



Australian  
Nursing &  
Midwifery  
Federation

# ANMF Submission to the Senate Inquiry into the Value and Affordability of Private Health Insurance

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Lee Thomas  
Federal Secretary

Annie Butler  
Assistant Federal Secretary

Australian Nursing & Midwifery Federation  
PO Box 4239 Kingston ACT 2604  
T: 02 6232 6533  
F: 02 6232 6610  
E: [anmfcanberra@anmf.org.au](mailto:anmfcanberra@anmf.org.au)  
W: [www.anmf.org.au](http://www.anmf.org.au)



## About the ANMF

Established in 1924, the Australian Nursing and Midwifery Federation (ANMF) is the largest professional and industrial organisation in Australia for nurses, midwives and assistants in nursing, with branches in each state and territory of Australia. The core business of the ANMF is the professional, political and industrial representation of our members and the professions of nursing and midwifery.

As members of the union, the ANMF now represents over 259,000 nurses, midwives and assistants in nursing nationally. They are employed in a wide range of enterprises in urban, rural and remote locations, in the public, private and aged care sectors including nursing homes, hospitals, health services, schools, universities, the armed forces, statutory authorities, local government, and off-shore territories and industries.

## Introduction

The Australian Nursing and Midwifery Federation (ANMF) congratulates the Senate Community Affairs Reference Committee for establishing the Inquiry into the Value and Affordability of Private Health Insurance and thanks the Committee for the opportunity to provide input into the Inquiry into the Value and Affordability of Private Health Insurance.

This Inquiry has particular relevance to our membership as the Australian Nursing and Midwifery Federation is committed to the provision of health as a public good with shared benefits and shared responsibilities. We consider that access to adequate healthcare is the right of every Australian and a crucial element of the Australian social compact. While acknowledging and respecting the need for an effective private health system, and the contribution private health makes to the health of Australia, the ANMF does not support public subsidy of the private health system.

Currently, private health insurance funds two in every five hospital admissions in Australia. This represents 33% of all days of hospitalisations. Around 90% of day admissions for mental healthcare, 50% of all mental health admissions, 70% of joint replacements and 60% of chemotherapy, are funded by private health insurance.<sup>1</sup>

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<sup>1</sup> Private Healthcare Australia (2017) *Pre-Budget Submission*, <http://www.privatehealthcareaustralia.org.au/wp-content/uploads/Private-Healthcare-Australia-Budget-Submission-2017-18.pdf> Accessed 11.7.17



The sustainability of the entire health system, not just private health insurance require policy reforms that address the inefficiencies, market failures, and unwarranted service variations that add unnecessary cost and result in poorer health outcomes for Australians.

The ANMF is dedicated to improving standards of patient care and the quality of health and aged care services. As such, we are committed to publicly funded universal health insurance as the most efficient and effective mechanism to distribute resources in a manner that generally ensures timely and equitable access to affordable healthcare on the basis of clinical need rather than capacity to pay.

Of particular concern to ANMF members, and relevant to the Inquiry are the following six issues:

1. The public subsidising of private insurers to the detriment of public health;
2. The significant out of pocket expenses born by private health insurance policy holders;
3. The lack of transparency of private health insurance products including data collection, sharing and reporting;
4. A lack of focus on health outcomes and funding of low value procedures;
5. Regulatory barriers – misaligned funding streams acting as a barrier to contemporary models of care; and
6. Value of PHI for people living in regional, rural and remote areas.

These issues are addressed in the sections below.

## **1. Public subsidisation of Private Health Insurance**

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*Private insurance is a high-cost and inequitable mechanism to achieve what the tax system and a single insurer can do far better. Its administrative overheads are high, and it lacks the incentives or capacity to control moral hazard and to contain health care costs.<sup>2</sup>*

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The ANMF is committed to Medicare, Australia's publicly funded universal health insurance, as the most efficient and effective mechanism to distribute resources in a manner that generally ensures timely and equitable access to affordable healthcare on the basis of clinical need rather than capacity to pay.

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<sup>2</sup> Ian McAuley, July 2016 Private health insurance and public policy, Centre for Policy Development, <https://cpd.org.au/2016/07/ian-mcauley-private-health-insurance-and-public-policy/>, Accessed 10.7.17



We believe the Australian Government must take responsibility for ensuring that overall spending on healthcare remains affordable and that policy settings work to contain inflation. The scale and unpredictability of health costs means that insurance, be it public or private, is inevitably a major feature of the sector.

Whilst acknowledging and respecting the need for an effective private health system, the ANMF does not support the current public subsidy of the private health system. The public contribution is too great and does not provide reasonable return for all taxpayers and the wider community, in either health or economic terms.

