AUSTRALIAN DENTAL ASSOCIATION

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Ms Catherine King MP
Shadow Minister for Health and Medicare
Parliament House
Canberra

By email: privatehealth@australianlabor.com.au

Dear Ms King

RE: Proposed Productivity Commission Inquiry into the Private Health Sector

Thank you for providing the Australian Dental Association (ADA) with the opportunity to participate in the consultation on the Proposed Productivity Commission Inquiry into the Private Health Sector.

The ADA has for some time been concerned about the declining affordability and value for money offered by general treatment ("extras") cover, and the discriminatory, anti-competitive and sometimes unethical practices of some health funds towards consumers and health practitioners. Accordingly, the ADA has made a wide range of recommendations to the Australian Competition and Consumer Commission and various Senate Inquiries, and we welcome the Australian Labor Party's intention to request a Productivity Commission Inquiry into the Private Health Sector and in particular, private health insurance.

The Discussion Paper covers a range of issues related to private health including, product design, out-of-pocket costs, competitiveness, transparency and the premium setting process. In our response, we have limited our comments to the issues we feel we can confidently speak to.

1. Does the current system of incentives and penalties to purchase private health insurance provide sufficient support for the sustainable application of the community rating principle?

The ADA is of the view that the current system of incentives and penalties encourages purchasing of private health insurance is based almost entirely on the cost of the policy rather than placing emphasis on a consumer's health and their evaluation of what is actually included in their policy. In other words, they take cover to avoid the penalty.

It is not clear how the community rating (CR) is supported or compromised by incentives and penalties. The model of community rating only works when there is a large pool of participants including many people who are in good health and who do not claim on a regular basis. This ensures that there are sufficient resources to meet the benefits payable to the smaller number of policyholders who require hospital care. As the Australian population ages, individuals may have a higher health expense. As stated in the discussion paper It is the opposite of the concept in insurance of "risk rating", where premiums are assessed having regard to the individual circumstances of the person seeking cover (people assessed as higher risk pay a higher premium).

The ADA supports the concept of CR continuing.

The removal of CR would lead to higher profits for private health insurers (PHIs) to the detriment of disadvantaged Australians. There needs to be an incentive for PHIs to actually provide appropriate levels of cover and remove the "junk" policies that are offered to consumers who just want to avoid the penalties. These permit young and healthy people to select cover which provides minimal coverage, undermining the cross-subsidy from healthy people to sick people that is they key policy objective of community rating. As stated in the discussion paper the age structure of the insured population has changed significantly since 2001, to the point that the ratio of those under 65 to those over 65 is worse than when Lifetime Health Cover was introduced. Therefore, the junk policies offered for as low as $1100 are not the solution to funding CR.

An option that could be considered is that the $6billion+ PHI premium tax rebate subsidy be directed to CR cross subsidisation.

2. Would community rating be strengthened or eroded by raising the minimum standard for hospital insurance products?

The majority of low-cost basic hospital cover policies do not represent good value to consumers but are a significant revenue source for private health insurers. The exclusions mean little is actually covered. However, eliminating these may mean that many current holders will not be able to afford insurance if "bronze" is the minimum standard. Government needs to ensure an adequate standard of cover is actually offered under the "bronze" level of policy on offer as it is difficult to see any benefits to disadvantaged Australians.

3. Will the current growth in policies with exclusions continue or will it level out? What implications will there be for community rating?

Whilst it is difficult to predict without access to data from private health insurers, the ADA would anticipate further growth of policies with exclusions. If the profits of health insurers are tracked over time relative to inflation, dental fee increases and other measures one will notice that due to their responsibility to generate profits PHI premiums have increased on average 2-3 x CPI. The massive increase in exclusions in their policies in the past decade has added to this profitability. Real increases in rebates per service have been almost non-existent for the last decade. Some have actually decreased rebates per service, and this fall in the real value of rebates is particularly noticeable amongst the publicly listed PHI who have a responsibility to their shareholders to maximise their profits and return to shareholders. To sustain this growth and profitability it is highly likely private health insurers will have to reduce their product offerings, fuelling further exclusions.

4. What effect will the current Government's categorisation of products into Gold/Silver/Bronze/Basic tiers have?

This comes some way towards making PHI products comparable, but PHI exclusions and variations continue to exist making it very difficult for consumers to truly compare products. It would be flawed, for example, to rate a good combined hospital cover policy highly if it contains fine print exclusions, and from the ADA's standpoint, poor dental cover. The ADA has noted that PHI's use dentistry and other allied health insurance extras cover as a method of offsetting the hospital policy benefit payout costs they incur. Healthcare cover in the extras category can often be a profit driver for health insurers, for example via the use of differential rebates.

5. How does the current system of risk equalisation affect competition and innovation?

The current system of risk equalisation assists smaller funds to compete with the larger funds in offering products so should be maintained.

