RURAL DOCTORS ASSOCIATION OF AUSTRALIA

Value and affordability of private health insurance and out-of-pocket medical costs

Submission to the Senate Community Affairs References Committee

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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.

CONTACT FOR RDAA

Peta Rutherford
Chief Executive Office
Rural Doctors Association of Australia

ceo@rdaa.com.au
P: 02 6239 7730
M: 0427 638 374

EXECUTIVE SUMMARY

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.

It is well recognised that in rural and remote Australia inequities in the social determinants of health and inequities of access to health care professionals and services are significant. The degree of remoteness and a range of other unique geographic, climatic, demographic, cultural and socio-economic factors impact on the provision of health care in these areas.

Rural and remote people are also less likely to be covered by PHI than in urban areas. Affordability; lack of access to health professionals, services and products; and difficult to understand industry information prevent people living in rural and remote communities from fully benefitting from private healthcare and influence its uptake.

Current PHI arrangements appear to be predicated on urban-centric assumptions about the availability of health professionals, services and products. They do not adequately address the needs of rural and remote people, and ever-increasing costs of premiums, excess and gap payments and other out-of-pocket medical expenses within the private and the public health spheres are putting a further strain on individuals and families in these communities. RDAA has previously pointed to the impact of these issues in its submissions to the Private Health Insurance Consultation in 2015 [1] and the Australian Competition and Consumer Commission in 2017 [2], and reiterates the importance of ensuring that access to health professionals and services in rural and remote areas is supported, not compromised, by any private health insurance arrangements.

The issues of access, affordability and applicability must be immediately addressed to ensure that existing health system inequities being experienced by rural and remote people and communities are not made worse. Australian Government and health industry mechanisms which support health professionals to provide private health services in rural and remote communities and relevant and affordable PHI policies, products and services that are more suited to the needs of rural and remote people are both necessary if value for money is to be realised.

KEY ISSUES

Access

In rural and remote areas there are markedly fewer health professionals, including medical specialists and allied health providers, and private hospitals. This lack of locally available health services impacts on uptake of PHI in these areas.

In some areas patients are able to access private treatment locally, either in a private facility or as private patients in a public hospital. There is likely to be little difference between public and private wait times in rural settings where services are often delivered by the same doctor whether they be resident or visiting. Visiting specialists using public hospital facilities may see only public patients or a mix of public and private patients. Visits are at scheduled intervals, so there is little difference to wait times. Where a visiting specialist provides services in a private rural hospital wait times may be lessened but given that most hospitals in rural and remote areas are public this becomes a moot point.

Some patients are able to travel to private facilities further afield, but for those who cannot – for financial, health or other reasons – issues related to the interaction of private and public hospitals are also moot. Furthermore, while wait times for procedures in more distant private facilities may be less, the additional financial and social imposts will be significantly higher.

Preferred provider and no gap provider arrangements can also be problematic in rural and remote areas where patients are unable to access insurance providers' nominated health professionals and can impact on perceived value of PHI.

The decisions rural and remote people make about the relative value of PHI are often governed by whether services can be accessed locally. Lack of nearby access to the full range of services covered by PHI means that rural people are, in essence, paying more for less. High out-of-pocket expenses, including lost income, the costs associated with travel and accommodation for patients and carers, and social costs such as time away from family and community, are also incurred when private health services are not locally available. Value for money is a key concern.

It should be also be noted that being able to access private healthcare services locally (in public or private facilities) also has critical flow-on effects in helping to retain generalist and specialist clinicians in rural communities, supporting the viability and sustainability of rural general practice and secondary care. Rural hospitals can reduce the pressure on large regional and metropolitan hospitals by decreasing their patient loads. The provision of subsidies and incentives to improve access to services in particular for the development and realisation of a National Rural Generalist Pathway will be an important step.

The fundamental needs of rural people for more easily available primary care and specialist services, and the underlying workforce and infrastructure issues contributing to poor access, must be recognised, prioritised and addressed to improve health and wellbeing outcomes.

Affordability

When compared with people living in more urban settings, rural and remote Australians have markedly poorer health outcomes including higher rates of risk factors, higher rates of potentially avoidable hospital admissions, higher rates of chronic disease and higher rates of mortality[3]. The level of disadvantage experienced by rural and people including in relation to education, employment and income[4] as well as poorer access to health professionals and services [5] are significant contributory factors.

In rural and remote areas many people are experiencing socio-economic stressors. Insecure employment and income – caused, for example, by down turns in the mining sector, the impact of drought on the agricultural sector or demographic shifts – and high levels of financial pressure has an adverse effect on the physical, mental and social health of individuals and families.

