BACKGROUND PAPER: IMPROVED VALUE FOR RURAL CONSUMERS

Introduction

In June 2016 Minister Ley announced the Coalition's commitment to ensure people in rural and remote areas receive better value for money from their private health insurance. The Minister stated that government would work with rural health and consumer groups, private health insurers and other key stakeholders to develop a private health insurance product designed specifically for Australians living in rural and remote areas.

This paper briefly outlines the rural and remote population, their health status and access to health services before posing options to begin the discussion about what can be done to improve the value of private health insurance for rural and remote Australians.

Australia's rural and remote population

Defining 'rural and remote'

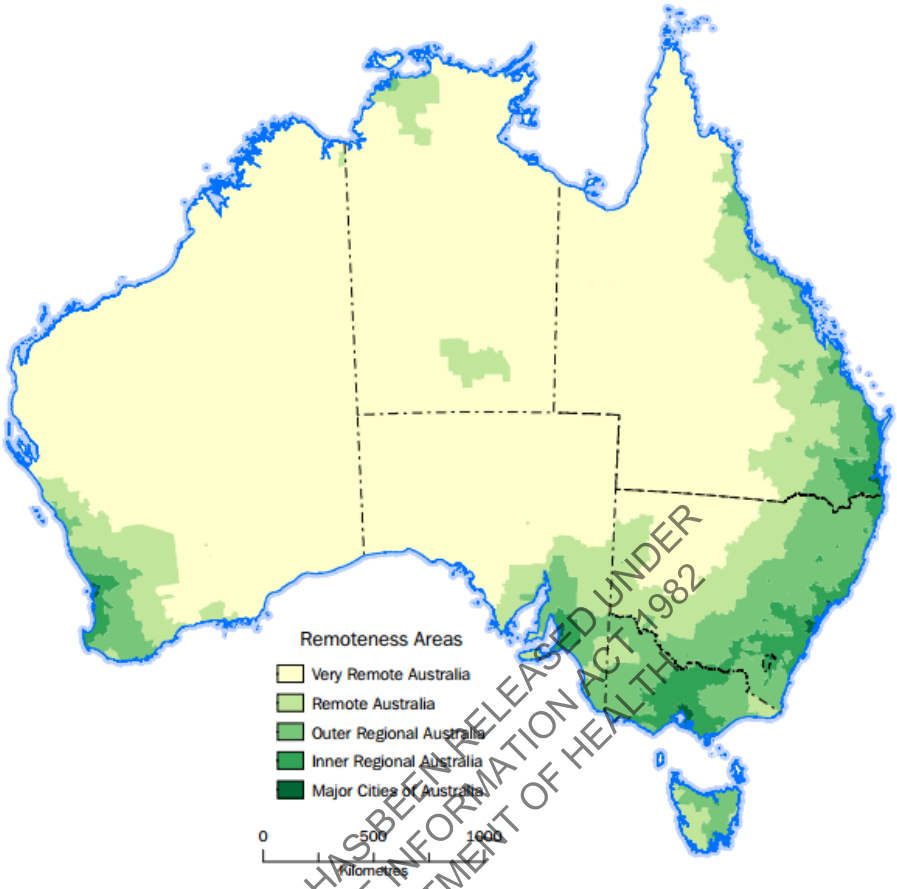
There are wide variations between rural and remote communities. While major urban centres within outer regional areas are considered to be within the 'rural' classification, these areas tend to be relatively well-off in terms of health status and access to health services in comparison to smaller outer regional towns and more remote areas.[1] This can make consideration of 'rural' issues more complex. Because different sources use different definitions of rural and remote, care must be taken when interpreting data as it may not be directly comparable.

