Summary of the workshop on improving the value of private health for rural and remote consumers

Discussions in the workshop on options for improving the value of private health for rural and remote consumers are representative of the views shared by the organisations in attendance and do not necessarily represent the views or policies of the Australian Government.

1 Overview

A workshop was held on 12 December 2016 with 32 participants from a range of stakeholder groups, including consumers, doctors, hospitals and insurers, to discuss improving the value of private health for rural and remote consumers.

2 Welcome and introduction

Dr Jeffrey Harmer, Chair of the Private Health Ministerial Advisory Committee (the Committee), welcomed workshop participants and provided a brief overview of the aim of the workshop – to share ideas on how the value of private health services can be improved for rural and remote consumers to inform the Committee's advice to the Minister for Health, the Hon Sussan Ley MP.

Susan Azmi from the Department of Health gave a presentation to provide background on private health insurance and specific issues related to rural and remote consumers, such as lower levels of coverage and lower use of services.

3 Critical issues

Participants discussed the critical issues affecting the value of private health insurance in rural and remote Australia. Critical issues discussed included:

- lack of access to services, including access to specialists, allied health professionals and private hospitals
- costs of travel and accommodation when receiving treatment
- perceived poor value for money
- continuity of care
- lack of incentives for private practitioners to operate in rural areas
- lack of support for out of hospital care
- lack of choice of healthcare providers.

4 Changes to improve the value of private health insurance for rural and remote consumers

Participants were then asked to discuss what changes/improvements could be made to increase the value of private health insurance in rural and remote Australia. During discussions, diverse views on many issues were raised.

Matters discussed included:

- increasing accessibility to services by:
  - improving transport and accommodation benefits
  - encouraging innovation in delivery of services
  - maintaining default benefits structure for hospitals which don't have contracts with private health insurers.
- discouraging 'gaming' in the health system – for example, the practice of public hospitals encouraging patients to elect to use their private health insurance on admission. However, other participants were supportive of private patients in public hospitals. An example was given of a visiting medical officer working in a rural public hospital relying on private patients in public hospitals as an important income stream.

- supporting out of hospital services (especially at-home care for older people)
- attracting specialists to rural and regional Australia
- reducing specialist restrictions on private providers (for example, overseas trained physicians are eligible to apply for Area of Need positions as declared by Australian state or territory government authorities in places where there is a shortage of medical specialists, usually in rural and remote areas. Currently this program does not extend to private providers.)

5 Options to improve product design

Participants discussed two options that could improve private health insurance products for people in rural and remote areas:

- introducing a specific product tailored for rural and remote consumers
- modifying existing products to include more benefits for rural and remote consumers but available to anyone.

Most participants considered a modified product to be preferable. Participants were concerned that a specific rural-only product would have a smaller funding pool on which to draw. On the other hand, participants identified a risk that increased travel and accommodation benefit may encourage patients to unnecessarily seek services outside their local areas, which may negatively impact on local service providers and undermine their viability. Others were concerned that a modified product could result in increased administrative complexity for insurers.

6 Options to directly address affordability

Participants discussed options to directly address affordability for rural and remote consumers.

Increase the private health insurance rebate based on location

There was some support for this option, with the disclaimer that modelling would be required before proceeding. Other participants queried the focus on affordability and opined that there was more merit in focusing on increasing the value of products through increased access to services and benefits.

Reducing out of pocket costs

It was proposed that increasing the MBS benefit for in-hospital treatment from 75 per cent to 100 per cent was one way of reducing out of pocket expenses for rural and remote consumers. Insurers would continue to pay the previous gap amount of 25 per cent.

Changes to the risk equalisation scheme

A key feature of Australia's private health system is community rating. Community rating means that people who are older and sicker do not have to pay higher premiums. This requires cross-subsidisation from younger, healthier members. Risk equalisation is the mechanism by which that cross-subsidy is delivered.

Concerns were raised about changing risk equalisation to favour rural and remote consumers. Some participants felt that making adjustments to benefit rural and remote consumers could set a precedent and lead to other segments wanting to receive similar benefit.

Further concerns were raised that past attempts to change risk equalisation had resulted in unintended outcomes. Some participants thought that more modelling needed to be undertaken before ruling changes to risk equalisation in or out.

7 Options to improve access to health care services

Participants then discussed options to improve access to health care services.

Access to allied health

Participants believe that there needs to be an expanded referral pathway. This would enable other health professionals, in addition to GPs, to make referrals and remove this is a barrier to access. In order to improve service access for consumers, primary health networks, private providers and community health services need to find ways of working together more effectively.

Participants discussed telehealth services as an area of potential growth with the capacity to improve value for rural and remote consumers. Several participants raised expanded access to MBS items for allied health professionals for consultations as an option.

Alternative models of care

Participants discussed access to alternative models of care, including mobile clinics, outreach services, telehealth consultations for allied health services and blended models for funding and service delivery.

Several participants mentioned the mobile surgical bus working in conjunction with government, community and local health organisations to provide surgical services to rural New Zealand. It was noted that, while this model works well in New Zealand, there are geographical constraints that would impact on Australia adopting this model.

Participants discussed insurers providing support at the primary health point of care through, for example, Health Care Homes. Participants were concerned this could lead to inequity for those without private health insurance – for example, if insurers funded a health check mobile clinic for members and those without private health insurance in the region were unable to utilise the service.

Second tier default benefit arrangements

The second tier default benefit is a mechanism that was introduced to protect hospitals that do not have insurer contracts. In essence, for non-contracted hospitals, insurers pay 85 per cent of their average contracted benefit for that service.

There was strong sentiment that second tier default benefit arrangements for rural and remote areas should be kept as this provides a level of guaranteed funding if a contract is not in place and therefore provides an incentive for private health providers to deliver services. Some participants suggested that the second tier default amount needed to be raised as small facilities providing services do not have the benefit of economies of scale their metropolitan counterparts enjoy.

Participants also raised the need for more streamlined contracting processes for smaller facilities.

Some participants raised concerns over the difficulties private hospitals have when setting up new facilities without contracts in place with insurers. The counter argument put to this was that forced contracting distorts the market.

8 Most applicable and useful improvements

Participants discussed the most significant improvements that could add value to private health in rural and remote Australia. These include:

- enhancing benefits for rural and remote consumers
- improving access to out of hospital models of care
- restoring the private health insurance rebate and recommencing indexing
- reinstating indexation of Medicare rebates
- providing incentives to GPs to coordinate complex care arrangements

- undertaking risk equalisation modelling to assess viability of various options to improve health outcomes in rural and remote areas
- providing better information to private health providers on coverage (how many members insurers have in a particular area) to assist them with assessing the viability of a facility
- taking action to prevent public hospitals from encouraging patients to be admitted as private patients
- considering a rural and remote tax deduction.

Participants noted that a range of these options could be implemented as a package.