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The value and affordability of Private Health Insurance and out-of-pocket medical costs in Australian health care

In Australia, the public and private sectors work together as a part of a health system that provides patients with universal access to affordable health care. The balance between the private and public systems has delivered a very good standard of care that is recognised internationally. The current system is subsidised by the Australian taxpayer, and, as such, the Federal Government should maintain an active role in private health insurance in order to ensure that it delivers on community expectations.

The private health sector is a large contributor to the system. In 2014-15, 42% of all hospital separations were funded by private health insurance (PHI); 50% were public patients and the remainder were self-funded[1]. Not only is it a large contribution, but it is a cost effective one. In 2014-15 there were 4.5 million privately insured hospital separations for approximately $12.3 billion in outlays[2] [3], or around $2,700 per separation, compared to 5.9 million[4] separations in the public sector for a combined government outlay of around $43 billion (or $7,300 per separation)[5]. While the service mix and complexity may differ between the sectors, it is argued that the private sector very efficiently complements the public sector. If consumers withdraw from the private sector, these services will need to be provided by the public sector. Under current capacity, the public sector will either not meet the additional demand, or will only do so at a higher cost to governments.

We need to ensure that the regulation that underpins the interaction between private health insurers, hospitals and patients promotes the efficient supply of health services. PHI has specific features that make the design of efficient regulation especially complex. This is further compounded by the specific historical development and place of PHI in the Australian context – as a form of supplementary and complementary insurance to Medicare, with the primary purpose of providing private hospital cover. Current regulation, as well as defining the scope of the cover PHI provides, includes restrictions on premiums through Community Rating and Lifetime Cover, means tested

[1] Australian Institute of Health and Welfare: *Australia's Hospitals – at a Glance 2014-15*, page 7
[2] ABS 4390.0 Private Hospitals Australia 2014-15 Table 2
[3] Australian Institute of Health and Welfare: *Australia's Hospitals – at a Glance 2014-15*, page 8
[4] Australian Institute of Health and Welfare: *Admitted patient care 2014-15*, Table 2.22
[5] Australian Institute of Health and Welfare: *Health Expenditure Australia 2014-15*, Table A6

subsidies for PHI take-up (the PHI rebate which is among the top 20 most expensive Federal Government programs[6]), along with means tested tax penalties (the Medicare Levy Surcharge) for the failure to take out cover, and price controls over increases in PHI premiums.

The AMA has been reviewing the operations of the private sector - both private hospital and private health insurers, for quite some time. Private Health Insurance firms were primarily not-for-profit organisations, however there has been a marked change in the last decade with around 70 per cent of the insured population now covered by for-profit funds. During the same period of time, there has been a noticeable shift from funds acting as passive payers to 'active funders – extracting sizable profits from the sector for shareholders and executive remuneration.

Health insurers traditionally focused their operations on minimising their expenditure through creating barriers to utilisation and reducing management expenditure. However the shift to offering insurance products with considerable exclusions and altering benefits schedules ad-hoc has created confusion in the market; increased the probability that the consumer will face out-of-pocket costs; and, the AMA asserts, has led consumers to question the potential value of the product.

This submission discusses how a combination of factors undermines the value of private health insurance and requires patients to contribute to their treatment. It outlines how the underinvestment in health by government means that funding is not keeping up with the increase in demand for health care and how the benefits schedules by the system funders (MBS and private health insurers) have not kept pace with the costs of operating a business that delivers high quality clinical care. It also discusses the community's expectations of our health system and how this is at odds with how the system is financed.

Health financing system in Australia

The structure of the health system in Australia is complex, with a multi-payer multi-level system, and an ability to shift either costs or services between payers and levels. Demand for health services has increased on average 2.5%[7] over the ten years to 2014-15 and health expenditure has grown on average by 4.5% over the same period. Average health expenditure per person by all sources in 2014-15 was $6,846[8]. Only about 5% of the growth in per capita health expenditure, as a percentage of GDP, from 6.4% in 1989-90 to 9.7% in 2013-14, has been attributable to ageing[9]. The rest relates to changing demands for improved technology, and an increasing demand for services.

Health expenditure by governments has not kept pace with demand

However, the contribution by governments has flat-lined in recent years, and does not reflect the changing expectations of the community. The ratio for health expenditure to tax revenue from the states, territories and local governments rose from 22.5% in 2009 up to 24.4% in 2011, and then dropped back down to 22.6% in 2014[10]. Federal Government expenditure as a proportion of

[6] http://www.budget.gov.au/2016-17/content/bp1/download/bp1_bs5.pdf , p 5-12
[7] AIHW, Health Expenditure 2014-15, Table 2.5
[8] AIHW, Health Expenditure 2014-15, Figure 2.10
[9] Media Release, University of Wollongong, https://media.uow.edu.au/releases/UOW234253.html
[10] AIHW, Health Expenditure 2014-15, Figure 2.8

taxation revenue dropped from a high of 28.8% in 2009, down to 24.9% in 2012, rising to 26.4% in 2014[11].