6. Could it be improved?

The ADA does not have a comment on this matter.

7. Should insurers be required to pay benefits for services provided by all providers, or should selective contracting and benefit differentiation continue?

Yes. The government should insist that the same benefits for services are paid to all providers; this would be consistent with the principles under Medicare. Preferred provider schemes restrict service, and reduce competition while maximising private health insurers' profits. Furthermore, differences in the level of cover offered for services provided by different hospitals and health care providers restrict consumer choice and confuse the public.

Benefits paid may differ depending on the level of specialisation of the provider that provided the service – for example, for dental services, specialist rebates should be higher than GP rebates. However, equivalent benefits should be paid for all services provided by health providers in the same registration category.

Selective contracting and benefit differentiation should be scrapped as recommended by the Senate Inquiry into the value and affordability of private health insurance. The overall aim of the industry should indisputably be to improve the health of Australians. If we take a step back from that aim, differential rebates seek to drive consumers not only to contracted providers which have agreed to allow insurance companies to dictate their fees but critically also to *insurer owned clinics* which return profits back to the insurance company. It is inexplicable that an insurer provides the service it insures. This is a clear conflict of interest that flies in the face of open competition.

The average consumer is unable to make a clinical decision. The more complex the issue the more difficult it becomes. Therefore, they should be treated by a clinician of their choice that they trust and who has a firm understanding of their medical and dental history. Differential rebates are used by PHI to undermine that right by making the key driver of choice of practitioner the out of pocket cost and ensuring that it is lower when the patient sees a preferred provider, even if the preferred provider's actual fees for service are higher.

8. Are any changes to the second-tier default benefit warranted?

There is a lot of commentary about insurers' opposition to the second-tier default benefit, which largely focuses on private health insurers' concern about how this potentially affects their position of influence which is aimed at maximising PHI profit. There is no consumer focus.

The second-tier default benefit of 85% for hospital treatment was designed to protect small hospital operators. Private hospitals and medical groups have supported retention of the benefit to ensure the viability of non-contracted hospitals and maintain the capacity of patients to choose where and how they are treated.

9. What is the impact of preferred provider networks?

The term 'preferred provider' is a misnomer. It creates an aura of quality around the provider when in reality it is purely based on a contractual agreement between the provider and insurer, where the insurer fixes the cost. The cost is set to maximise PHI profitability.

Preferred provider arrangements have created a market distortion between dental providers that may disadvantage dentists both within and outside the preferred provider scheme. Preferred provider arrangements are usually at fixed fees set by the PHI and by definition, they are anticompetitive as the normal market forces of supply and demand are being manipulated by the PHI. PHI advertising directs consumers to preferred providers or to PHI clinics with emphasis on out of pocket expenses. In some cases, non-preferred providers have a lower fee for service. It is not good value for policy holders, as choice of provider is eroded and in many cases the PHI restricts both what and how many services the preferred provider can perform. This means that access to services and rebates is not entirely based on health care needs but on insurer preferences.

Such schemes provide the insurers with opportunities to exercise an unacceptable level of control via dictation of fees and active attempts to steer fund members towards preferred provider practices. Despite some fund members preferring to access preferred providers and dentists choosing to provide dental services via these schemes, there is no evidence that they result in better patient outcomes. In fact, they have the potential to disrupt continuity of care, and discriminate against patients in rural and regional areas who cannot access preferred providers.

10. Should private health insurers be better able to assist their policyholders to make choices about their care? If so, how would clinical decision-making be protected?

A simple answer to this question is no. A private health insurer or health fund exists to fund health, not to decide on a patient's clinical care. Health insurers have already begun to influence clinical decisions by putting cost pressure on patients via differential rebates. To further add to the ability of PHIs to impact patient's clinical decisions would be to the detriment of all Australians. Some PHIs provide their own services. This is totally inappropriate and should be legislated against. This would be akin to Medicare providing the services as well as the rebate.

11. What measures can be taken to improve competition in the private health sector?

Increasing the comparability of insurance products to provide greater transparency and a level playing field would work towards improving competition but prohibiting the payment of differential rebates is the main measure that should be implemented. It should be legislated that patients receive the same rebate for the same service under the same policy.

***12. What has been the effect of the transfer of functions from PHIO to the Commonwealth Ombudsman and PHIAC to APRA? Have these transfers improved efficiency or reduced* costs?**

The ADA is not aware of any significant effects.

13. Has the sector benefited from prudential oversight by a regulator with a wider perspective?

No, as APRA do not consider consumer related issues.

14. How has the Commonwealth Ombudsman responded to an increasing number of inquiries and complaints?

The Ombudsman concentrates on individual complaints and does not respond to standardised complaint campaigns, so any complaints considered to be related to a campaign are not counted in the number of complaints received in any given reporting period.

