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Speaking Notes – Panel Discussion
AMA Vice President Dr Chris Zappala
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Private Health Insurance – Where to from here?

The AMA has supported some of the Government's recent attempts to improve private health insurance and health literacy.

Helping people to understand what their insurance covers across insurers, policies, and clinical definitions is a step forward.

These reforms should help build some confidence for people that their insurance has true value.

But the Government reforms do not address affordability – this problem is starkly obvious with the last round of premium increases.

The rate of increase in premiums has slowed, but still outstrips inflation and, more importantly, outstrips wages growth.

How much longer can private health insurance stay affordable with increases in premiums averaging 4 to 5 per cent a year when wages growth is firmly stuck around 2 per cent?

Private health insurance is in trouble, with a dozen or so successive quarters of decreasing coverage to 44.6 per cent.

Further reforms are required.

But any such changes should not compromise patient care or cede decision-making power to the insurance company. Managed care - the stealthy goal of payers - is anathema to high quality medicine.

Loss of a doctor's clinical independence is unacceptable to the AMA, and I hope Australians would realise the risks if this trend continues. It would drive a reaction that is negative to the value proposition of private health insurance.

The AMA believes that the next round of reforms – and there must be more reform – needs to focus on protecting the independent clinical decision-making by clinicians, who are chosen freely by the patient, with consultations conducted in an appropriate facility; and the abolition of poorly indexed, differential insurance rebates.

I suspect that the insurance companies will tell you that reforms need to be about costs, particularly the costs of doctors.

The health insurers are worried about a possible 2 per cent cap on premium increases for two years and how this will impact their bottom line. You must remember that doctors and patients have faced a zero per cent increase in Medicare rebates for several years.

The AMA acknowledges that the system needs to change if we are to improve patient confidence.

Out-of-pocket costs are negatively affecting consumers' perception of the value of insurance.

The AMA realises we have some heavy lifting to do in this regard. We do not support egregious billing or the use of administrative and booking fees. They are inappropriate, and unacceptable.

Let us be clear about what constitutes out-of-pocket costs to patients. This is not a conversation that can be limited to what doctors' charge. It must necessarily include the other components of payment from the Medicare Benefits Schedule (MBS) and the health funds.

Nationally, in 2016-17, Australians spent $29.4 billion on out-of-pocket health-related expenses. Most of this was on:

- prescription and non-prescription medications ($10.8 billion or 37 per cent);
- dental services ($5.7 billion or 19 per cent); and
- other health care such as aids and allied health services outside Medicare ($6.7 billion or 23 per cent).

Medical costs make up only 21 per cent of out-of-pocket expenditure for individuals.

In terms of outlays by funds for private specialists, again, the amount spent on doctors is only a small percentage. Of the $3,965 million in the December 2018 quarter paid by insurers for hospital treatment benefits, only $613 million – around 15 per cent – was for medical services.

The answer to the affordability problem is not 'doctor bashing'. The statistics and the facts do not support it. If it continues, this malicious diversionary tactic will backfire on the entire industry.

Let's not forget that benefit schedules can inexplicably vary significantly - not just between insurers, but between State and Territory.

The resultant gaps are not borne from doctor fees being too high, but due to insurance companies paying hugely variable amounts that do not reflect the cost of providing the service.

For example, if a doctor does not have an arrangement with a fund, then only 25 per cent of the Medicare rebate is paid, which drastically increases the gap for a service that might be completely covered without a gap in another hospital with another doctor.

Critically, **if legislation forced funds to pay the same amount, appropriately indexed and defined, for each item, regardless of whether the doctor has an agreement with a fund or where the service is occurring, gaps would significantly reduce overnight.**

In the AMA Private Health Insurance Report Card last year, the AMA highlighted total hip replacement and how the fund rebate can range from $329 to $1,120.

These widely differing rebates are incredibly confusing for patients.

It as an issue that has not been addressed by the reforms to date. It is not addressed by the Government's new fee transparency website proposal either.

Doctors' fees - without information on insurers and MBS rebates - will not inform patients about their out-of-pocket costs.

Surely, if we are going to do transparency of ***fees*** to help patients, let's demand transparency of ***rebates***.

We must be honest about the reason out-of-pocket costs arise. There has been a five-year freeze on the MBS rebate – a rebate that was inadequate to begin with.

But practice costs have not been frozen.

From 2010 to 2018, PHI premiums increased by a cumulative 49 per cent - compared with the health CPI cumulative increase of 40 per cent.

By contrast, doctors were faced with a paltry 5.7 per cent increase in the Medicare rebate.

It is clear who is ahead in this regard.

In 2005, the 'for profit' health insurers made up 16 per cent of the market. Today, this figure is nearly 70 per cent. Profit before tax of the industry for the year up to December 2018 was $1.6 billion.

By extension then, insurance companies are plausibly worried about reporting to shareholders and maintaining profits.

If feeling threatened, insurance companies may resort to increased use of selective contracting and increased pressure on healthcare providers or hospitals to sign contracts, or be left out in the cold with disadvantaged patients.

You are at the coal face, negotiating ever more cut-throat deals.

As doctors, we are worried about this. We are worried that this enables insurers to influence, even dictate, the healthcare pathways available to their customers.

The nature of healthcare funding and gaps cannot be shrouded in complexity or hidden from the consumer.

I hope that in transitioning existing policies over to the new classifications insurers improve health literacy, and minimise covert reductions in coverage.

I am certain that doctors and private hospitals both want a strong private health system. I'm sure we can work together to preserve it.

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