NATIONAL RURAL HEALTH ALLIANCE INC.

Committee Secretary
Senate Standing Committee on Community Affairs
PO Box 6100
Parliament House
CANBERRA ACT 2600

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

I am writing further to your call for submissions to inform the inquiry into the "*Value and affordability of private health insurance and out-of-pocket medical costs".*

The National Rural Health Alliance (the "Alliance") is extremely concerned about the value and affordability of private health insurance (PHI) in rural and remote Australia.

The Alliance considers that private health insurance products need to enable better access to services and supports designed specifically to enhance access for rural and remote Australia and which go beyond existing PHI inclusions if value-for-money is to be achieved.

The Alliance considers that the inequity faced by people with PHI in rural and remote Australia needs to be addressed by measures such as the following:

1. An increased range of benefits for non-hospital based services in rural and remote Australia
2. Increased access to higher rebates to cover transport and accommodation when forced to travel to access the required health services
3. Viability supplements for private rural and remote services funded from the risk equalisation pool
4. Continued access to treatment as a private patient in a public hospitals.
5. Progressive reductions, based on geographic remoteness, in financial incentives and penalties which aim to encourage people to take out PHI.

Private health insurance is an example of resources being disproportionately spent in metropolitan areas as compared to rural and remote Australia. Rural residents pay the same premiums, and face the same financial penalties (eg. Medicare Levy Surcharge and Lifetime Health Cover loading) as metropolitan residents, but get poorer access to services and fewer opportunities to use their PHI.

This means rural consumers currently subsidise urban consumers through both their insurance premiums and their share of taxpayer revenue used to fund Private Health Insurance Rebates.

A 2012 study in Health & Place notes *'government subsidies of private health insurance further disadvantage rural populations where private healthcare is generally not available'*.(Bourke L, Humphreys JS, Wakerman J & Taylor J 2012. *'Understanding rural and remote health: a framework for analysis in Australia*', Health & Place 18(3), p 500.)

This inequity should not be allowed to continue. If the value of PHI for people in rural and remote Australia cannot be improved by measures such as those outlined in this submission, the Alliance contends that financial penalties such as the Medicare Levy Surcharge and Lifetime Health Cover loading should be progressively reduced based on geographic remoteness.

About the Alliance

The Alliance is comprised of 38 national member organisations covering more than 250 000 individual members and a further 450 member organisational members. We are committed to improving the health and well-being of all people living in rural and remote Australia. Our members include consumer groups, representation from the Aboriginal and Torres Strait Islander health sector, health professional organisations (representing doctors, nurses, midwives, allied health professionals, dentists, optometrists, paramedics and health service managers) and health providers. A full membership list is at **Attachment A.**

Rural and Remote Australia

Approximately seven million people live outside major cities in Australia. These people are, on average, generally poorer, sicker and older than their city counterparts. Sixty-five percent[1] (440,000) of Australia's Aboriginal and Torres Strait Islander peoples live in rural, regional and remote Australia.

Compared with major cities, social determinants of health tend to be worse for people living in these areas – specifically they have lower incomes, poorer access to and lower levels of education, with the local economy frequently linked to external factors such as climate variability and commodity prices, and cost of living (excluding housing) tends to be higher.

Prevalence of chronic disease tends to be higher in rural and especially in remote areas, partially reflecting social determinants and risk factors.[2] Health outcomes tend to be worse again, with people presenting later for clinical care when their illness, injury or disease is further progressed. Rates of hospitalisation and death rates increase with remoteness.[3] Access to almost all health care services can be logistically more difficult for people living in rural and remote areas - greater distances, lack of public transport, and more dispersed services.

[1] http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4364.0.55.0012014-15?OpenDocument
[2] http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129555476
[3] http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129555476

Accessing health services in rural and remote Australia can be very difficult, if not impossible. Currently, many people living in rural and remote Australia travel vast distances to access specialised services that are not available within their community. Further, they often chose to delay seeking specialised services until they are acutely unwell due to the inconvenience associated with leaving their home, community and livelihood. As noted above, this results in people presenting with illness and injury that has not been well managed, is further advanced and the patient is significantly sicker with fewer treatment and/or management options.

Private Health Insurance

Of those people who live in Inner regional communities, 49.9% do not have private health insurance, increasing to 52.3% in outer regional and remote communities (as compared to 39% in major cities).

The most recent data for 2012-2013 from the Australian Institute of Health and Welfare shows that access to private hospitals outside major cities is extremely limited, and approaching zero access once you reach outer regional communities[4]. Additionally, we know that access to allied health providers – whose services may be included under 'extras cover' – is also very poor in rural and remote Australia.

