now on a lower fixed income, and that any reduction in their rebate will result in a direct negative impact on the number of people who will retain PHI.

While we have only anecdotal evidence, we believe that PHI may be at a tipping point in affordability and value for older Australians and any reduction in the rebate may be the final straw for many. We already hear many stories about people cutting back on basic necessities in their lives in order to meet PHI premiums.

Matt Levey from CHOICE puts the current position very clearly, reflecting the concerns we tend to hear from older people:

> Premiums have increased an average of 54.6 per cent since 2009, well ahead of CPI. According to CHOICE's national Consumer Pulse survey, it is the hardest market for people to find the product that best suits them. This toxic combination of surging prices and complexity is leading many Australians to downgrade or drop their cover completely.[11]

[11] Matt Levey "How to counter the walled garden of health Insurance" *Health Voices. Journal of the Consumers Health Forum of Australia* 20 (April 2017) http://healthvoices.org.au/volume/issues/april-2017/

If older people do desert the private health system in larger numbers there will be flow-on impacts to the public hospital system with increased costs or longer waiting lists, especially for hip and knee replacements.

COTA believes that the value and efficacy of the private health insurance rebate as a whole ought to be regularly and carefully evaluated, but we strongly reject singling out older consumers as a focus for cost saving as counterproductive.

The Risk Equalisation Trust, administered by APRA, is a crucial tool to support the principle of community rating, by compensating insurers with a higher health-risk membership demographic by redistributing money from insurers paying less than average benefits to those paying higher than average benefits. COTA recognises that a risk equalisation pool, managed by a third party, is in the interests of older people. Another way of putting it is that risk equalisation is in the interests of all privately insured people across their lifespan, and really comes into play when they reach older age.

It is a key incentive for people to maintain PHI throughout life, but is not generally well-understood by younger consumers as in their own interests for later stages of their lives. There is much more that can be done to educate consumers about the basic concept and workings of this important aspect of PHI.

j) the operation of relevant legislative and regulatory instruments

COTA has no comment on this.

k) any other related matter

COTA believes that running across many of the issues discussed above is the crucial need for great improvement in the capacity for consumers to be able to understand and compare PHI products.

System-wide consistency in product terminology, transparency regarding product inclusions and simplicity in product presentation are all required to support consumer decision-making and better health treatment outcomes.

All consumers could benefit from improved communication and information from private health insurers through targeted channels. For older consumers of PHI it is particularly important that alternatives to digital information are made available and that customer service at all stages of engagement with PHI (researching products, decision-making, purchase, review, treatment planning, claiming and complaint) recognises their specific requirements.

Ends