For the purposes of this paper, the term 'rural and remote' is used to refer to areas classified as outer regional, remote or very remote under the Remoteness Area structure within the Australian Bureau of Statistics (ABS) Australian Statistical Geography Standard. In the analysis within this paper, inner regional has not been included in the definition of rural and remote. The inner regional classification covers a diverse range of communities. While the classification may reflect a community's level of direct access to services, it does not always provide a good indication of a community's access to major cities. This access to major cities and their health services is an important factor in the considerations of this Committee. Diverse communities in the inner regional classification include Ballarat in Victoria, Rockhampton in Queensland, Hobart in Tasmania, and Tharwa in the Australian Capital Territory. Figure 1 shows the remoteness area boundaries.[2]

[1] For example, Charters Towers with a population of approximately 8,000 and Townsville with a population of approximately 172,000 are both classified as outer regional.

[2] Australian Bureau of Statistics 2013, *Australian Statistical Geography Standard (ASGS): Volume 5 – Remoteness Structure,* July 2011, cat. no. 1270.0.55.005.

Figure 1: Australian Statistical Geography Standard Remoteness Structure: Remoteness Area Boundaries



Population numbers

In 2015, approximately 71 per cent of the population lived in major cities, 18 per cent lived in inner regional Australia, 9 per cent lived in outer regional Australia and 2 per cent lived in remote or very remote Australia.[3]

Table 1: Estimated Resident Population by remoteness (2015)

	Estimated Resident Population (2015)	Percent of total population
Major Cities	16,864,416	71%
Inner Regional	4,302,781	18%
Outer Regional	2,085,434	9%
Remote[4]	321,129	1%
Very Remote[3]	204,017	1%
TOTAL	**23,777,777**	**100%**

Health status

The health of people living in rural and remote Australia is generally poorer than their

[3] Australian Bureau of Statistics 2016, *Regional Population Growth, Australia*, 2014-15, cat. no. 3218.0.
[4] It should be noted that while there is a relatively higher proportion of Aboriginal and Torres Strait Islander peoples in remote areas of Australia, the majority of Aboriginal and Torres Strait Islander peoples are still more likely to live in urban rather than remote areas (ABS 2013).

metropolitan counterparts, and health outcomes become worse as remoteness increases.[5] Poorer health outcomes may reflect a range of factors that are detrimental to health. People are often disadvantaged with regard to educational and employment opportunities, income, and access to goods and services.

People in rural and remote areas also have poorer health risk factor profiles than people in major cities. Compared with people in major cities, rural and remote Australians are more likely to:

- be a daily smoker (outer regional and remote 21 per cent compared with 13 per cent in major cities);
- drink alcohol at levels that place them at risk of harm over their lifetime (23 per cent compared with 16 per cent);
- be insufficiently active (72 per cent compared with 64 per cent);
- be overweight or obese (69 per cent compared with 61 per cent); and
- have high blood pressure (24 per cent compared with 22 per cent).[6]

Access to health services

Australians living in rural and remote areas do not have access to the range of health care services that are available to people in urban areas, in part due to lack of infrastructure, difficulties in attracting and retaining workforce and affordability of services.

Infrastructure

In 2014-15, there were 1,316 hospitals in Australia, comprising 698 public hospitals and 618 private hospitals.[7] Figure 2[8] shows the locations of public hospitals in Australia and Figure 3 shows the location of private hospitals, both same day and overnight. Of the 698 public hospitals across Australia, 178 were located in a major city, 189 in an inner regional area, 217 in an outer regional area, 61 in a remote area and 53 in a very remote area.[9] Of the 618 private hospitals, 510 were located in a major city, 85 in an inner regional area and 23 in an outer regional area.

The number of large, specialised hospitals decreases with distance from major cities. Hospitals in rural and remote areas are smaller and are more likely to provide multi-purpose and non-acute services.[10]

[5] Australian Institute of Health and Welfare 2016, *Australia's health 2016*, cat no. AUS 199. The AIHW notes that the higher proportion of Aboriginal and Torres Strait Islander peoples in remote areas contributes to, but does not completely account for, the generally poorer health of people living in remote areas.
[6] Australian Institute of Health and Welfare 2016, Australia's health 2016, cat no. AUS 199.
[7] Australian Institute of Health and Welfare 2016, *Hospital resources 2014-15: Australian hospital statistics*, cat no. HSE 176.
[8] Figure 2 depicts 696 public hospitals. The two excluded services which are captured in the AIHW figure of 698 have since been reclassified as non-hospital facilities.
[9] Australian Institute of Health and Welfare 2016, *Hospital resources 2014-15: Australian hospital statistics*, cat no. HSE 176.
[10] Rural Health Standing Committee, *National Strategic Framework for Rural and Remote Health* 2011.