The perception in the Australian community that out-of-pocket costs for health care have increased as a proportion of total health expenditure is not supported by the Government's data. The proportion of health expenditure funded by individuals (i.e. not government or 3rd party/insurance) has remained relatively static at 17% over the decade to 2014-15[12].

The MBS was never expected to meet the full costs of service provision

Medicare operates by paying a specified benefit (in the form of a rebate) for a health or medical service for which a claim is submitted. Only services provided by private practitioners (the majority of Australian doctors work in private practice) are covered by Medicare. Services provided in a public hospital only attract a Medicare benefit if the patient elects to be treated as a private patient[13].

The level of Medicare benefit is calculated as a percentage of a mandated schedule fee for the service, and varies depending on the setting. A service provided in hospital attracts a benefit equal to 75% of the MBS schedule fee; a service provided out of hospital generally attracts a benefit of 85%. In the case of non-referred attendances (those provided by a general practitioner (GP)) the benefit is set at 100% of the schedule fee. If the health practitioner chooses to bulk bill, they receive the Medicare benefit as full payment for the service and the patient pays nothing[14].

Universal benefits and services are benefits available to everyone as a right. Medicare is often considered to be a universal system, however the current system does not guarantee universal access to GPs or specialists, but does guarantee universal access to the benefit under the MBS[15].

The Australian Constitution prevents a national government from coercing or conscripting medical practitioners. To circumvent this requirement, Medicare was developed as a national health insurance scheme. Thus the benefits are payments to patients not doctors, and bulk billing is one of the mechanisms through which that 'insurance' payment can be made directly to medical practitioners by the government.

Therefore, Medicare was never intended to provide the cost for all of the service, and, at its inception, was designed to contain a contribution from the patient towards their care.

MBS indexation is lower than general inflation

Since 1985, successive governments have applied an annual indexation to MBS fees that has been well below the market indices that have a direct impact on the cost of providing medical services, being the Labour Price Index and the Consumer Price Index. The indexation method of applying the Department of Finance and Administration's Wage Cost Index 5 (WCI5) is deeply flawed as a methodology as it fails to reflect the costs of practice and very substantially overestimates the productivity gains available in face-to-face consultations.

[11] AIHW, Health Expenditure 2014-15, Figure 2.5
[12] AIHW: Health Expenditure 2014-15, Table 2.1
[13] Biggs, A 2016. *Medicare: a quick guide*
[14] Biggs, A 2016. *Medicare: a quick guide*
[15] Elliot, A. 2003 *Is Medicare Universal*

The costs of operating a business grow at a different rate to the indexation of Medicare benefits. These costs primarily include rent of premises, labour, medical training and medical indemnity insurance. For example, the total hourly rates of pay excluding bonuses for personnel in the Health care and social assistance sector rose from $85.00 to $121.10 in the 10 years to 2015, an average increase of around 3.5%[16].

Health inflation has tracked general inflation at 2.4% and 2.9%[17] respectively over the 10 years to 2014-15. The growth of health expenditure has run at an average of 4.7% over the 10 years to 2015[18], yet the Medicare benefits, which were already falling behind general inflation, were not indexed for a period of almost four years commencing with the freeze by the Labor Government in 2013 and the Coalition Government's decision not to index the MBS in 2014. The slow re-indexing of the MBS commenced in July, but MBS items that relate to specialist procedures will not be indexed until 2019. Notably pathology and diagnostic imaging has been frozen for nearly two decades, and there are no immediate plans to unfreeze all of these items.

While rebates have remained unchanged, the costs of providing quality medical services continue to rise. The freeze on indexation, combined with the inappropriately low indexation method used in prior years, means that doctors have no choice now but to pass the costs on to patients - this will drive an increase in out-of-pocket costs. Surveyed AMA specialist members who practice in the private sector, report that they would not be able to sufficiently cover the costs of operating their business if they only charged the MBS fee (92.7%).

The AMA has always encouraged medical practitioners to reasonably determine their service fees based on their own practice costs. The cost of running medical practices, which varies across the country, includes employing practice staff and operating expenses such as computers, rent, electricity, general insurance and professional insurance. The AMA fees list is provided to members as a general reference to assist with costing for services and the AMA understands that most practitioners do not charge above the AMA fee[19].

The value of Private Health Insurance is an issue

PHI offers several advantages over the public system: a patient has the option of being treated by their own doctor, they have more control over when and where they receive medical care and the waiting times for elective surgery tend to be considerably shorter.

Private health cover is a significant cost for many families, and, therefore, the affordability of PHI is important to consumers. The ever increasing premiums have obviously impacted upon the type of products that people are choosing to purchase. However, policy holders should be able to expect a reasonable level of cover for their premiums.

