Public Health Association of Australia submission on Private Health Insurance Consultations 2015-16

Contact for recipient:
Australian Competition & Consumer Commission
A: GPO Box 520, Melbourne VIC 3001
E: phireport@acc.c.gov.au T: (03) 9290 1800

Contact for PHAA:
Michael Moore – Chief Executive Officer
A: 20 Napier Close, Deakin ACT 2600
E: phaa@phaa.net.au T: (02) 6285 2373

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Introduction

The Public Health Association of Australia

The Public Health Association of Australia Incorporated (PHAA) is recognised as the principal non-government organisation for public health in Australia and works to promote the health and well-being of all Australians. The Association seeks better population health outcomes based on prevention, the social determinants of health and equity principles. PHAA is a national organisation comprising around 1900 individual members and representing over 40 professional groups.

The PHAA has Branches in every State and Territory and a wide range of Special Interest Groups. The Branches work with the National Office in providing policy advice, in organising seminars and public events and in mentoring public health professionals. This work is based on the agreed policies of the PHAA. Our Special Interest Groups provide specific expertise, peer review and professionalism in assisting the National Organisation to respond to issues and challenges as well as a close involvement in the development of policies. In addition to these groups the Australian and New Zealand Journal of Public Health (ANZJPH) draws on individuals from within PHAA who provide editorial advice, and review and edit the Journal.

In recent years PHAA has further developed its role in advocacy to achieve the best possible health outcomes for the community, both through working with all levels of Government and agencies, and promoting key policies and advocacy goals through the media, public events and other means.

Vision for a healthy population

The PHAA has a vision for a healthy region, a healthy nation, healthy people: living in an equitable society underpinned by a well-functioning ecosystem and healthy environment, improving and promoting health for all.

Mission for the Public Health Association of Australia

As the leading national peak body for public health representation and advocacy, to drive better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.

Priorities for 2016 and beyond

Key roles of the organisation include capacity building, advocacy and the development of policy. Core to our work is an evidence base drawn from a wide range of members working in public health practice, research, administration and related fields who volunteer their time to inform policy, support advocacy and assist in capacity building within the sector. The aims of the PHAA include a commitment to:

- Advancing a caring, generous and equitable Australian society with particular respect for Aboriginal and Torres Strait Islanders as the first peoples of the nation;
- Promote and strengthen public health research, knowledge, training and practice;
- Promote a healthy and ecologically sustaining human society across Australia, including tackling global warming, environmental change and a sustainable population;
- Promote universally accessible people centered and health promoting primary health care and hospital services that are complemented by health and community workforce training and development;
- Promote universal health literacy as part of comprehensive health care;
- Support health promoting settings, including the home, as the norm;
- Assist other countries in our region to protect the health of their populations, and to advocate for trade policies that enable them to do so;
- Promote the PHAA as a vibrant living model of its vision and aims.
**Preamble**

PHAA welcomes the opportunity to provide input to the Australian Competition and Consumer Commission (ACCC) Report to the Senate on Private Health Insurance. The PHAA strongly advocates for a reduction of social and health inequities as an over-arching goal of national policy and recognised as a key measure of our progress as a society. The increased use of private health insurance (PHI) is associated with higher health care costs and greater inequity of access. The Australian Government, in collaboration with the States/Territories, should outline a comprehensive national cross-government framework on reducing health inequities. All public health activities and related government policy should be directed towards reducing social and health inequity nationally and, where possible, internationally.

**Health Equity**

As outlined in the Public Health Association of Australia’s objectives:

> Health is a human right, a vital resource for everyday life, and a key factor in sustainability. Health equity and inequity do not exist in isolation from the conditions of society that underpin people’s health. The health status of all people is impacted by the social, political, and environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the unfair and unjust effects of conditions of living that cause poor health and disease.

The PHAA notes that:

- Health inequity differs from health inequality. A health inequality arises when two or more groups are compared on some aspect of health and found to differ. Whether this inequality (disparity) is inequitable, however, requires a judgement (based on a concept of social justice) that the inequality is unfair and/or unjust and/or avoidable. Inequity is a political concept while inequality refers to measurable differences between (or among, or within) groups.\(^1\)

- Health inequity occurs as a result of unfair, unjust social treatment – by governments, organisations and people,\(^2\) resulting in macro politico-economic structures and policies that create living and working conditions that are harmful to health, distribute essential health and other public services unequally and unfairly, preventing some communities and people from participating fully in the cultural, social or community life of society.

**Social Determinants of Health**

The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries. This is particularly pertinent when considering issues such as policy related to public funding of PHI.

The determinants of health inequities are largely outside the health system and relate to the inequitable distribution of social, economic and cultural resources and opportunities. Health inequities are the result of the interaction of a range of factors including: macro politico-economic structures and policy; living and working conditions; cultural, social and community influences; and individual lifestyle factors.
PHAA Response to ACCC PHI Consultations 2015-16

As stated in our December 2015 submission to the Commonwealth Department of Health on Private Health Insurance Consultations 2015-16, the PHAA believes that the present arrangements for private health insurance in Australia provide ample scope for reform to deliver more equitable and efficient health care. Our key concerns are that these arrangements and some of the possible changes foreshadowed in the current consultations may adversely affect access to care on the basis of need, while doing little to address adequate funding of public hospitals and a chronic weakness in the primary care sector.