Data from the Australian Institute of Health and Welfare show that the premium rebates that the Australian Government paid for private health insurance (PHI) rose by 1.0% from \$5.6 billion in 2013–14 to \$5.7 billion in 2014–15.<sup>3</sup> Additionally, health insurance adds significant costs to the health system through Medicare subsidies of private patients in private hospitals, utilising Medicare funded diagnostic and pathology services and allied health services.

The majority of Australians – 13.5 million people, representing 55% of all Australians – hold a private insurance policy covering them for hospital and/or general treatment.<sup>4</sup> The administrative cost of private health insurance, in part funded through government subsidy is significant. Only around 85 cents in the dollar passed through PHI makes its way to fund health care, compared with around 95 cents when health care is funded through taxation and Medicare.<sup>5</sup> In the year to 31 March 2017, the before tax profits of the PHI industry were reported as \$1.7 billion, a 5% increase on the preceding 12 months.<sup>6</sup>

Supporters of PHI subsidies defend the industry on the basis that through supporting private hospitals, the demand on public hospitals is reduced. It is argued that consumers with PHI benefit from greater choice and control, such as the ability to choose to be treated by their own doctor, shorter waiting times for elective surgery and access to services not covered by Medicare (such as

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<sup>3</sup> AIHW- Health Expenditure in Australia 2014–15. <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129557188>, Accessed 10.7.17

<sup>4</sup> Australian Prudential Regulatory Authority (2017) *Private Health Insurance Quarterly Statistics*, March, p.3. <http://www.apra.gov.au/PHI/Publications/Documents/1705-QPHIS-20170331.pdf>, Accessed 10.7.17

<sup>5</sup> Private Health Insurance and Public Policy, Paper to accompany presentation to the 2016 Health Insurance Summit, Sydney, 28 July 2016. <http://cpd.org.au/wp-content/uploads/2016/07/PHI-conference-July-2016.pdf>, Accessed 10.7.17

<sup>6</sup> Australian Prudential Regulatory Authority (2017) *Private Health Insurance Quarterly Statistics*, March, p.3. <http://www.apra.gov.au/PHI/Publications/Documents/1705-QPHIS-20170331.pdf>, Accessed 10.7.17



dental, optical and physiotherapy). The Commonwealth Department of Health Annual Report (2015/16), outlines a key community benefit of private health insurance is to reduce pressure on the public hospital system, stating

*“The Government has reduced the pressure on the public hospital system by supporting individuals to purchase private health insurance. Rebates make private health insurance more affordable and provide greater choice.”<sup>7</sup>*

However, in the paper accompanying the 2016 presentation to the Health Insurance Summit, Ian McAuley states this argument is

*“... at best fanciful and at worst deceptive, because it considered only the demand side, while neglecting the supply side of health services. So long as medical specialists, nurses, operating theatres and other resources are in limited supply, resources will go to where the money is. This point is supported by the peak body for public hospitals, the Australian Healthcare and Hospitals Association, which opposes continued subsidies to PHI on the basis that they do not benefit the public health system.”<sup>8</sup>*

A recent report prepared by Catholic Health Australia, ‘Upsetting the Balance – how the growth of private patients in public hospitals is impacting Australia’s health system’, describes some of the negative impacts that the growth of privately insured patients being treated in public hospitals has on public patients.<sup>9</sup> The report notes that the number of privately insured patients treated in public hospitals has increased by an average of 10 per cent per annum since 2008–09. The authors describe a number of factors driving the growth in numbers of private patients in public hospitals including, some hospitals’ practice of encouraging patients to declare and use their private health insurance, the offering of inducements to use private health insurance, the patients’ desire to avoid out-of-pocket costs that may otherwise be encountered in a private hospital setting and the proliferation of private health insurance policies with exclusions and restrictions. The authors refer to current evidence showing that public patients have longer waiting times than private patients in public hospitals. The report notes

*“It is a fundamental principle of Australia’s healthcare system that access to care is based on clinical need, and ability to pay should not be a factor in waiting times for treatment. Private patients being*

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<sup>7</sup> Department of Health (2016) *Annual Report 2015-16*, p.125.