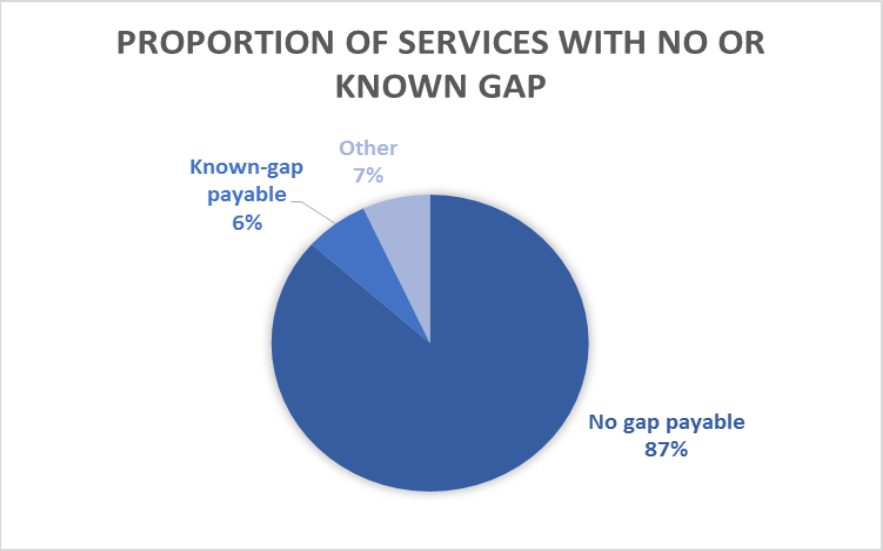
People without health insurance do not quote lack of value as a primary reason for not having insurance (17.7%). The main reason quoted is that it is too expensive (60.9%), followed by Medicare

[16] ABS 2017: Wage Price Index: All WPI series: Original (Financial Year Index Numbers for year ended June quarter)
[17] AIHW: Health Expenditure 2014-15, Table 2.4
[18] AIHW 2015: Health Expenditure Australia, Table 2.3
[19] Hansard: Community Affairs References Committee, 5 July 2017, page 17

is sufficient (29.1%). Importantly, only 8% of people surveyed did not purchase private health insurance because of the potential out-of-pocket costs[20].

This finding is also supported by data on out-of-pocket costs. The March 2017 quarter bulk billing is at record levels with the bulk billing rate for GP attendances being 85.6%, up from 85.1% in the March quarter 2016[21]. The bulk billing rate for total MBS services for the March quarter was 78.7%, up from 78.5%. The average out-of-pocket costs for specialist attendances was $73.8 for the March 2017 quarter[22]. The proportion of services for hospital treatment with no gap was 86.6% and the proportion of services with known gap was 6.5%. In total, more than 93% of services provided in hospital and covered by private health insurance were provided at the no gap or known-gap rate. A detailed breakdown of medical services provided at no and known-gap rates by MBS specialty blocks is at Attachment A.

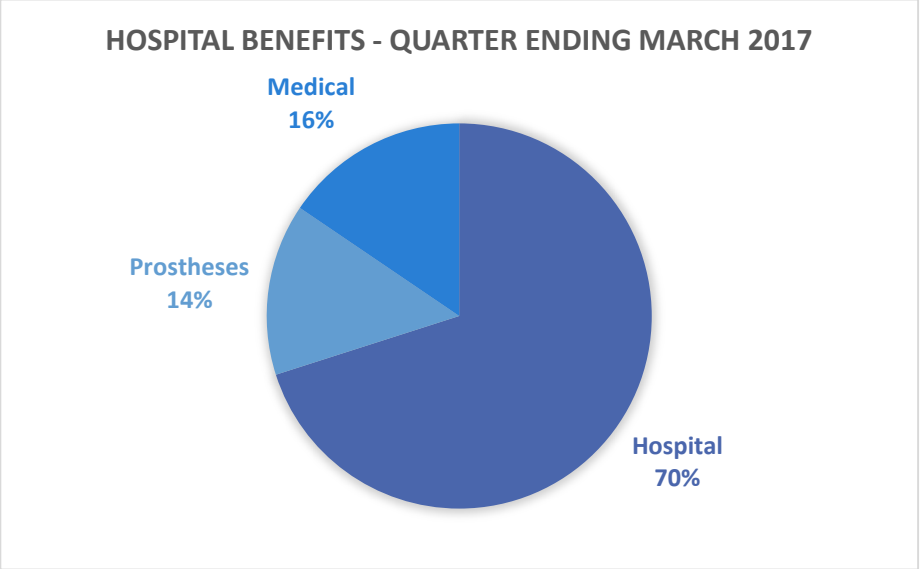
Figure 1: Proportion of services provided at no or known gap[23].



Medical expenses are a small proportion of total benefit outlays for private health insurers. Medical expenses, as a proportion of benefits, have remained static between 2007-08 and 2015-16 (16.0% and 15.6% respectively)[24]. Calls for regulation of medical fees to reduce benefit outlays by private health insurers fail to understand that medical fees comprise less than 16.0% of the total outlays. It would take a substantial drop in medical fees to materially impact premiums. Medical fees are not driving consumer dissatisfaction with the private health insurance product.

