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Opening Remarks
Senate Community Affairs Reference Committee Inquiry
Value and affordability of private health insurance and out-of-pocket medical costs
Public hearings, Sydney, 31 October 2017
AMA President Dr Michael Gannon

Good morning. My name is Dr Michael Gannon. I am a private Obstetrician and Gynaecologist in Perth, and President of the Australian Medical Association.

The Committee has an important and potentially challenging inquiry on its hands.

I understand that the Committee will hear from consumers and private health insurers that medical practitioners are diminishing the value of private health insurance through their billing practices.

I would like to begin by dispelling a few myths about the causes of consumer discontent with private health insurance.

Then I will discuss the changes that the AMA would like to see that would improve the value proposition of private health insurance for consumers.

Out-of-pocket medical costs are not the cause of discontent among consumers with their health insurance.

Most consumers understand that they **may need** to contribute to the cost of their care. The problem facing consumers is that they believe they are covered, but have inadvertently purchased a product that is, unfortunately, useless. If a policy does nothing more than avoid the tax penalty, how is it not a 'junk policy'?

Out-of-pockets costs are not growing. The proportion of health expenditure funded by individuals, not government or insurers, has **remained relatively static at 17 per cent** over the decade to 2015-16[1].

Importantly, of that 17 per cent **only 10 per cent is spent on medical services**. The spend on other health practitioners is 9 per cent, and other hospital outlays is 11 per cent. The majority of individual expenditure is on dental services and pharmaceutical products.

Out-of-pocket **medical** expenses are a small proportion of what patients pay for their health care.

The second myth is that medical expenses are the cause of increased premiums. Medical expenses are a small proportion of total benefit outlays for private health insurers. Medical expenses, as a proportion of benefits, have **remained static at around 16 per cent** since 2007[2].

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[1] https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2015-16/data, T3.2
[2] Derived from PHIAC and APRA: *Operations of the Private Health Insurers Annual Report* between 2008 and 2015.

In fact, administration expenditure by private health insurers is around 10 per cent. So, it is costing insurers almost as much to run their business as it is to pay for the doctors who treat their customers. I would ask that this inquiry investigate the reasons why.

With regard to individual out-of-pocket costs, I acknowledge that there are individuals who, because of various circumstances, have incurred large out-of-pocket costs for their health care.

I would urge the inquiry to explore some of those circumstances in detail so that we can all truly understand how that has happened. I also stress that the AMA **does not support exorbitant charges or egregious fee setting**, i.e. fees that the majority of a practitioner's peers would consider to be unacceptable. Further, we believe that providing informed financial consent is not only best practice, it is demanded by medical ethics.

The clear majority of practitioners charge a reasonable amount. The vast majority of health care provided in Australia is provided at no direct cost to the patient - 88.1 per cent of services are provided at no-gap, and a further 6.9 per cent have a known-gap charge of less than $500[3].

A major source of gaps is the extended freeze on Medicare Benefits Schedule (MBS) rebates, which has led to insurers also freezing payments to doctors or indexing well below inflation. As you will know, the cost of providing a service has increased over this timeframe.

The MBS continues to fall behind. Health inflation has sat between 3.6 per cent and 6.6 per cent per annum over the past seven years. Over the same period of time, PHI premium increases have been between 4.8 per cent and 6.2 per cent. Even when not frozen, MBS rebates have increased at best by 2 per cent, meaning that the MBS rebate is far removed from the cost of providing a quality specialist service.

Let me give you an example from my own practice. For an initial consultation for a Gynaecological patient, for which I put aside 40 minutes, I would be paid $72.00 under the MBS. This would just cover the pay and superannuation of my receptionist and practice nurse/midwife and rent on my premises, but not other fixed costs like equipment, disposables, and professional indemnity insurance. And that is before I could consider a wage for myself.

I am not alone. Ninety-three (93) per cent of AMA specialist members surveyed, who practice in the private sector, reported that they would not be able to sufficiently cover the costs of operating their business if they only charged the MBS fee. The MBS items and, therefore, the benefits paid by insurers need to improve considerably to reduce the amount paid by patients.

That brings me to the next challenge for this inquiry.

The Committee and the community are faced with an issue of social policy – what is the role of the private health insurer?

From our perspective, it is a payer for medical services.

Private health insurers are moving private health care in Australia towards a system similar to that of the United States – a 'Managed Care' system.

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[3] http://www.apra.gov.au/PHI/Publications/Documents/1708-QPHIS-20170630.pdf

The health insurance funds now have the ability to selectively contract with hospitals, meaning that insurers will not provide coverage for certain services if these facilities do not meet the insurer's business needs. This reduces choice for the patient – something that private health insurance is designed to offer.

The insurers are trying to convince the Government that they can reduce health expenditure through controlling what services are provided or, as they would put it, reducing low value care.

The AMA does not support low value care. However, we do not believe that the Insurers should decide what procedures should be funded. Insurers should not decide what care is appropriate, or interfere with the relationship between the patient and the doctor.

Health insurers in Australia are focused on minimising their expenditure, and are creating barriers for patients accessing care. These are the same patients who have paid substantial premiums for top cover. The worst case recently reported to us was that of an elderly woman who was told by her insurer that her surgery was covered, only to have the insurer not pay after the surgery was performed. She was out-of-pocket $7,000.

Private health insurers are demanding that practitioners provide evidence that the treatment is clinically needed prior to surgery. I have been notified of widespread rejection of these requests – mostly relating to potentially malignant lesions.

I can assure you that if your Dermatologist thought you had a Melanoma and it needed admission to a hospital setting to do it, you would consider it clinically necessary to remove it.

Private health insurers should not determine the provision of treatment in Australia. Health insurers should not interfere with the clinical judgement of medical practitioners. There is an inherent conflict.

This leads me to my next point of who is running the private health insurance industry.

The shift to a for-profit industry has created the need to ensure that there are sufficient profits to allow a return to shareholders. This is driving much of the growth in increased premiums.

APRA data show an industry surplus (before tax) of $1.56 billion for the 2015-16 financial year[25], up from $1.45 billion for the previous year[26]. Nib's 2017 half-year results showed a sizable return on equity of 31.7 per cent[27]. It would be impolite to go into the earnings of their CEOs.

This inquiry has come at a crucial time. Insurers are understandably concerned about the viability of the sector.

However, they need to improve their offerings. Insurance products should be easy to understand, payments should be made on clinical need, and the 'de facto' risk rating system created through products with incomprehensible exclusions and 'carve-outs' needs to cease.

The AMA supports a system of Bronze, Silver, and Gold product standards. We believe that all policies should cover maternity services and mental health services.

The policies must be based upon an agreed set of standard understandable clinical definitions.

We do not support ‘junk policies’.

These categories must be more than labels. We need to deliver on removing the policy confusion in the 20,000 plus policies.

In conclusion, the AMA believes that universal health care demands a strong private health system, and that system needs the support of the private health insurance rebate, and retention of the community rating system.

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