<http://www.health.gov.au/internet/main/publishing.nsf/Content/annual-report2015-16>, Accessed 10.7.17

<sup>8</sup> *ibid*

<sup>9</sup> Catholic Health Australia. *Upsetting the Balance – how the growth of private patients in public hospitals is impacting Australia’s health system* [http://cha.org.au/images/CAT2006\\_Report\\_v4\\_FA\\_Low\\_Res\\_Digital.pdf](http://cha.org.au/images/CAT2006_Report_v4_FA_Low_Res_Digital.pdf) Accessed 26.7.17



*treated more quickly violates this principle and the terms of the National Health Reform Agreement.”*

Private health insurance has failed to deliver on one of its fundamental stated goals, namely, taking pressure off the public system to preserve the fundamentals of universal access. Instead, the Government now spends \$6 billion per year to, in effect, subsidise a private industry at the expense of those funds being made available in some form to shore up the public health system. Major improvements in clinical care are generated in the public sector. The most complex, difficult and urgent cases are dealt with in the public sector. The sickest Australians are cared for in the public sector. The most sophisticated surgery and post-surgical care occurs in the public sector. Breakthroughs in healthcare are developed, trialled and implemented in the public sector. The public sector is modern and responsive. Innovation, change and research into health and into disease are all led by the public sector. Teaching, research and innovation are all less developed in the private system. Staffing levels, skill-mix and access to a full range of health professionals are all superior in the public system. The ANMF believes that the \$6 billion in subsidisation of private health insurance would be better directed to support the Australian public health system.

The proportion of Australians with some form of private health insurance is now around 55%,<sup>10</sup> consequently removing the flawed subsidy would provide a political challenge, however with very little evidence that PHI does relieve pressure on public hospitals, governments should consider the value of their investment in this measure and consider policy refinement which reduces the level of subsidies over time. In the short-term, a clear opportunity exists to discontinue the public subsidisation of ancillary benefits (extras cover) through rebates, which includes the funding of some disciplines with very little evidence of health benefits, such as natural therapies.

## **2. Out of Pocket expenses**

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*“I think sometimes it’s unfair. Because we pay a Medicare levy, we pay private health insurance, and we pay a gap, so we pay three times.”<sup>11</sup>*

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Many people accessing PHI are exposed to high out of pocket expenses. Within a complex and confusing health insurance market, only 17% of those Australians with PHI hold policies with no-gap, no co-payment and no deductibles cover. The remaining 83% must navigate an almost

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<sup>10</sup> The Commonwealth of Australia (2016) *Budget 2016-17, Budget Paper 1*, 5-22.

<sup>11</sup> <http://theconversation.com/explainer-why-do-australians-have-private-health-insurance-38788>, Accessed 10.7.17



incomprehensible sea of exclusions, deductibles and product limits to even use their policies, let alone reap value from them.

The average out-of-pocket (gap) payment for a hospital episode was \$318 in the March 2017 quarter. The out-of-pocket payments for hospital episodes increased by 4.3% compared to the same quarter for the previous year.<sup>12</sup> The impost of private health insurance related out-of-pocket costs expose a considerable burden to many Australians, with more than half of people with private health insurance having disposable incomes under \$50,000 per year.<sup>13</sup>

Gap payments may include costs for the hospital stay, doctor's fees, procedures, equipment and prostheses. There is very little information for consumers about the gap they will be expected to pay. The responsibility is borne by the patient to, before they go to hospital, ask their surgeon to estimate what their charges will be, and to ask their health fund how much is covered with their policy.

Out-of-pocket costs vary greatly depending on which hospital the procedure will take place at, the specialist administering the procedure, and the individual's policy and excess, as insurers have different arrangements with different hospitals. There is a further lack of clarity and consistency to doctors' fees, as they are free to set their own fees and may decide on a case-by-case basis whether to use an insurer's gap cover arrangement.

Policy makers argue that patients should exercise the right to 'shop around' to access not only the best care, but also the best price for any medical interventions. However, this neglects the significant challenges and costs associated with accessing specialist consultations borne both by the patient, though the payment of any out-of-pocket costs of a consultation, and public purse through applicable MBS payments to doctors.

Price transparency can play a significant role in stimulating provider choice among consumers and ensuring they are extracting value for their PHI products, and limiting their exposure to out-of-pocket costs. In the US, insurers have invested in developing price transparency tools to support consumers to make informed choices about their health care. One such example is Castlight Insurance who have developed a toolbox whereby policy holders may compare prices and quality across healthcare services and providers. The data shown in the toolbox is sourced from insurance claims and a range of national organizations providing information on care quality. Policy holders

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<sup>12</sup> APRA <http://www.apra.gov.au/PHI/Publications/Documents/1705-QPHIS-20170331.pdf>, Accessed 10.7.17  
<sup>13</sup> [Private Healthcare Australia \(2017\) Budget Addresses Affordability of Health Care, p.1.](#)



are able to add their own satisfaction scores.<sup>14</sup> Research has shown that price transparency tools appear to have had some success in reducing costs for some healthcare services. A recent study showed that its use was associated with lower total claims payments for laboratory test and imaging.<sup>15</sup>

### 3. Lack of Transparency of Private Health Insurance Products

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*“...industry and related regulatory incentives are currently driving consumers to lower-priced policies than they would prefer, with an emphasis on tax rather than health outcomes.  
- ACCC Annual Report 2014-15*

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Currently in Australia, there are more than 30 private health insurers offering hundreds of different policies with widely varying coverage and conditions. The Consumer Health Forum estimates that there are 58,000 different health insurance policies in the Australian market<sup>16</sup>. It is virtually impossible for consumers to directly compare policies and costs. Consequently, the majority of consumers do not understand how their policies work or what coverage they provide and frequently find themselves unexpectedly out of pocket.