[20] ABS 2017: National Health Survey: Health Service Usage and Health Related Actions, Australia, 2014–15
[21] MBS quarterly statistics http://health.gov.au/internet/main/publishing.nsf/Content/Quarterly-Medicare-Statistics - average from July 2016 through to March 2017
[22] MBS quarterly statistics http://health.gov.au/internet/main/publishing.nsf/Content/Quarterly-Medicare-Statistics - average from July 2016 through to March 2017
[23] APRA: March 2017 quarterly statistics at http://www.apra.gov.au/PHI/Publications/Pages/Quarterly-Statistics.aspx
[24] Derived from PHIAC and APRA: *Operations of the Private Health Insurers Annual Report* between 2008 and 2015.

Figure 2: Hospital Benefits – Quarter ending March 2017[25]



There have been calls for increased transparency of medical practitioner fees, which claim that publishing practitioner fees will place downward pressure on fees[26]. However, research conducted in 2013 found that transparent price information is not sufficient to substantially lower health care expenditures[27].

Finally, if transparency of fees is warranted in one area of the sector, it is valuable for all areas. Private health insurers, hospitals, and other key stakeholders should all provide details of costs to the system. This could include senior management remuneration and/or fully itemised hospital list of charges post-surgery so the patient can see exactly how their insurance has supported them.

Key driver of increased private health insurance premiums

Changing demand for service

Increases in health expenditure are driven by four main factors: growth in population[28], providing more services for each patient, improved and more expensive technology, and an increase in the proportion of older people with more complex care needs.

There has been a marked increase in health-care technology, which means illnesses are diagnosed more accurately, treated less invasively and earlier, and these treatments are more effective. For

[25] APRA: Quarterly statistics http://www.apra.gov.au/PHI/Publications/Pages/Quarterly-Statistics.aspx
[26] Consumer Health Forum Media Release (2017) *Time for public listing of specialist fees*, 6 March
[27] Collado, M and Ducas, A: *Health Affairs* 2016: Patients, Physicians, And Price Transparency: If You Build It, Will They Come?
[28] ABS 2016. Australian demographic statistics, December 2015. ABS cat. no. 3101.0. Canberra

example, in 2014-15, 8.1 million Australian adults (45.7%) had been tested for cancer in the last two years. This has increased from 38.5% in 2011-12[29].

An increase in service provision is not necessarily a bad thing. The number of persons visiting a GP increased from 18.5 million to 19.5 million between 2011-12 and 2014-15. More telling is the increase in the type of consultation, with a 21% increase in persons wishing to moderate their drinking, a 19% increase in those wishing to increase physical activity and an 18% increase in visits to a GP that discussed eating healthy food and improving dietary habits[30]. The increases in productivity associated with sound preventative health care programs are well documented. For example the net benefit from programs to reduce coronary heart disease was estimated back in 2001 to be $8,478 million[31].

The trend for increasing service provision is also mirrored in demands for services for specialist treatment and therefore funding through the private health insurance system. Between 2000-01 and 2004-05, for example, the growth in separations from private hospitals outpaced that in public hospitals (4.8% versus 2.4%). This trend has continued, albeit at a lower rate, of 1.7% versus 1.0% between 2010-11 and 2014-15[32]. PHI outlays for total hospital benefits have increased on average by 8% between 2007-08 and 2015-16.

Eight-six per cent of premiums are returned to members as benefits. Whilst there may be scope to improve this amount of return to members, funding the growth in services required by Australians, combined with the increase in costs due to technology, will necessitate increases in premiums.

Consumers understanding of PHI

Health insurance is a complex product

There is no doubt that there is a significant disconnect between most consumers' understanding, and therefore expectations, of the services and benefits they are entitled to under their private health insurance policy and the reality of what their product provides. Consumers often believe that longevity of membership with a health insurer entitles them to 'full cover' and that 'full cover' equates to 'no gaps'.

One AMA member noted:

> *I have patients over 60 with 'blue ribbon' or 'premium' cover finding they are not covered for cataract surgery. They are devastated after being members for 20 years or more.*

Consumers expect insurance to operate in a similar manner to other common insurance products, such as car insurance.

A large proportion of consumers are downgrading their level of cover and further research would be beneficial to establish whether this is as a result of lower wage growth than the cost of insurance (lower discretionary income) or encouragement to downgrade. The number of policies with some

[29] ABS 2017, 4364.0.55.002 - Health Service Usage and Health Related Actions, Australia, 2014-15
[30] ABS 2017, 44364055002DO020_20142015 National Health Survey: Health Service Usage and Health Related Actions, Australia, 2014–15
[31] Ableson, P at http://www.appliedeconomics.com.au/pubs/reports/health/ph00.htm
[32] AIHW 2016: Admitted Patient Care, Table 2.7

form of exclusion has increased from 9.8% in June 2009 to 39% in March 2017[33, 34]. Government data does not show the quantum of services that are excluded by these policies.

AMA members report their patients do not fully understand how excesses, co-payments and waiting periods apply and according to the Australian Private Hospitals Association, 40% of policy holders do not know if they have any exclusions and of those who know, 33% do not know what the exclusions are[35]. It is increasingly difficult for consumers to ensure that they have the correct level of coverage, especially as it often changes after purchase.