In their 2005 "For debate" article in the Medical Journal of Australia, Lokuge, Denniss and Faunce presented evidence that led them to conclude that:

- The key barriers to take up of PHI in regional Australia (by which they mean Inner and Outer regional and Remote and Very remote locations) were affordability and choice;
- Regional Australia has lower levels of private health membership due to the limited availability of private inpatient facilities; and
- There are structural failures in PHI as a vehicle for federal health financing that disadvantage regional Australians[5].

Certainly between 2005 and 2012-13 there has been little change in the access of people from rural and remote Australia to private hospital care. The Australian Institute of Health and Welfare published 2012-13 data on the number of private hospitals by location and hospital type and overwhelmingly, private hospitals are located in the major cities. That report found:

> "Use of private hospitals in 2012–13 was highest for those residing in *Major cities* (175 separations per 1,000 persons) and lowest for those residing in *Very remote* areas (67 separations per 1,000 persons)."

[4] http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129548953 – Table 2.2

[5] https://openresearch-repository.anu.edu.au/bitstream/1885/81400/2/01%20Lokuge%20B%20et%20al%20Private%20health%20insurance%202005.pdf

Thus value and affordability are the two key issues which people in rural and remote Australia consider when determining whether to purchase PHI.

With regard to cost, people living in rural and remote Australia are often less well off than those in major cities and also face higher costs of living for many goods and services. This makes additional discretionary purchases much more difficult, and makes decisions on how to direct any additional disposable income more complex: should it be spent on PHI or on other household and family needs?

In terms of value, many people in rural and remote Australia do not see the value in PHI The reputed value of PHI comes from being able to access a 'private service' with 'choice of doctor'. In rural and remote areas, the absence of local private hospitals means that people need to be prepared – and able – to travel often significant distances to access these services, which can be highly disruptive both socially and economically.

The nature of health services in rural and remote areas also means that there is often little choice of doctor – there may be only one or a small number of doctors and as such, the idea of choice is limited. Further, there is dubious value in extras cover – there may be few if any providers in the local area thus making the product not usable in many rural and remote communities.

Where people living in rural and remote Australia have the means to travel to large regional centres or major cities to access large private hospital facilities or to be treated as a private patient in a public hospital, the value of private health insurance is much the same as for people living in major cities. These patients can and do access private hospitals, have choice of provider and access to private rooms in addition to utilising their 'extras cover'. However it is important to note that the travel and accommodation (as well as any lost income) are expenses that would be met by the individual rather than the private health insurer. Many people living in rural and remote Australia do not have the means to do this.

People living in rural and remote Australia are often frustrated by their inability to access 'preferred providers' and therefore lower out-of-pocket expense. 'Preferred providers' have a relationship with private health insurers and agree to a set fee for their service (ie with lower out-of-pocket costs). This means that consumers are forewarned of the cost of the service and can elect to be treated by a 'preferred provider' which is often a cheaper option for them. However in many rural and remote communities where there is already limited choice, there may be no 'preferred provider' and therefore the consumer may face higher out of pocket costs for the service.

Lower access to private services in rural and remote Australia means that people who live in those areas, and who have PHI, are not utilising their PHI and are therefore cross-subsidising the cost of PHI for people in metropolitan and inner regional Australia.

These people pay for PHI but get very little back for what they pay. However, by adding to the PHI pool, and not utilising their proportionate share of those funds, they help keep down the cost of insurance for metropolitan Australia.

This is highly inequitable and represents a further area of disadvantage for people living in rural and remote Australia.

Improving value and affordability

It is important to note that feedback from rural and remote consumers, communities and the provider workforce focuses on improving the value of the product rather than reducing the cost. This offers an opportunity to consider how to make PHI products more attractive to people living in rural and remote Australia.

To become a product that is attractive to a greater number of people living in regional and remote Australia, PHI needs to deliver improved access outside the major cities and inner regional locations to a greater range of services. The Alliance therefore proposes that specific new products be included in PHI, with access to those products being based on measures of geographic remoteness (eg. the Modified Monash Model).

1. ***An increased range of benefits for non-hospital based services in rural and remote Australia***

It also could include access to a broader range of services taking into consideration the services available in rural and remote communities (supported through a viability payment as identified above) in areas such as:

- community based rehabilitation services;
- mental health community based beds and support services;
- oral health;
- mixed sub-acute and non-acute services;
- private prevention, primary health care and early intervention services; and
- telehealth and other digital services.

2. ***Increased access to higher rebates to cover transport and accommodation when forced to travel to access the required health services***

A further area where value could be enhanced is through increased access to travel and accommodation support:

- This could involve an expansion of benefits for when a patient needs to relocate for treatment (including potentially for a spouse or parent, carer, or other support person).
- It should not need to be purchased as an additional or ancillary benefit but rather should be included as a standard entitlement in health insurance products, with restrictions based on eligibility criteria similar to current state-based patient travel assistance schemes.

