RURAL DOCTORS ASSOCIATION OF AUSTRALIA

Private Health Insurance

Submission to the Australian Competition and Consumer Commission

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ABOUT RDAA

RDAA is the peak national body representing the interests of doctors working in rural and remote areas and the patients and communities they serve.

RDAA's vision for rural and remote communities is simple – excellent medical care.

This means high quality health services that are:

- patient-centred
- continuous
- comprehensive
- collaborative
- coordinated,
- cohesive, and
- accessible

and are provided by a GP-led team of doctors and other health professionals who have the necessary training and skills to meet the needs of those communities.

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EXECUTIVE SUMMARY

Almost one third of Australia's population lives in the range of farming, mining, tourism and Aboriginal and Torres Strait Islander communities that make up rural Australia. The diversity of these communities is reflected in differences in their social and economic determinants of health. On average people in rural and remote areas have lower incomes, lower levels of education and lower health literacy. These and other social determinants of health, and factors such as poor nutrition and exposure to a broad range of physical risks related to occupation, contribute to rural people having higher rates of disease and injury and shorter life expectancy than people living in major cities.

RDAA recognises that private health insurance (PHI) has a role to play in Australia's health system, but has a number of concerns with respect to its relevance and cost for people living in rural and remote communities.

While PHI can provide benefits to fund members – including rebates for private health services; rebates for a number of ancillary services not covered by Medicare; shorter waiting times for some services, including elective surgery; and choice of specialist – PHI policies appear to be predicated on urban-centric assumptions about the availability of health professionals, services and products.

In rural and remote areas lack of access to health professionals, services and products, the affordability of PHI cover and difficult to understand industry information and practices often diminish or negate any benefits. The plethora of health insurance policies available, the range of variations and exclusions and the lack of plain English explanations hamper the ability of rural people to assess the adequacy and appropriateness of health insurance products against their requirements. Fewer people are covered by PHI than in urban areas.

The Australian Government and the health insurance industry must address the fundamental needs of rural people for more easily available primary care and specialist services by ensuring that PHI products and services are relevant to rural and remote people are offered at an affordable price.

RECOMMENDATIONS

RDAA believes that it is important to:

- Ensure robust policy and regulatory frameworks for private health insurance to prevent potential conflict of interest or discriminatory practices that exacerbate inequities.
- Ensure that access to health services in rural and remote areas is supported, not compromised, by private health insurance arrangements.
- Include appropriate rural representatives on all Australian Government health-related decision-making bodies to ensure that any changes to policy and regulation are sensitive to the differential impact they may have in rural and remote Australia.
- Maintain the community rating system for PHI to ensure that consumer protections are not eroded.

KEY ISSUES

RDAA has identified a number of key issues to inform the Australian Competition and Consumer Commission's annual report to the Senate on Private Health Insurance:

PHI policies must recognise that the needs of rural and remote people are different to those in urban centres and relevant products and services must be provided at an affordable price.

The fundamental health care needs of rural and remote people centre on access to primary care and specialist services, not alternative health and other inaccessible options. People living in rural communities are often dependent on public hospital services.

Many people living in Australia's rural and remote communities are experiencing socio-economic disadvantage. For these people the increasing cost of PHI for annual cover, and out-of-pocket costs including for excess and gap payments, is prohibitively expensive.

Those rural people who are insured often make considerable financial and other sacrifices to afford premiums. They do so in order to get timely access to care, avoid long waiting lists for public hospital and specialist consultations if they need to travel to a larger regional centre for treatment, and cover in the event of an unexpected emergency.

Their decisions about the relative value of PHI are also governed by whether services can be accessed locally. High out-of-pocket expenses, including lost income, travel and accommodation, are also incurred when private health services are not locally available. Lack of nearby access to the full range of services covered by PHI means that rural people are, in essence, *paying more for less.*

Rural people, even if they are not PHI fund members, also subsidise the PHI industry through their federal tax contributions, further compounding access and cost inequities. In 2016-17 the estimated cost of the Private Health Insurance programme is $6.5 billion[1].

In places where private patient arrangements exist, those rural people who can afford — or make sacrifices to afford — PHI find it particularly valuable to be able to access visiting specialists and services like obstetrics, colonoscopies, endoscopies, radiology and general surgery as private patients at their local public hospital. They may also maintain it for unexpected accidents and emergencies. However, rural people are often

significantly under-served: there is lack of access to these and many other private healthcare services and products so easily available in larger regional and urban centres. Offering PHI cover at affordable rates that is inclusive of care coordination, travel and accommodation, and remote technologies and support, and can be tailored to individual needs would assist in redressing the inequities experienced by rural and remote people.

The Australian Government's Lifetime Insurance Cover requirement that people take out PHI by their 31st birthday, or pay a 2% loading for every year they are aged over 30 [2], makes already expensive PHI even more expensive for people who are already experiencing disadvantaged.