In 2014, Medibank reduced the benefits it will pay for pathology and diagnostic imaging services to the level only of the Medicare schedule fee. In 2015 nib removed over 225 items from its schedule of medical benefits, three of which are for treatment of macular degeneration. The ACCC has commenced action against both Medibank Private and nib alleging contravention of the Australian Consumer Law by engaging in misleading or deceptive conduct, unconscionable conduct and making false or misleading representations[36] [37].

It is therefore not precisely clear to consumers what treatments are excluded. The PHI products most commonly cited by our members as impacting on the care of their patients are products with exclusions or minimum benefits, and policies that are for treatment in public hospitals only. This problem will grow as the proportion of exclusionary policies does.

Insurers are creating a de facto risk rating system. By increasing exclusions and creating products that are less likely to require them to pay benefits, they effectively reduce their exposure.

The AMA strongly contends that insurance policies need to cover services that the general consumer would expect to see in a policy. All policies should include mental health services and pregnancy related services. Should pregnancy remain seen as a "special" biological condition and excluded from general coverage, the insurance costs will eventually become so high as to not be affordable and the unintended consequence will be that only the very wealthy can afford pregnancy cover. Under the current settings, there is a real risk that this inequitable treatment will also apply to those with cover for mental health conditions. Including pregnancy and mental illness in all categories of cover will provide assurance to the majority of persons covered that their insurance will provide a benefit should it be required.

Our members also report cases where even health fund staff do not understand the nature of the exclusion policies.

> *One elderly lady had to retrospectively pay $7000 for hospital fees as her fund would not cover her for skin cancer related reconstructive surgery – retrospectively because the hospital had checked her cover with her health fund before the surgery and was told she was covered.*

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[33] Private Health Insurance Administration Council: *Operations of the Private Health Insurers – Operations Report 2013-14 Data,* Table: Policies by type

[34] Private Health Insurance Administration Council: *Private Health Insurance Membership and Benefits – March 2017*, Table: Australia

[35] SMH, '*Private health insurers may be breaking the law by varying customers' policies: ACCC*', 20 Oct 2015

[36] https://www.accc.gov.au/media-release/accc-takes-action-against-nib

[37] https://www.accc.gov.au/media-release/accc-takes-action-against-medibank-for-alleged-misleading-and-unconscionable-conduct

When policies change haphazardly and reduce choice, consumers lose faith that the product provides value for money. PHI provides choice for the patient and without that choice, its value is diminished.

Practitioners actively seek to ensure that their patients fully understand their likely costs. Ninety[38] per cent of AMA practitioners surveyed stated that they find out if a patient has private health insurance, as a part of the conversation about the likely fees for treatment. This information is an important part of an informed financial consent processes. Over 86.8% of AMA member practitioners surveyed take their patients financial situation into account when setting the fee for treatment. Finally, the vast majority (76.1%) advise their patients to check their private health insurance prior to treatment.

Informed Financial Consent (IFC) is an important step to reducing out of pocket costs.

However it is not uncommon for certain necessary services to be assessed by PHIs for benefit payment post-treatment – even if clinical rationales are provided. Often, PHIs choose the clinical circumstances in which they reimburse patients. The result is patients having necessary procedures (e.g. removal of certain skin melanomas) without knowing if their private health insurer will accept their suitability for rebate. This type of selection by private health insurers is undermining patients' ability to plan a treatment in a private setting, and therefore choice. It prevents medical practitioners from providing informed financial consent.

Benefits schedules are not published

One of the main reasons for out-of-pocket costs is that insurers set the amount of benefit they will pay for a medical service and these benefits differ from insurer to insurer for the same medical service. For example, for an uncomplicated delivery of a baby, in 2016 fund A paid a benefit $2150.35, whilst fund B paid $832.74.

These benefits schedules influence how the 'gap/known gap' arrangements for medical services operate. Using the example above, if a practitioner charges $2,100.00 for an uncomplicated delivery of a baby, a patient covered by fund A will not have an out-of-pocket cost, where a patient covered by fund B will. To add to the confusion for consumers, benefits schedules vary from state to state. For example, members have reported that one insurer doesn't offer a known gap scheme at all, which impacts their customers via providing less benefits for treatment. Effectively this means that their benefits are significantly likely to be lower than other funds.

Consumers do not understand that unless the doctor accepts the insurer's schedule of medical benefit as their fee, that the insurer is only required to pay a minimum benefit amount. Members have reported that some private health insurers have chosen not to index their benefits schedules for over 5 years, and have frozen them in a similar manner to the freezing of the MBS schedule. This creates an even larger gap between the increase in the cost of operating a business and the benefits paid for services provided by that business. The vast majority of practitioners (71.9%) surveyed feel that they are pressured to accept the benefit schedule fee (sometimes, often, always). It is this level of pressure applied to practitioners that demonstrates that the benefits schedules are not adequately covering the cost of practice.