The Australian Competition and Consumer Commission’s (ACCC) recent annual report on PHI highlighted consumers’ frustration with this situation and criticised the industry for its unnecessary complexity and lack of transparency and even misleading claims. Most critically, the ACCC concluded that the industry and related regulatory incentives are currently *“driving consumers to lower-priced policies than they would prefer, with an emphasis on tax rather than health outcomes”*.<sup>6</sup>

Recent examples of poorly communicated changes to policies have left policy holders exposed to large, unexpected out-of-pocket costs. The Australian Competition and Consumer Commission (ACCC) in the 2014 -15 Report to the Senate on Private Health Insurance<sup>17</sup> states

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<sup>14</sup> [Through the looking glass - A practical path to improving healthcare through transparency. KPMG](https://assets.kpmg.com/content/dam/kpmg/be/pdf/Markets/through-the-looking-glass.pdf)

<https://assets.kpmg.com/content/dam/kpmg/be/pdf/Markets/through-the-looking-glass.pdf> Accessed 26.7.17

<sup>15</sup> Gibbons C. Turning the Page on Paper-Based Assessments. Three techniques and one technology to transform patient reported outcomes. Cambridge Centre for Health Services Research, University of Cambridge [PowerPoint presentation] University of Birmingham, 14 September 2016.

<sup>16</sup> <https://chf.org.au/media-releases/healthycover-getting-better-value-health-insurance>, Accessed 11.7.17

<sup>17</sup> Private Health Insurance Report 2014-15 <https://www.accc.gov.au/publications/private-health-insurance-reports/private-health-insurance-report-2014-15>, Accessed 11.7.17



*“Consumers can experience a change to benefits in a number of ways, including through a change to an insurer’s rules or a change to an insurer’s arrangements with health care service providers (HCSPs).<sup>18</sup> Available evidence suggests that benefit changes are widespread and increasing over time, and that inadequate notification can have a significant impact on consumers.”*

The impacts identified in the ACCC report include:

- *“bill shock” or unexpected out-of-pocket expenses post-treatment;*
- *consumers losing the opportunity to port to another insurer to maintain the level of cover held before the change was imposed—this loss of opportunity to port can mean consumers re-serve waiting periods to obtain their previous level of cover;*
- *cancelled and delayed medical procedures where consumers learn of a benefit reduction prior to medical treatment;*
- *long waiting periods for treatment in the public health system where a consumer cannot afford to pay for a no-longer-covered service out of their own pocket; and*
- *Inadequate health insurance coverage given consumers’ health needs.”*

The transfer of risk from the state to households when purchasing private health insurance products represents a deliberate cutback of protection. The government has assumed that individuals have the knowledge and skills to process large amounts of complex health insurance information and make appropriate decisions in a market which presents them with an enormous array of choice. With an average family policy costing in excess of \$4,000 annually, there is an imperative to ensure that policies are clear to understand and easy to compare. To ensure better value for holders of PHI, the Government must require greater transparency from PHI companies. Information for consumers must be simplified and standardised and be easily accessible and funds must provide more information to consumers on how their contributions are being used. In addition, the ACCC and other relevant bodies must pursue false and misleading claims and inappropriate practices by PHI companies.

### **Low Value “Junk” Policies**

Australians commonly take out private health insurance to avoid financial penalties leveraged through the taxation system. Australia’s tax system encourages high-income earners to take out private health insurance as well as paying the 2% levy to help fund Medicare and the National Disability Insurance Scheme. If people do not take out PHI, they pay a tax penalty in the form of the Medicare Levy Surcharge (MLS). Some under-31-year-olds take out private health insurance to

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[18 Ibid.](#)



avoid paying a lifetime health cover loading which takes effect by July 1 following their 31st birthday. If they take out private health insurance after the age of 31, they pay an extra 2% for every year delay.

