



**AMA**

**AMA Submission**

**Department of Health Consultation**

**Options to reduce pressure on private health insurance premiums by addressing the growth in private patients in public hospitals**

**September 2017**

Submitted to: [phiconsultation@health.gov.au](mailto:phiconsultation@health.gov.au)

### **Introduction**

Australia's health system relies on a mixture of public and private service provision. Compared to other countries, Australia appears to have struck the right balance, delivering high quality outcomes for patients at a relatively modest cost in comparison to similar countries. Patient choice is a fundamental feature of our health system, which includes the option for patients to use their private health insurance in a public hospital.

The option for patients to use their private health insurance in a public hospital is not new or remarkable. It is a longstanding feature of our health care system and is currently dealt with under the National Health Reform Agreement, which guarantees the right of privately insured patients to elect to be treated as a public or private patient in a public hospital.

The AMA supports this choice for patients.

There are very good reasons why a patient may choose to use their private health insurance for treatment in a public hospital. For example, in regional and rural areas there may be no other option available due to the lack of private sector services. Public hospitals are also equipped to handle the most complex of cases and, in many instances, may represent the most appropriate clinical setting for treatment. It may also be the most cost effective option for a patient, particularly in light of the growing number of private health insurance policies with exclusionary features or excesses and co-payments. A patient may also wish to be able choose to be treated by a doctor that they have previously seen.

There are also significant benefits that flow to public hospitals. In a constrained funding environment, the supplementary revenue generated from private patients makes an important contribution towards the recruitment and retention of medical practitioners (through specific arrangements reflected in industrial instruments), improved staffing, the purchase of new equipment as well as teaching, training and research. These all support the delivery of high quality care to public and private patients alike.

### **The value of private health insurance**

There is growing concern in the community about the value of private health insurance, with several factors contributing to this. Successive Governments have targeted the private health insurance rebate so that its value has diminished over the years. Private health insurers (PHI) also offer a bewildering array of products with varying levels of cover and many exclusions, which often leave patients confused and upset when they find unexpected out of pocket costs are incurred because common medical procedures are not covered.

The indexation of medical fee schedules by both the Commonwealth (MBS) and the PHIs has also stagnated. However, medical practitioners continue to face increases in all the usual costs of running a business like wages, rent, utilities, insurances etc. Again, this exposes policy holders to potential out of pocket costs.

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Despite falling membership, PHI profits are also growing with the most recent report of the Australian Prudential Regulation Authority showing the industry achieved a 17.2 per cent increase in before tax profits over the 12 months to 30 June 2017<sup>1</sup>. Shareholder returns are improving at the expense of PHI members who face significant premium increases.

Private health insurance in Australia is in need of meaningful reform, focusing on more robust levels of coverage, greater transparency in the policies offered and the abandonment of 'junk policies' that are simply designed to avoid the Medicare Levy Surcharge.

### **Value through choice of doctor and hospital**

The AMA notes that the paper outlines that savings within the health service provider chain could be gained from the administration of second tier default benefits, and is willing to discuss how these might work.

However, the AMA would strongly oppose any dilution of the second tier benefit rate itself, or its application to facilities that do not have a contract with a health fund. The second tier rate ensures that consumers, who have duly paid their insurance premium, have access to the hospital and doctor of their choice – regardless of whether that doctor or hospital has been successful in securing a contract from a health fund.

It is well known that the benefit of choice underpins the value proposition for private health insurance. It is also critical that referring doctors are able to refer to the appropriate specialist for a patient's particular condition based on their expertise – second tier provides this ability. It is the mechanism that provides protection from our system becoming one of managed care.

Any downwards movement in the second tier benefit rate would only restrict patient choices and drive up out of pocket costs, further undermining the value proposition of private health insurance.

### **Are private patients in public hospitals really a problem?**

Given these significant challenges, the AMA is concerned about the attention being given to the issue of private patients in public hospitals and the extent to which changes are required in this area. In particular, there is an obvious hypocrisy on the part of PHIs who offer and increasingly promote public hospital only private insurance policies - yet object to the growth in their members opting to use their insurance in a public hospital.

To put some perspective on the issue of private patients in public hospitals, it is important to look beyond percentage rates of increase as these can be misleading. An analysis of the raw data shows that the combined increase in public patients in public hospitals and private patients in private hospitals significantly exceeds the growth of private patients in public hospitals - by a factor of almost four to one. This is illustrated in the following Table 1.

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<sup>1</sup> Australian Prudential Regulation Authority (APRA), Private Health Insurance Quarterly Statistics, June 2017.

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**Table 1** Separations by principal source of funding, public and private hospitals<sup>2</sup>

Category	2011/12	2015/16	Increase
Private patient in a private hospital	3,025,841	3,601,976	576,135
Private patient in a public hospital	584,429	871,902	287,473
Public patient in a public hospital	4,658,853	5,186,320	527,467

Clearly, while the percentage growth in private patients may appear high in comparison to the other categories, this simply reflects the fact that it is calculated on a much smaller base.

Australian Institute of Health and Welfare (AIHW) data also shows that while there has been an increase in the proportion of private patients who are admitted for surgery through public hospital emergency departments since 2011/12, the proportion has been stable since 2013/14. The proportion of private patient admitted for elective surgery in a public hospital has also been stable over the same period. This is detailed in Table 2 below.