[38] 2017 Survey of AMA specialist private practitioner members: response rate of over 1000.

This information on benefit amounts changes whenever private health insurers change their benefit schedules and is not easily accessible or comparable leading to significant inequities between patients claiming for the same procedure.

The AMA recommends that private health insurers should be required to publish their schedules of medical benefits in a way that is easily accessible to consumers and comparable with each other. As we have pointed out in submissions to the ACCC, this information is either not published or difficult to find on health insurers' websites. Currently, a consumer cannot determine what level of cover they are purchasing.

Contracting between Insurers and Hospitals impacts upon benefits

A final complicating factor is the contracting between insurers and hospitals. Private facilities receive health insurance hospital benefits for the hospital treatment they provide to privately insured patients through either:

- contracts between the facility and the insurer;
- minimum benefits - as set out under the *Private Health Insurance Act 2007*; or
- second-tier default benefits – also stipulated in legislation and generally only applicable to smaller hospitals.

Contracts between the facility and the insurer provide a greater benefit for the patient. Since 1995 health insurers have been able to enter into commercial contracts with hospitals that detail the price they will pay for treatment of *their* members at that facility, along with any terms/conditions related to the payment. Contracting was introduced to enhance competition and better manage costs.

Insurers are required to pay a minimum benefit amount for a procedure if not in contract with a hospital or if the second tier benefits schedule does not apply.

As illustrated by the public disagreement during the negotiations of the recent contract between Medibank Private and the Calvary hospital group in 2015

> "for bookings/admissions received after the date of termination [of the contract], Calvary will have no other alternative than to charge patients a "hospital-gap" to make up any shortfall in the reduced benefit it will receive from Medibank - which will be in addition to the gaps already imposed by the fund"[39].

Thus, if the patient wishes to see a practitioner that has admitting rights at a hospital, and that hospital falls out of contract with the patient's insurer, the patient may unexpectedly only receive minimum benefits.

Members have stated:

> *Patients don't understand that their health fund will only cover them in particular hospitals, even with the same doctor.*
>
> *[Health fund name] pays gap cover for cardiac bypasses undertaken in some hospitals but not others, even if done by the same medical team.*

[39] Calvary Media Release, 2015 Q*uality of patient care threatened by Medibank contract demands*, 7 July 2015

This shows that the contracting rules complicate the purchasing of insurance even further for the consumer and increases the chances of an out-of-pocket expense.

Under some contracts between private health insurers and practitioners, the practitioner is not allowed to advise patients that another fund would have a contract with the hospital or pay a better level of benefit. The AMA recommends that insurers are prevented from using these types of clauses, as they undermine the ability for patients to move between funds.

At this point, the consumer needs to anticipate their health care needs, which hospital they might like treatment at, whether that hospital is likely to change its contracting arrangements with the insurer and what the insurer will pay in a benefit compared with other insurers for the health service.

Private patients in public hospitals

Some privately insured patients choose to be treated in a public hospital rather than a private hospital. These patients are able to choose their clinician, but, depending upon their insurance, may not be able to choose a private room. There may be fees for the practitioner and hospital accommodation costs.

There are a variety of reasons a privately insured patient may choose to be treated in a public hospital. These include:

- Their preferred clinician has a private practice at that hospital.
- Their clinician is the only specialist in their area who treats their particular medical problem.
- The public hospital may be the only hospital with the appropriate technology for the treatment needed.
- It may be the closest hospital to the patient's home and family.

Private Health Ministerial Advisory Committee

The AMA, together with other key stakeholders in the private health sector on this Committee, is working to develop a set of recommendations to develop easy-to-understand categories of health insurance, so that consumers understand what their policies will and will not cover. It is hoped this will help remove some of the issues with products that lead to out-of-pocket costs.

This work is currently ongoing.

Payment for health services – informed financial consent

IFC works best when doctors, hospitals and health insurers work together to provide information to patients about the costs associated with treatment, and the private health insurance benefits payable, prior to admission to hospital.

IFC is a conversation between a medical practitioner, or his or her representative, and a patient so that the patient understands and consents to the potential:

- fee for a medical service (procedure or treatment) that will be performed by the medical practitioner;
- costs for any implantable prostheses and devices that will be used during the medical service;
- Medicare rebates and private health insurance benefits that apply to the medical service performed by the medical practitioner;
- variations in fees and costs that might arise if the planned medical service is changed for clinical reasons; and
- notes if there may be downstream costs that cannot be estimated by that practitioner.

Often, this conversation will be followed up in writing so that the patient has a second opportunity to consider their potential costs prior to treatment.

The AMA encourages good IFC practice and the provision of information about medical fees to patients. Patients should always ask their doctor about his/her fees, and the fees of other doctors involved in their care, before going to hospital as a private patient.

The profession takes this responsibility seriously, and 96.9% of private practitioners surveyed provide IFC either all the time or wherever practicable. For emergency procedures or treatments, or complicated procedures, it may not be possible to obtain IFC before the service is performed if the patient is unconscious or otherwise incapable of receiving or understanding the information. It is, obviously, not appropriate to delay treatment that would compromise a patient's care in order to obtain IFC.