A recent article by Choice magazine identified three categories of private health insurance that offer limited value to policy holders and could be considered “junk policies”, which may have been designed and sold to reduce exposure to tax penalties: <sup>19</sup>

1. Private hospital policies that only provide cover for a very small number of procedures such as accidents, wisdom teeth removal, appendix surgery, knee investigations and reconstructions – all other services and illnesses are excluded or only covered if the treatment is delivered in a public hospital.
2. Private hospital cover for accident and ambulance only – with all other services and illnesses excluded.
3. Public hospital policies that only provide cover in a public hospital – these policies enable the choice of doctor, however the policies require the joining of public hospital waiting lists.

It seems that the non-health related incentives to purchase PHI have resulted in the development and sale of poor quality PHI products that offer few health benefits. This is an unacceptable situation and the government should carefully consider dropping the private health insurance rebate and/or exemption from the MLS for junk health insurance policies. Health insurance is not like general insurance; health is not a simple commodity such as a car or a house and should not be regarded as such. Government has a key role to play in regulation of the PHI industry to ensure that health insurance products are focused on efficient and equitable delivery of good health outcomes. Current regulatory structures are not achieving this goal.

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<sup>19</sup> <https://www.choice.com.au/money/insurance/health/articles/junk-health-insurance>, Accessed 11.7.17



#### 4. Lack of Focus of Health Outcomes and Funding Low Value Procedures

*Costs are being driven by waste, unnecessary and/or low value care, which are estimated to account for up to 30% of total healthcare expenditure.*

The public subsidisation of healthcare services accessed through PHI and other means should be aligned to evidence-based care. Currently the promotion of the notion of ‘choice’ is used as a motivator for consumers to purchase PHI. This choice may extend to deciding which doctors provide their care, the hospital the care is delivered in or even the type of procedures they may

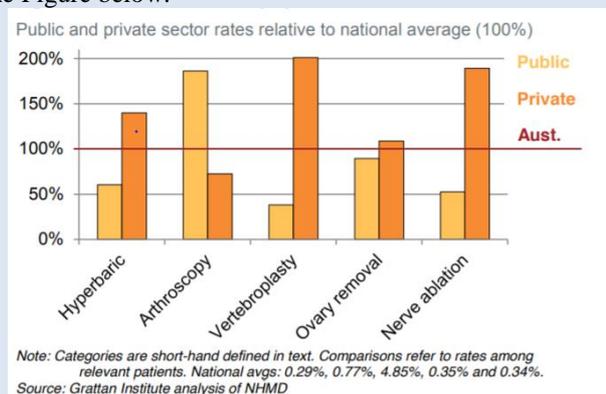
##### Grattan Institute Report – Questionable care: avoiding ineffective treatment

The Grattan Institute Report – Questionable Care: avoiding ineffective treatment, identified five treatments that should not be given to certain types of patients:

1. vertebroplasty for osteoporotic spinal fractures: surgery to fill a backbone (vertebrae) with cement
2. arthroscopic debridement for osteoarthritis of the knee: inserting a tube to remove tissue
3. laparoscopic uterine nerve ablation for chronic pelvic pain: surgery to destroy a ligament that contains nerve fibres
4. removing healthy ovaries during a hysterectomy and
5. hyperbaric oxygen therapy (breathing pure oxygen in a pressurised room) for a range of conditions including osteomyelitis, cancer, and non-diabetic wounds and ulcers.

There is poor evidence for these treatments, yet the five examples identified by the authors revealed a significant amount of potentially ineffective care. Nearly 6000 people a year, an average of 16 people a day in 2010-11, received these interventions.

Private hospitals were over represented in these figures with three of the five ‘do not do’ procedures were conducted more frequently in a private health care setting ‘by a large margin.’ The “do not do” rates, classified by sector may be seen in the Figure below.



The authors describe disinvestment strategies governments may employ in an attempt to stem ineffective care, however note there are political and cultural challenges in doing so.



have. Whilst choice is a worthy goal, this needs to be tempered to ensure that those interventions that are funded are required, and delivered to a high standard so that good health outcomes are achieved. It is possible that a mix of consumer demand and the perverse incentives of the funding mechanism may result in consumers accessing ‘low value’ procedures – those procedures which show little health benefit.

Examining unwarranted variation in the delivery of health services is also an imperative to maximise the efficiency and effectiveness of healthcare and address issues of equity. For example, the Second Atlas of Healthcare Variation, prepared by the Australian Commission on Quality and Safety in Health Care<sup>20</sup> reveals that across Australia there was a five-fold difference in the number of people being given lumbar spinal decompression in some geographical areas compared with others, and more than 80 per cent of patients who were receiving that treatment had private health insurance.