In addition to affordability and access issues, complex arrangements with preferred providers, an array of exclusions, and unclear or misleading language contribute to confusion and make it more difficult for people in rural and remote communities to make informed decisions about the relevance, adequacy and comparative value of health products and services covered by PHI.

The need to be able to compare health insurance products has given rise to a number of websites and apps purporting to provide an easy mechanism to be able to do so. While these may be helpful to some people, these mechanisms are of lesser use in rural and remote areas because of the generally lower literacy (including health literacy) levels and poorer digital ability.

Inequities of access must not be made worse by PHI arrangements.

It must be recognised that increased profitability is a key driver within the health insurance industry impacting on the competitive behaviours of both for-profit and not-for-profit health insurers.

To this end private health insurers explore a range of initiatives to increase their capacity to differentiate their products and increase market share. Some initiatives, such as those focused on support for behavioural change, may prove to be beneficial but their efficacy must be independently evaluated. People living in rural and remote areas may be unable to take advantage of such programs for a number of reasons including lack of access to health and wellbeing products and services, poorer access to allied health professionals and services, lesser access to digital technologies and poorer health literacy and digital ability.

Others, including the discontinued trial of preferential appointments where patients with PHI are given priority for appointments over those without PHI, give rise to equity concerns and the possibility of a tiered "have and have not" system of healthcare. In rural and remote communities, where access to services is already problematic, this type of initiative could further compromise the provision of health care and exacerbate inequities.

Any inherent conflict of interest and potentially discriminatory practices must be subjected to careful scrutiny and regulation to ensure that Medicare does not become a default safety net in a tiered healthcare system.

Policy and regulatory modifications to PHI arrangements must be carefully designed to ensure that access to services in rural and remote areas is supported not compromised, by changes. If changes led to a reduction in the number of private healthcare services that are currently being provided in rural and remote areas, rural and remote patients, who are already underserviced, would be negatively impacted.

It should be noted that being able to access private healthcare services locally also has critical flow-on effects in helping to retain generalist and specialist clinicians in rural communities, supporting the viability and sustainability of rural hospitals and taking pressure off the large regional and metropolitan hospitals by reducing their patient loads. The provision of subsidies and incentives to improve access to services should be considered.

Consumer protections must not be eroded.

Community rating is a key feature of Australia's PHI system and must be protected.

The view that responsibility for health costs associated with lifestyle choices and risk factors should be borne by the individual — not by all those paying for PHI — has been promulgated as an argument for differential premiums. Such a move could further compromise the affordability of PHI for many rural and remote Australians and have significant adverse impacts on their health and on the health system more broadly.

Any initiative that simplifies the notion of "choice" in relation to health behaviours gives rise to a number of concerns, not least of which is the assumption that choices are informed and made independently of other factors.

In rural and remote Australia the importance of social, cultural and environmental determinants of health cannot be overstated. The inequities that exist in these areas inhibit the capacity of individuals and families to make healthy choices and to access preventive healthcare. For example, poor nutrition may be a result of the reduced availability and high cost of fresh food in some rural and remote communities. Rural and remote patients should not be burdened with extra PHI costs simply because they have a higher risk of chronic and complex disease.

Furthermore, if insurers are allowed to charge higher premiums on the basis of specific health risk factors, such as smoking or obesity, there is a danger that this will become a precedent for extending differential pricing to other risk factors such as genetic predisposition.

It must also be noted that while some people may benefit financially in the shorter term from lower premiums under a differential pricing approach, potential benefits may be eroded over time by rising rates of health risk factors associated with affluence and ageing.

Differential pricing could also increase financial stress for many Australians, not just those living in rural and remote areas. In a report by the Private Health Insurance Administration Council it is noted that *the proportion of the population covered by private health insurance in Australia has declined significantly since the 1970s. In 1971 more than 77 per cent (or 10.2 million people) were covered and this had declined to 47 per cent (or 11.2 million people) by 2014.*[3]

If more Australians decide that private health insurance is unaffordable and not worthwhile given the range of exclusions and very high out-of-pocket gap fees, this decline could continue. There will then be increased pressure on the public health system and consequent cost implications.

ENDNOTES

1. Table 8.1, Budget Strategy and Outlook Budget Paper No. 1 2016-17. p 5-22. http://www.budget.gov.au/2016-17/content/bp1/download/bp1.pdf Accessed 14 March 2017.

2. Lifetime Health Cover (LHC) - Factsheet for 31 year olds http://www.health.gov.au/internet/main/publishing.nsf/Content/lhc-factsheet31yearolds Accessed 14 March 2017.

3. Private Health Insurance Administration Council. *Barriers to entry in the Australian private health insurance market.* Research Paper 3. June 2015. p7 http://www.apra.gov.au/PHI/PHIAC-Archive/Documents/Barriers-To-Entry_June-2015.pdf Accessed 14 March 2017.