**Table 2** Emergency and elective admissions to public hospitals by funding source<sup>3\*</sup>

	Emergency admissions involving surgery		Elective admissions involving surgery	
	Private patient	Public patient	Private patient	Public patient
2011/12	14%	77%	7%	88%
2012/13	16%	76%	7%	88%
2013/14	18%	75%	7%	87%
2014/15	18%	75%	8%	88%
2015/16	18%	75%	8%	88%

\* Other funding sources not covered in the table include workers compensation, self-funded patients, motor vehicle third party claims, Department of Veterans' Affairs and other.

We can also see from the options paper that when a privately insured patient chooses to use their private health insurance to be treated in a public hospital, the cost to PHI is quite

<sup>2</sup> Australian Institute of Health and Welfare 2013. Australian hospital statistics 2011–12. Health services series no. 50. Cat. no. HSE 134. Canberra: AIHW.

<sup>3</sup> AIHW, Admitted patient care 2015–16, 2014–15 and 2013–14: Australian hospital statistics. AIHW, Australian hospital statistics 2012–13, 2011–12

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modest. According to the paper, growth in hospital insurance benefits per episode for treatment in a public hospital averaged 0.5% per annum between 2010/11 and 2015/16. This much less than the 2.5% growth per annum over the same period in the private hospital sector.

### **Options for reform**

Great care needs to be exercised in considering any changes that might impact on the funding available for public hospital services, particularly in the context of existing funding pressures on public hospitals. The options paper itself is unable to show that any significant premium relief would flow from reform in this area, while the earlier analysis in this submission also serves to put some perspective on the scale of the issue.

The AMA cannot see any case for radical change, although we agree that there may be opportunities to address potential concerns over cost shifting and to ensure equity of access to care.

While the options paper outlines a number of options for reform, they are put forward in a simplistic fashion and are largely ignorant of the broader funding and policy environment. In this regard, the AMA would observe that a number of key areas need to be addressed as follows:

#### *Sustainable funding for public hospitals*

Total spending on public hospitals (from Commonwealth, State and Territory, and non-government sources) grew by 2.7 per cent to \$48.094 billion in 2014-15 (compared to the 10-year average of 4.4 per cent)<sup>4</sup>. The Commonwealth and the states and territories all bear significant responsibility for this situation, with each putting in variable funding effort over the years.

These funding levels are reflected in the performance of our public hospitals. The most recent AMA Public Hospital Report Card showed that, against key measures, the performance of our public hospitals is essentially frozen at the unsatisfactory levels of previous years. To the extent that public hospitals have increasingly promoted to patients the option to use their private health insurance while in a public hospital, there is no doubt that this has largely been driven by inadequate funding arrangements.

If the current situation is to change, then the next COAG Health Agreement must lock in a formula that delivers adequate and sustainable funding for public hospitals. This must recognise growing community need and the ongoing failure of our public system to meet key performance targets.

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<sup>4</sup> AMA Public Hospital Report Card 2017

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### *Growth of excesses, co-payments and exclusionary policies*

In June 2017, 82.9 per cent of hospital cover policies had excesses and co-payments, and 39.9 per cent of hospital cover policies were exclusionary<sup>5</sup>. There is no doubt that many of these policies are not fit for purpose, having been constructed on the basis of price as opposed to clinical need.

Reforms being developed by the Private Health Ministerial Advisory Council must ensure health insurance policies are designed to meet the common medical needs of consumers and that different levels of coverage are clearly articulated and easily understood by consumers.

### *Ensuring access to public hospital services is based on clinical need*

While the AMA strongly supports the right of patients to be treated as a private patient in a public hospital, we are concerned at evidence suggesting that some private patients are being prioritised over publicly funded patients. In consulting with members, we can find no evidence that this practice is being driven by the decisions of doctors, although it could be a product of administrative processes and systems implemented by hospitals themselves. To the extent that this may be happening, it is inequitable and in direct contravention of Medicare principles.

Access to services in public hospitals must be based on clinical need and, to the extent that this is not happening now, it may be necessary to strengthen future COAG Hospital Funding Agreements to better describe this obligation and as well as develop better compliance mechanisms.

### *Genuine and informed choice for patients*

There are anecdotal reports of patients being pressured by public hospitals and/or offered unfair inducements to use their private health insurance, which is clearly cost shifting. It contradicts the principles of the existing National Health Reform Agreement and is not supported by the AMA. Future COAG Hospital Funding Agreements, and associated compliance arrangements, should incorporate more robust and auditable patient election processes that are based on the following principles:

- Patients freely elect to being treated as a private patient after being given all the information (including choice of doctor) required to make an informed choice between public and private care;
- Public hospitals must not offer unfair inducements or unduly pressure patients to declare or use their private health insurance; and
- Public hospital management must not coerce doctors and other staff into unduly influencing patients to elect to use their private insurance.

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<sup>5</sup> Australian Prudential Regulation Authority, Private Health Insurance Membership Trends, June 2017.

## **Conclusion**

None of the proposals in the options paper adequately address the measures outlined by the AMA. Most of them are blunt reforms that would simply reduce the level of funding available to public hospitals in favour of private health insurers as well as reduce the choice available to privately insured patients.

The development of a durable solution to this issue needs to be proportionate and considered in the context of broader private health insurance reforms and future public hospital funding arrangements. This will require extensive consultation, including with the states and territories who, in relation to private patients in public hospitals, appear to have had very limited input to date.