The 2015 report, “Exploring Healthcare Variation in Australia: Analyses Resulting from an OECD Study” released by the Australian Commission on Quality and Safety in Health Care<sup>21</sup> notes that

*Unwarranted variation raises questions about quality, equity and efficiency in health care. For instance, it may mean some people have less access to health care compared with others. It may suggest that factors other than patients’ needs or preferences are driving treatment decisions. It may indicate that some people are having unnecessary and potentially harmful tests or treatments, while others are missing out on necessary interventions.*

The current MBS Review has identified that there are many areas where low value care is driving unnecessary utilisation and cost growth in health care, yet without significant reform, these procedures continue to be performed and government and private insurers are compelled to fund them in the existing regulatory environment. Costs are being driven by waste, unnecessary and/or low value care, which are estimated to account for up to 30% of total healthcare expenditure.

Obstetric care is another area where research has shown that accessing private care (generally through use of PHI) leads to higher rates of intervention. In 2012, research published by Dahlen et

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<sup>20</sup> <https://www.safetyandquality.gov.au/atlas/atlas-2017/> Accessed 26.7.17

<sup>21</sup> <https://www.safetyandquality.gov.au/wp-content/uploads/2014/05/Exploring-Healthcare-Variation-in-Australia-Analyses-Resulting-from-an-OECD-Study.pdf> Accessed 26.7.17



al.<sup>22</sup> showed that women in private hospitals in NSW, categorised as low-risk, had much higher rates of obstetric intervention than those giving birth at a public hospital. The study found that in data from 2000 to 2008, only 15% of low-risk first time mothers in private hospitals had a normal vaginal birth without intervention compared to 35% in public hospitals. Overall, first-time mothers had a 20% lower chance of having a normal birth in private hospitals compared to public hospitals. The authors conclude,

*Low-risk primiparous women giving birth in private hospitals have more chance of a surgical birth than a normal vaginal birth and this phenomenon has increased markedly in the past decade with the gap between the public and private sector growing wider. Australia strives to provide a health system which offers equal access and equity to its population. The findings of this study suggest that a two-tier system exists in Australia without any obvious benefit for women and babies, and a level of medical over-servicing, which is difficult to defend within a system that is bound by a finite health dollar.<sup>23</sup>*

The MBS review provides an opportunity to address the funding of ineffective or low value procedures, and given the proportion of low value care undertaken in the private health setting, attention in these area may yield positive health outcomes for Australians, and costs savings in the form of rebate saving and out-of-pocket and premium costs for PHI policy holders.

Arguably, there is also a lack of attention to health outcomes at a population and health system level. The lack of focus on health outcomes is compounded by the lack of coordinated activity around the collection and sharing of health data across the health system. Currently opportunities are missed to increase the efficiency and effectiveness of the health care system - clinical performance data is not captured, or is collected and not shared. Aggregating data across both the private and public sectors from the acute and primary health care settings would enable the gaining of insights into population health, health care systems performance, quality metrics and the cost and efficiency of services. With appropriate privacy provisions in place, this information could be shared with clinicians, administrators, researchers and policy makers to enhance health outcomes and the performance of both the public and private health care systems. In some instances, this information could be shared with health consumers to support their informed choices about treating clinicians, procedure selection, quality metrics, such as rates of adverse events and the outcomes of interventions relevant to them.

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<sup>22</sup> Rates of obstetric intervention among low-risk women giving birth in private and public hospitals in NSW: a population-based descriptive study, HG Dahlen, S Tracy, M Tracy, A Bisits, C Brown, C Thornton, *BMJ open* 2 (5), e001723, <http://bmjopen.bmj.com/content/2/5/e001723.full> Accessed 11.7.17

<sup>23</sup> *Ibid.*



There is a requirement for greater transparency in the price, performance, and quality outcomes of healthcare providers funded by PHI, which is fundamental to improving consumer choice, to placing downward pressure on costs throughout the health system, to delivering better targeted and effective treatment for patients, and to developing improved health outcomes.

#### **5. Regulatory barriers – misaligned funding streams acting as a barrier to contemporary models of care**

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*The ANMF strongly supports funding models which provide for positive health outcomes through sound health policy designed to meet patient needs. Funding must allow for the involvement of a range of health care professionals in the care. This model allows for a person to be seen by the right health professional for their needs, in an appropriate place, at the right time - that is, a 'needs' driven funding model, not one driven by a particular health care professional.*

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The current systems for health funding, including the regulatory barriers around PHI funding in Australia create serious barriers to effective health promotion and chronic disease management, and limit effectiveness in terms of equity, access and value for money. There is a need for recognition of the interconnectivity and interdependence of the healthcare system and changes made to optimise opportunities for enhanced patient outcomes. Major reform is needed to achieve models of care that are based on the best available evidence; are efficient and cost effective; are measured and provide for positive health outcomes and sustainable service delivery.