Consumers do pay for health services

There is a general expectation in the Australian community that health care should be 'free' at the point of service provision. Most Australians oppose paying to see a doctor[40].

This appears to be based upon the argument that an individual's outlay for healthcare is not discretionary.

However, the data suggests that Australians do spend significant amounts of money on discretionary health items, and this expenditure is growing.

Approximately a third of what individuals spend on health – to the tune of $9.3 billion – goes on vitamins, supplements, over-the-counter painkillers and other unsubsidised drugs. It is more than the combined sum we spend on dental care and hospitals[41]. Australians spend $3.5 billion on complementary medicines and therapies each year – around 13% of individuals' total health expenditure[42]. A considerable proportion of this expenditure is for unproven treatment.

[40] Consumers Health Forum of Australia. Media release *Medicare co-payment plan a massive concern to voters, new poll finds* 11 May 2014

[41] http://www.smh.com.au/money/saving/how-much-australians-spend-on-health-20170222-gujalb.html

[42] Expenditure is sourced from the National Institute of Complementary Medicine website; percentage is derived from comparison with AIHW Health Expenditure Australia 2012-13 Table 3.10 on individuals' funding of health expenditure.

Patients also contribute to their health care for ancillary treatment. For the quarter ending March 2017, 41,080 general treatment services were provided at a cost of $5,600,900. The insurers contributed $3,185,799 in benefits, or only 57%[43].

It is clear that Australians are prepared to purchase some products, but it is not clear why they are not prepared to contribute to the purchasing of high quality health care. The health system would be financially stronger if some of this discretionary expenditure was spent on proven treatments.

Summary

The private health sector is a large contributor to the Australian health system, which has delivered very good health outcomes for the people of Australia. The balance between the private and public system is important to delivering these outcomes. This review should promote the efficient supply of health services.

The expectations of the community for the provision of health services, with improved technology, are ever increasing. Combined with an ageing population, these pressures require additional government funding and will inevitably require increases in premiums for PHI to cover increasing benefit outlays.

The value of PHI is undermined by its complexity. Changing benefits schedules, contracting arrangements, and post-treatment assessment for benefit payments ensure that a consumer cannot know what they will be covered for at the time of purchasing an insurance policy. The AMA recommends that benefits schedules are published by PHIs, and that practitioners should not be prevented from discussing benefits payable with a patient by the PHI contract.

Finally, it is not the cost of medical expenses or potential out-of-pocket costs that discourage consumers from taking up PHI. The vast majority of services (over 86%) are provided at the fee (benefit level) that the insurers determine, and the vast majority of practitioners explain their fee structure to their patients prior to treatment under the principle of IFC. Medical fees are a small proportion of PHI outlays (16%), so a change to medical fees is unlikely to have a material impact upon premiums.