15. Could the model for PHI premium increases be improved?

There are a number of issues that should be considered in the premium increase decision. The first is a requirement for the funds to 'show cause' to ensure accurate reporting of their financials. The second is the inclusion of a consultation process with consumers and other stakeholders. Finally, the ADA would request that serious consideration is given to how conditions might be placed on any increase to ensure a commensurate increase in rebates paid.

16. Is there a case for a "one-stop shop" to combine the various regulatory and oversight functions?

The ADA does not have a comment on this matter.

17. Should private health insurance have a greater role in paying for outpatient services such as radiotherapy? What impact would this have on overall costs? What impact might it have on uninsured patients?

There are currently many inequities in the system meaning that there is no simple solution but there could be some exploration of private health insurers paying a rebate on top of the Medicare rebate to reduce out of pocket expenses for patients.

18. Should private health insurance be allowed to play a bigger role in funding the management of chronic conditions at home, in community settings and out-of-hospital?

The ADA does not support a greater role for health insurers in service provision They are a health insurer not a health provider.

19. What would the impacts be on other parts of the health care system were this to be the the case, including costs to government of the provision of out-of-hospital Medicare services?

Evidence supports the cost efficiency of community and out-of-hospital care. While institutionalised care is expensive, change can only occur by a change in the ideology of Australians that enables such management systems.

20. How could the universality and sustainability of Medicare be protected?

The Child Dental Benefits Schedule is a good example of how a complementary scheme can be introduced mirroring the Medicare model but operating under a separate piece of legislation.

21. Is general treatment or extras cover the most efficient way to fill gaps in Medicare?

Definitely not under the current model. The ADA believes that we need to include targeted and means-tested

dental programs under Medicare as outlined in the Australian Dental Health Plan available at www.ada.org.au/ADHP

An alternate proposal is to allow consumers to save for their own health care under a scheme which attracts tax incentives equivalent to the private health insurance rebate. The ADA engaged the Centre for International Economics to develop up a model that could be introduced in Australia. A copy of their report is available at www.ada.org.au/HSA.

22. Is the information consumers need to make good choices about their interaction with the private health system (both at the point of entry and subsequently, including when they need care) adequate and easily available? What improvements could be made?

No. this information is usually hidden and often misleading. The details around exclusions, annual caps, differential rebates, qualifying periods, etc are often hidden in documents such as 'business rules' which are unpublished and can be hundreds of pages long. Many improvements are required to enable consumers to make good choices. To be able to judge the relative value of different health fund policies and make an informed choice of policy, consumers need to know what rebates are offered for different treatments in different circumstances. Health funds should be required to make this information available to all consumers by publishing it on the publicly accessible areas of their websites.

23. How can knowledge and use of the Private Health Insurance Ombudsman's comparison website be improved? How can consumers be made aware of the portability protections available to them?

Public awareness and education campaigns are required. At the moment, it is very difficult for a consumer to make a comparison between policies, because information that the Ombudsman can publish is insufficient to allow any assessment of the value for money offered by each policy.

24. What are the legislative and other barriers to improving transparency of out-of-pocket costs and how could these be addressed?

The current legislation is inadequate as it does not prohibit the payment of differential rebates and does not require that health insurers publish details of all the rebates they do and do not offer in particular circumstances.

Furthermore, under current legislation, insurers are allowed to "tick the box" to indicate that they "cover" certain categories of general treatment (e.g. "major dental") even if they only provide rebates for *one* of many potential services that a consumer may need within that treatment category. This is highly misleading, and not allowed in the case of hospital treatment policies.

Improved transparency will only occur with greater simplification and comparability requirements around private health insurance advertising.

Independent public awareness and education campaigns would help consumers to have a greater understanding of out-of-pocket costs and the comparability across different products.

25. Should informed financial consent arrangements be formalised? How could current arrangements be improved? Could bills for in-hospital treatment be simplified?

It would be difficult for formalised consent arrangements to meet the disparate needs of all sectors. Formalising financial consent would likely increase the cost of simple procedures in which implied consent is given by consumers (i.e. implied consent for a consultation by the consumer attending).

26. Is there a need for the government to set prostheses benefits, or could the supply of prostheses be dealt with in another way?

The ADA does not have a comment on this matter.

27. If the Prostheses List is to continue, what further consideration could be given to the transparency of pricing for listed medical devices and other items?

The ADA does not have a comment on this matter.

28. What changes, if any, should the Commonwealth consider in relation to private patients in public hospitals?

The ADA does not have a comment on this matter.

We believe the terms of reference of the inquiry as currently stated should provide the Productivity Commission with the scope to fully investigate the matters that need to be addressed.

The ADA is happy to expand on any or all the comments provided, and we look forward to engaging in the Inquiry once it commences formally. Should you have any questions, please do not hesitate to contact Ms Eithne Irving, General Manager, Policy on 02 8815 3332 or eithne.irving@ada.org.au

Yours sincerely,

Dr Carmelo Bonanno
President