Although such factors as distance and time away from the farm also play a role, the generally lower incomes and higher costs to access treatment, including for travel and accommodation, in addition to any necessary pathology, diagnostic imaging and procedure costs either not covered or only partially covered by Medicare, are already contributing to rural people being less likely to seek medical treatment or delay visiting a doctor, often until the health issue becomes acute and requires a higher degree of

intervention. The additional costs of PHI cover and out-of-pocket excess and gap payments, is often prohibitively expensive.

For rural and remote people already experiencing lower socio-economic prosperity paying for the already high – and increasing – cost of PHI premiums, excess and gap payments, is simply not an option. Australian Government "carrot and stick" measures (PHI Rebate, Medicare Levy Surcharge, Lifetime Health Cover loading) to encourage uptake of PHI is not an inducement for people in this situation. For disadvantaged 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[6] can make already expensive PHI even more expensive.

Those rural people who are insured often make considerable financial and other sacrifices to afford PHI premiums. They do so in order to get timely access to care for elective procedures and, if they need to travel to a larger regional or urban centre for treatment, avoid long waiting lists for public hospital and specialist consultations.

Many Australians are reassessing their PHI coverage as costs of PHI continues to rise and perceptions of value for money decline. In 2015, the Private Health Insurance Administration Council 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[7]. Most recently, the Australian Competition and Consumer Commission (ACCC) has found that *consumers are shifting towards lower-cost policies with lower benefits. Between June 2014 and June 2016 there was a 400 000 reduction in hospital policies with no exclusions (which can be equated with 'top cover'), while an additional 600 000 hospital policies with exclusions were taken out.*[8]

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, these trends could continue. There will then be increased pressure on the public health system and consequent cost implications.

Any changes to the Medicare Benefits Schedule payments and PHI legislative and regulatory arrangements, that lead to increased costs, such as

introducing or increasing co-payments and excess and gap payments, will impact negatively on the health, social and financial wellbeing of rural and remote people.

Applicability

For PHI to be relevant, and of value to rural and remote people, PHI policies must recognise that the needs of rural and remote people are different to those living in urban centres and policies, products and services must be designed to meet those needs.

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. Subsidies for gym membership, for example, are not relevant in communities where there is no gym.

- The Australian Government and the health insurance industry must address affordability issues, including by ensuring policies and products are relevant to the rural and remote context.

Generally lower levels of literacy, including health literacy, is an issue in rural and remote areas. Lengthy policies and product descriptions written in impenetrable language make understanding and comparing insurance policies and product information more difficult.

- Information must be communicated in plain English to ensure that rural people are able to assess the adequacy and appropriateness of health insurance products against their requirements.

It must also be noted that the ability of rural and remote people to compare PHI offerings may be hampered by poorer digital connectivity and ability in some areas.

- Transparency and accountability for PHI policies, products, processes and practises, including for the increasing number of commercial comparison websites, must be assured by government and industry mechanisms.

RDAA has previously pointed out 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 PHI providers explore a range of initiatives to increase their capacity to differentiate their products and services and increase market share.

Increasing levels of consumer complaints about PHI and current ACCC action against some of Australia's largest PHI providers for misleading conduct or anti-competitive practices[9] are indicative of the importance of robust legislative and regulatory frameworks to:

- ensure existing inequities experienced by rural and remote people are not exacerbated
- prevent potential conflict of interest or discriminatory practices
- safeguard consumer protections, including by maintaining the community rating system and ensuring membership and related health data cannot be exploited to deny coverage, and
- ensure confidentiality in relation to membership and related health data to prevent inappropriate use. PHI privacy policies must be clearly explained up front.

ENDNOTES

1. http://www.rdaa.com.au/sites/default/files/public/03Dec15%20RDAA%20Submission%20to%20PHI%20Consultation.pdf
2. http://www.rdaa.com.au/sites/default/files/public/17.03.16%20RDDA%20Submission%20to%20ACCC%20on%20PHI%20FINAL.pdf
3. http://www.aihw.gov.au/rural-health/access-to-health-services/
4. http://www.aihw.gov.au/rural-health/
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6. http://www.health.gov.au/internet/main/publishing.nsf/Content/lhc-factsheet31yearolds
7. http://www.apra.gov.au/PHI/PHIAC-Archive/Documents/Barriers-To-Entry_June-2015.pdf
8. https://www.accc.gov.au/system/files/1223_Private%20Health%20Report%202015-16_FA3_web.pdf
9. https://www.accc.gov.au/system/files/1223_Private%20Health%20Report%202015-16_FA3_web.pdf