Jodette Kotz
Senior Policy Advisor
Medical Practice Section

[43] APRA 2017, Private Health Insurance Members Benefits, March 2017

Return to Selection

In Hospital Medical Services paid for by Private health Insurers: Australia

Quarter Mar 2017

MBS Speciality Block Groupings	4.1.1 Total number of services			4.1.2 Total amount charged for hospital and general medical services			4.1.3 Total Medicare benefits paid for hospital and general medical services			4.1.4 Total fund benefits paid for hospital and general medical services			4.1.5 Number of gap services			4.1.6 Average gap per service where gap paid		
	No gap agreement	Known gap agreement	No Agreement	No gap agreement	Known gap agreement	No Agreement	No gap agreement	Known gap agreement	No Agreement	No gap agreement	Known gap agreement	No Agreement	No gap agreement	Known gap agreement	No Agreement	No gap agreement	Known gap agreement	No Agreement
1) Specialist, consultant physician, and consultant psychiatric attendances: Groups A3, A4 and A8; Items 104-108, 110-131, 300-352.	1,140,719	37,766	99,877	$121,961,170	$4,888,394	$10,442,143	$74,314,855	$2,454,114	$6,595,245	$47,634,592	$1,516,227	$2,912,996	-	34,367	44,834	$0	$27	$21
2) Procedures associated with intensive care and cardiopulmonary support and management: Subgroups T1.9 and T1.10; Items 13815 – 13888.	143,944	1,871	22,245	$29,143,506	$335,589	$4,105,437	$18,320,449	$196,285	$2,827,115	$10,823,221	$112,629	$1,083,572	-	1,754	3,556	$0	$15	$55
3) Obstetrics and gynaecology obstetrics: Subgroup T4; Items 16500 – 16636; and Surgical operations gynaecological: Subgroup T8.4; Items 35500 – 35759.	49,826	5,467	8,904	$48,314,967	$5,395,987	$12,086,807	$21,136,300	$1,963,725	$4,019,483	$27,179,882	$2,088,533	$1,824,234	-	5,310	6,752	$0	$253	$925
4) Anaesthesia: Groups T6, T7, and T10; Items 17603 - 18298, 20100-25205.	1,440,865	276,960	197,615	$179,975,205	$63,746,755	$39,199,190	$79,673,171	$17,661,351	$13,099,728	$100,329,783	$21,669,425	$9,097,970	-	267,366	162,836	$0	$91	$104
5) General surgical operations: Subgroup T8.1; Items 30001 – 31472.	153,207	20,767	19,779	$49,928,137	$11,041,596	$20,083,892	$26,734,664	$4,386,171	$6,011,992	$23,196,955	$3,395,151	$2,433,211	-	18,653	14,197	$0	$175	$820
6) Colorectal surgical operations: Subgroup T8.2; Items 32000 – 32212.	111,554	8,282	8,584	$58,024,384	$5,605,778	$6,854,359	$31,901,973	$2,459,032	$2,936,564	$26,124,215	$1,921,025	$1,481,441	-	7,951	7,137	$0	$154	$341
7) Vascular surgical operations: Subgroup T8.3; Items 32500 – 35330.	13,148	2,013	2,727	$9,746,202	$1,804,327	$2,799,765	$5,154,255	$808,423	$1,237,219	$4,597,715	$687,404	$487,502	-	1,958	1,666	$0	$158	$645
8) Urology: Subgroup T8.5; Items 36500 - 37654	42,542	11,161	8,966	$20,223,511	$7,995,335	$14,365,184	$10,123,908	$2,949,960	$3,948,879	$10,110,236	$2,651,725	$1,498,398	-	10,408	7,240	$0	$230	$1,232
9) Cardio-thoracic surgical operations: Subgroup T8.6; Items 38200 – 38766; and Diagnostic procedures and investigations cardiovascular: Subgroup D1.6; Items 11700-11724	164,081	7,527	19,699	$44,700,308	$4,036,238	$5,132,499	$23,933,655	$1,880,568	$2,690,719	$20,768,634	$1,637,238	$1,334,521	-	7,431	8,259	$0	$70	$134
10) Neurosurgical surgical operations: Subgroup T8.7; Items 39000 – 40903.	36,363	5,367	6,389	18,456,950	3,396,937	10,822,897	8,857,726	1,294,673	3,273,478	9,605,151	1,297,308	1,322,598	-	4,942	4,828	$0	$163	$1,290
11) Ear, nose and throat surgical operations: Subgroup T8.8; Items 41500 – 41910.	34,150	14,202	10,135	$11,092,903	$6,533,845	$9,053,137	$5,168,313	$2,222,886	$2,469,428	$5,933,690	$2,425,430	$933,823	-	13,536	8,090	$0	$139	$698
12) Ophthalmology surgical operations: Subgroup T8.9; Items 42503 – 42872.	47,738	10,159	8,169	$38,530,728	$12,982,379	$13,901,385	$18,668,925	$4,951,779	$4,419,307	$19,873,371	$5,169,532	$1,864,740	-	9,824	7,022	$0	$291	$1,085
13) Plastic and reconstructive surgical operations: Subgroup T8.13; Items 45000-45797.	20,838	4,668	7,881	$13,182,033	$4,530,458	$18,288,112	$6,453,750	$1,544,481	$4,224,829	$6,731,719	$1,294,695	$1,546,398	-	3,986	6,089	$0	$424	$2,056
14) Orthopaedic surgical operations: Subgroup T8.15; Items 47000 – 50426.	51,993	11,233	17,942	$53,079,174	$15,122,076	$42,488,100	$24,664,374	$5,676,619	$12,221,354	$28,475,509	$5,548,369	$4,654,582	-	10,536	14,623	$0	$370	$1,751
15) Assistance at operations: Group T9; Items 51300 – 51318.	81,593	9,937	16,391	$25,689,767	$4,121,616	$8,594,126	$13,295,736	$1,752,650	$2,868,838	$12,385,742	$1,593,689	$1,138,288	-	9,144	12,816	$0	$85	$358
16) Diagnostic imaging services; Category 5; all Groups I1-I5; Items 55028-63946.	228,930	53,937	188,236	$45,733,639	$16,484,612	$33,747,241	$29,494,906	$8,843,563	$21,262,024	$16,237,792	$5,272,314	$7,665,397	-	53,728	64,019	$0	$44	$75
17) Pathology services: Category 6; all Groups P1-P10; Items 65060 and over.	2,587,817	83,626	728,836	$80,867,570	$4,331,933	$22,007,529	$49,451,693	$1,475,236	$13,607,021	$31,413,690	$604,289	$5,256,454	-	83,380	202,516	$0	$27	$16
18) All other items.	571,050	21,430	119,080	$70,197,590	$5,689,766	$18,563,746	$42,114,883	$2,471,722	$8,650,609	$27,958,776	$1,623,610	$3,336,300	-	20,491	39,654	$0	$78	$166
Total all services	6,920,358	586,373	1,491,455	$918,847,743	$178,043,622	$292,535,549	$489,463,539	$64,993,239	$116,363,831	$429,380,671	$60,508,593	$49,872,424	-	564,765	616,134	$0	$93	$205