The fee for service model rewards providers for activity and not for outcomes and does not incentivise providers to address many of the underlying causes of hospital utilisation. Funding models should support sound health policy designed to meet population needs, and be more responsive to the range of health professionals who can safely and competently be engaged in all aspects of the health care sector. In order to do this significant policy reform is required to ensure that nurses and midwives are able, and funded, to work to their full scope of practice.

Currently the funding methodology drives activity to doctors to perform consultations and interventions, however much of this funded activity does match the skillset and training of doctors. Significant opportunities exist for maximising the use of the skills of nurses and midwives and enhance workforce utilisation. . As nurses and midwives work across the nation in every area



of health and aged care and provide efficient, expert, evidence-based care and services, better value for money can be achieved through enhanced utilisation of regulated, qualified registered nurses, midwives and nurse practitioners

Health promotion and prevention, lifestyle change and management of chronic conditions and other mechanisms for minimising admissions to hospitals are all of key importance to private health insurance in reducing healthcare utilisation, costs and improving health outcomes. Nurses already play a key role in supporting insurers to achieve these aims through implementation of chronic disease management programs, and delivery of a range of support services, however regulatory barriers limit the scope of nurses' practice. This is particularly true in the acute care setting, and consideration of reforms which enable funding of nurses to perform these activities may play a significant role in enhancing access to care, decrease the cost of the delivery of care and free capacity of doctors to align their efforts with their areas of specialisation. The reliance on the MBS and the current fee for service funding model does not support contemporary clinical practice, drives volume and does not recognise or reward the achievement of positive health outcomes.

Australia has a highly qualified and skilled nursing and midwifery workforce which is largely under-utilised. Nurses are well placed to assess, plan, implement and evaluate the unique requirements of patients while working in collaboration with the multidisciplinary team. New models of care are emerging and evolving including nurse navigator, care coordinator and case manager roles which use nurses' specific skills, such as their knowledge of population health, patient and family environment, community supports, insurance systems and advance care planning.<sup>24</sup> These roles enable nurses to work in partnership with individuals, families, communities to enable access to the type, level of services, support to achieve optimal health outcomes. Through empowering nurses, and leverage their skills and training, opportunities exist to reallocate clinical responsibilities and relieve some pressures on the health system and address challenges of through task reassignment such as addressing physician shortages.<sup>25</sup> The Queensland Nurse Navigator, an example of one such new role, is described in the section below.<sup>26</sup>

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<sup>24</sup> McMurray, A., & Cooper, H. The nurse navigator: An evolving model of care. *Collegian* (2016), <http://dx.doi.org/10.1016/j.colegn.2016.01.002>

<sup>25</sup> Ibid.

<sup>26</sup> [https://www.researchgate.net/profile/Anne\\_Mcmurray/publication/292680096\\_The\\_nurse\\_navigator\\_An\\_evolution\\_model\\_of\\_care/links/56bd0f0e08aed695994612e0.pdf](https://www.researchgate.net/profile/Anne_Mcmurray/publication/292680096_The_nurse_navigator_An_evolution_model_of_care/links/56bd0f0e08aed695994612e0.pdf)



#### **Nurse Navigator Role – Queensland**

The Queensland Government announced a major initiative - to position Nurse Navigators throughout various hospitals and health services in 2015. The Nurse Navigator roles aim to reduce fragmentation of health services, decrease unplanned hospital admission rates and positively impact length of stay through supporting people as they transition between their GPs and other primary care services, through their hospital and community health journey to home.

The expectation of this program is that Nurse Navigators will be able to guide patients to existing programs, such as Hospital in the Home (HiTH), and other community supports and provide the benefits of their knowledge of the complexities of the health system and PHI. The Nurse Navigator role seeks to support the building of health literacy, empowerment patients and optimise opportunities for self-management.

However, too frequently nurses and midwives are denied opportunities to realise their full potential and provide maximum contribution to the health system. Opening these opportunities and undertaking appropriate workforce reform will provide better service to more people, with enhanced cost effectiveness. This would involve, in particular, much better use of nurse practitioners and a significant expansion of nurse-led and midwife-led services.

#### **Nurse and Midwife-led Clinics**

Historically a driver of uptake of private health insurance was around the time people are contemplating starting a family. However, recently there has been a trend in decreasing births in private hospitals. The number of women giving birth in private hospitals dropped by 4,051 between 2009-10 and 2014-15.<sup>27</sup> The out-of-pocket costs associated with private obstetric care may be one reason for the reduction in access of private hospital obstetric care.