The PHAA has a policy on Private Health Insurance which can be found here: www.phaa.net.au/documents/item/881

The policy states that:

- PHI is an inefficient mechanism for funding health care services compared to universal public health insurance.
- PHI is an inequitable mechanism for the distribution of scarce health resources and it contributes to health inequity.
- Government funding for PHI via the premium rebate is a poor use of substantial public monies which could produce better and more equitable health outcomes by directly funding health care and implementing healthy public policy.
- In addition, the tendency for PHI funded private providers to be promoted as the health care pathway of choice for those who can afford it implicitly casts the universal public services as second class, eroding social justice and equity and contributing adversely to the social determinants of health.

In this submission, PHAA will specifically address issues regarding ‘limiting consumer access to, or choices of health care’ and ‘other potential consumer harm or detriment’.

Limiting of choice and access to health care

PHI has exacerbated the fragmentation of health care. Public hospitals (especially larger ones) provide a broad range of (variably) integrated services including emergency, medical, surgical, rehabilitation and other services including vital professional education. While they may offer a range of health care services, the core role of private hospitals is to provide a nursing and accommodation infrastructure for procedural medical specialists. PHI policy holders make up the vast majority of private hospital patients. Private hospitals tend to deal with (profitable) acute procedural matters rather than costly chronic conditions which largely remain within the public sector. Commercial considerations play an important part in driving this pattern.

Given the focus in private hospitals on elective surgery and the limited number of medical specialists, PHI provides a queue jumping facility for those who can afford it. Instead of a lengthy wait for an operation in a public hospital, one can be seen in weeks with PHI. Access is enabled via having PHI (which is strongly correlated with wealth) rather than according to patient need. Equity of access is thus compromised.

Equity is further eroded by the PHI rebate. PHI is held disproportionately more by wealthy Australians. Indeed, the Medicare Levy Surcharge makes it more expensive for high income earners not to have PHI than to have it. There is evidence that, compared to the rest of the population, those with PHI are richer, better educated, more health conscious, in better health and more likely to use certain discretionary health services. Hence, PHI use is generally highest among those with the least need for health care.³

Dental treatment is excluded from Medicare, so those without ancillary PHI dental cover (which is subsidised by the rebate) generally pay the entire cost themselves. There are heavily subsidised dental
services offered by state health authorities and a Child Dental Benefits scheme for some low income groups. However disadvantaged people have serious access problems and there are extensive waiting times for most of these services. Wealthier Australians with PHI are subsidised via the rebate and receive good access with little waiting. It is difficult to justify this arrangement on equity grounds.

Since 2007 a variety of chronic disease management plans are now covered by PHI, and benefits paid are rising exponentially. These interventions, publicly subsidised by the PHI rebate are only available to the privately insured. In addition, there has been Federal Government support for trials which provide faster access without co-payments for the privately insured to see their GP, a very obviously inequitable situation.

It might be possible to justify treating private health insurance like car insurance if all it did was to provide choice - of doctor, hospital, and timing of treatment as was largely the case 20 years ago and if it was genuinely private and was used to deliver private care. However it isn’t private and the hospital care, although provided in privately owned and run hospitals, is not private. All care provided by doctors is heavily reimbursed through Medicare rebates, drugs and devices are heavily subsidised by taxes, and 30% of PHI benefits are taxes. As 80% of admissions are no gap admissions, one should really view private hospitals as public hospitals accessible only by those with a capacity to pay co-payments in the form of PHI premiums.

**Potential harm or detriment to consumers**

The public survey being conducted as part of this Consultation includes floating the provision of PHI cover for GP and primary health care services. Allowing private health insurers to cover the gap between the Medicare rebate and general practice fees is likely to lead to higher costs and reduced access to care for the uninsured. With patients facing no out-of-pocket costs, GPs have no market incentive to contain fees. These could be expected to increase, initially for insured patients, with a likely flow-on to others. The net effects are to increase overall system costs, increase red tape for GP practices and reduce access for the uninsured.

Adding to this concern is the potential removal of the community rating meaning that higher premiums could be charged for those at greater risk, due to factors over which they may have some influence such as smoking, or those over which they have no influence, like age.

There are at least two major concerns with this. The first is that the resultant higher premiums for higher risk patients would inevitably lead to some of them giving up PHI and further burdening the inadequately resourced public sector. This would be fine if there was a parallel increase in funding of the public sector but the approach to date has been the opposite. The second relates to the inherent unfairness of such an approach to health insurance, whether private or public. As indicated above, private hospital care disproportionately deals with procedural admissions which have high turnover and are more profitable, essentially discriminating against those with chronic disease. Removal of community rating would exacerbate this discrimination.
Conclusion

The PHAA appreciates the opportunity to make this submission to the ACCC Private Health Insurance Consultations 2015-16.

We are keen to highlight that health care services should be organised so as to contribute to building social capital and cohesion rather than to eroding them. Good quality health care should be available to all, promptly provided on the basis of need, regardless of ability to pay, free at the point of delivery, and funded by progressive general taxation.

Truly private health insurance without public subsidy may have a role in the Australian health care system. This is evident in the UK setting where private insurers provide top-up services to those available through the National Health Service. This is an option available to those who can afford it and prefer it. It does not divert public resources away from population health.

Please do not hesitate to contact me should you require additional information or have any queries in relation to this submission.

Michael Moore BA, Dip Ed, MPH
Chief Executive Officer
Public Health Association of Australia

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References