3. *Viability supplements for private rural and remote services funded from the risk equalisation pool*

Improving value also requires examination of innovative models which encourage private investment in rural and remote areas. This may mean looking at models which support the economic viability of access to a mix of services which may not have the economies of scale of services in metropolitan areas, for example:

- through higher rebates or supplements similar to the application of the Aged Care and Home Care Viability Supplements used to support small rural aged care services which would otherwise not be viable (from 1 January 2017 this has been based on the Modified Monash Model, with higher supplements depending on remoteness – see https://agedcare.health.gov.au/funding/aged-care-fees-and-charges/viability-supplement-in-residential-care
- funded through the Risk Equalisation Trust Fund as a further strengthening of the community rating principle to prevent discrimination against people who live in rural and remote Australia

4. *Continued access to treatment as a private patient in a public hospitals.*

One important current area of potential value in PHI for many rural and regional residents is in being able to be treated as a private patient in a public hospital (albeit the more rural and remote services become, the more choice of doctor becomes less likely and less relevant). In this context, recent suggestions to remove the entitlement to be treated as a private patient in a public hospital would result in even further disadvantage for people who are already disadvantaged in the PHI arena.

5. *Progressive reductions, based on geographic remoteness, in financial incentives and penalties which aim to encourage people to take out PHI.*

The Alliance supports the need for innovative private health insurance products to be developed for rural and remote Australia, to achieve greater equity of access to privately funded services. However without equitable access to a range of products and services, country people continue to cross-subsidise city people who have far better access to (and make greater use of) private hospital beds.

Unless new products can be introduced which help bridge the divide in equity of access to services (and benefits paid), people in rural and remote Australia should not have to pay the same premiums and face the same incentives or penalties to take out PHI.

Should PHI products continue to offer little or no value to people living in rural and remote Australia, the Alliance would encourage the removal of the incentives for taking out private health insurance in rural and remote Australia. This could be done on a progressive sliding scale based on geographic remoteness eg. using the seven-scale Modified Monash Model classification system, with the Medicare Levy Surcharge and Lifetime Health Cover loading reducing from MMM4, to zero at MMM7.

A further option would be to examine whether PHI premiums could be based on accessibility of private health services and products, again based on a sliding geographic scale across regional, rural and remote areas.

The National Rural Health Alliance would welcome the opportunity to discuss further the issues affecting health service delivery and the resultant health outcomes in rural and remote Australia.

I am available should you wish to discuss private health insurance in rural and remote Australia in more detail and can be contacted on david@ruralhealth.org.au or 0411 474 912.

Yours sincerely

David Butt
Chief Executive Officer
National Rural Health Alliance
28 July 2017

Attachment A

National Rural Health Alliance - Member Body Organisations
Australasian College for Emergency Medicine (Rural, Regional and Remote Committee)
Australasian College of Health Service Management (rural members)
Australian College of Midwives (Rural and Remote Advisory Committee)
Australian College of Nursing - Rural Nursing and Midwifery Community of Interest
Australian College of Rural and Remote Medicine
Australian General Practice Network
Australian Healthcare and Hospitals Association
Allied Health Professions Australia Rural and Remote
Australian Indigenous Doctors' Association
Australian Nursing and Midwifery Federation (rural nursing and midwifery members)
Australian Physiotherapy Association (Rural Members Network)
Australian Paediatric Society
Australian Psychological Society (Rural and Remote Psychology Interest Group)
Australian Rural Health Education Network
Council of Ambulance Authorities (Rural and Remote Group)
Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
CRANAplus
Country Women's Association of Australia
Exercise and Sports Science Australia (Rural and Remote Interest Group)
Federation of Rural Australian Medical Educators
Indigenous Allied Health Australia
Isolated Children's Parents' Association
National Aboriginal Community Controlled Health Organisation
National Aboriginal and Torres Strait Islander Health Worker Association
National Rural Health Student Network
Paramedics Australasia (Rural and Remote Special Interest Group)
Rural Special Interest Group of Pharmaceutical Society of Australia
RACGP Rural: The Royal Australian College of General Practitioners
Rural Doctors Association of Australia
Rural Dentists' Network of the Australian Dental Association
Royal Far West
Royal Flying Doctor Service
Rural Health Workforce Australia
Rural and Indigenous Health-interest Group of the Chiropractors' Association of Australia
Rural Optometry Group of Optometry Australia
Rural Pharmacists Australia
Services for Australian Rural and Remote Allied Health
Speech Pathology Australia (Rural and Remote Member Community)