A recent report on medical gaps prepared for Private Health Care Australia shows eight out of ten obstetricians charge more than double the Medicare fee for a birth. Nearly one in five charge three times the Medicare fee. The average gap fee for a woman having a caesarean in a private hospital in 2015-16 was \$868 to \$874, for a vaginal delivery the gap averaged \$702 to \$717.<sup>28</sup>

The establishment of nurse/midwife-led clinics is expanding in Australia in the public health system. These clinics offer a number of benefits to prospective parents, including continuity of care and enhanced access. There is also strong evidence internationally of similar clinics achieving high levels of consumer satisfaction and cost effectiveness. Shared care arrangements have been

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<sup>27</sup> <http://www.heraldsun.com.au/lifestyle/health/aussie-mums-shunning-private-hospitals-due-to-obscene-obstetrics-charges/news-story/550b19af9239a8b0b6d42a572c409ce4> Accessed 11.7.17

<sup>28</sup> Ibid.



shown to improve patients' outcomes and facilitate timely access to specialist services. For medical staff, these clinics enable a freeing of capacity to focus attention on more complex patients.

Funding of midwifery care is available in some private health insurance extras policies, however funding limits are generally too low to support an entire pregnancy and birth, and people electing to engage a midwife privately, currently do so at considerable out-of-pocket expense.

Regulatory barriers are, in part, responsible for the failure of PHI to fund access to this contemporary model of care for policy holders. Further, the current funding of the obstetrician led model of antenatal care exposes families, who elect to use their private health insurance, to the risk of significant out-of-pocket costs. The risk of exposure to these costs and an inability for PHI to fund access to contemporary models of antenatal care, all act to decrease the practical value of private health insurance to this cohort. Policy reform needs to occur to identify mechanisms for private health insurers to fund the access to midwife-led, multidisciplinary models of obstetric care.

Antenatal care is one example of regulatory barriers in PHI which practically limit access to contemporary models of care. Opportunities also exist to remove restrictions that prevent or limit private health insurers from funding other evidence-based healthcare such as, preventative health interventions, or home based interventions that would keep patients out of hospital, with better health outcomes.

## **6. Value of PHI for people living in regional and remote areas**

Regional Australians have substantially lower levels of private health fund membership. It is likely that the lower level of membership in regional areas is related to the limited availability of private inpatient facilities, lack of access to medical specialists, allied health professionals and private hospitals. All of these factors act to make PHI less attractive in these settings. However, Australians living in regional and remote communities are subject to the same financial penalties as their metropolitan dwelling counterparts if they elect to not purchase private health insurance. The value of private health insurance for regional and rural Australians and the financial impost of being penalised through the taxation system for not purchasing PHI need to be considered for these populations.



Other initiatives that may be considered to enhance the value of PHI for people living in regional and remote locations include the provision of incentives for private practitioners to operate in rural areas the leveraging of models of care that would enhance access, such as telehealth, remote monitoring and the funding of nurses and allied health professionals to deliver care, closer to people's homes.

## **7. Conclusion - Better value for consumers of health care with PHI**

Practical policy reforms to enhance the affordability and value of private health insurance, and to reduce the subsidisation of private health insurance at the expense of the public health systems, need to occur. The ANMF urges the government to consider the following:

- Removal of the public subsidy of PHI. This could be done gradually – a 10% reduction in the rebate would return significant savings to the Government even accounting for potential increase in activity to be accommodated by public hospitals with less than a 2% reduction in private health insurance coverage.
- Ancillary rebates could be cut, starting with removal of rebates for treatments for which there is no sound evidence base. The savings from changes to the rebate should be redirected to the public health system.
- Removal of the rebate dropping the private health insurance rebate and/or exemption from the MLS for low value, “junk” health insurance policies.
- Removal of financial penalties for those who do not take out PHI regardless of their income, with a particular focus on Australians living in regional and rural Australia who receive very little benefit from holding private health insurance.
- Enhanced reporting requirements, analysis and data sharing to inform health outcomes, information about systems performance, adverse events and cost effectiveness.
- An increased focus of PHI regulation to ensure that funding is directed to services which improve the health outcomes for consumers and the community.
- Enhanced regulation to ensure transparency from PHI companies in regard to policy comparisons, exclusions and consumer exposure to out-of-pocket expenses.
- Regulatory reform to enable insurers to fund contemporary models of care, for which there is evidence of comparable or superior health outcomes and cost savings. This may, for example, include the funding of midwife-led obstetric care.



- Information for consumers must be simplified and standardised and be easily accessible and funds must provide more information to consumers on how their contributions are being used.
- Examination of initiatives to enhance access to health care for regional and rural Australians so that they are able to extract value from PHI.