Figure 2: Locations of public hospitals in Australia

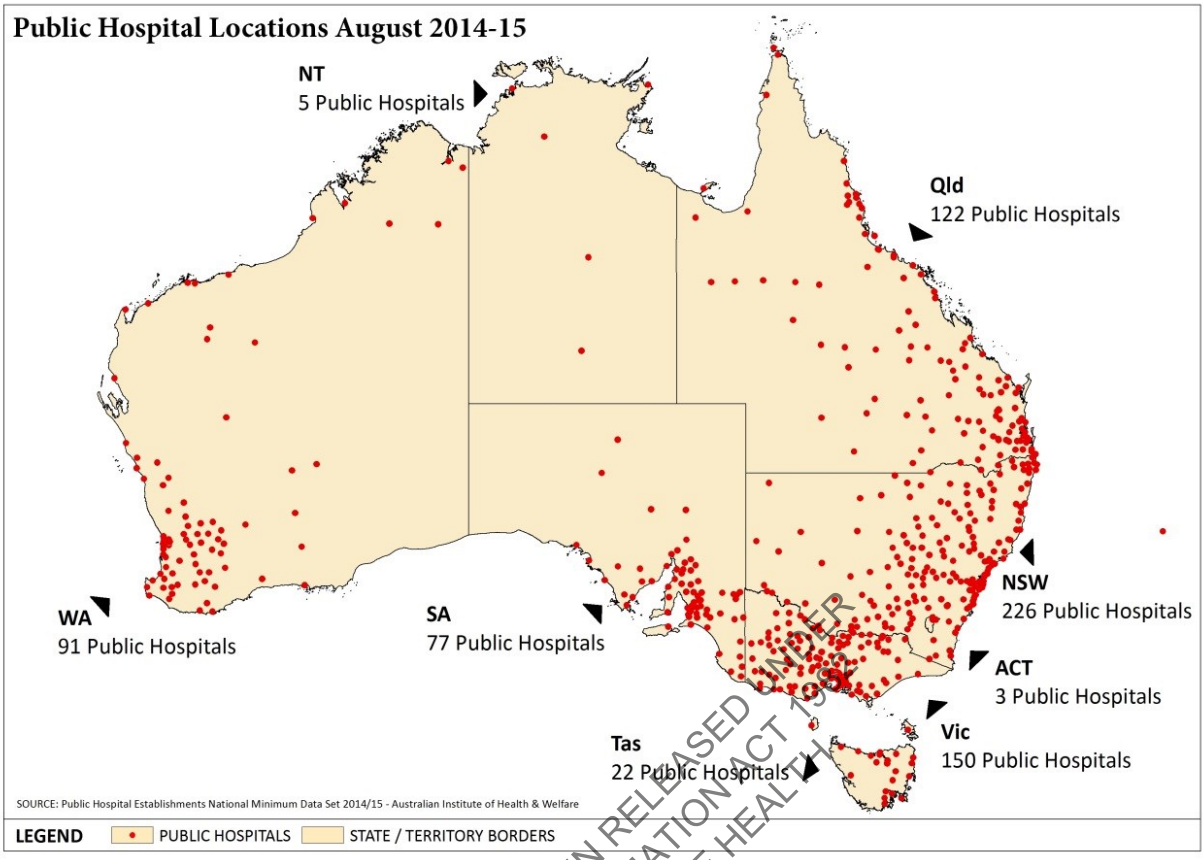
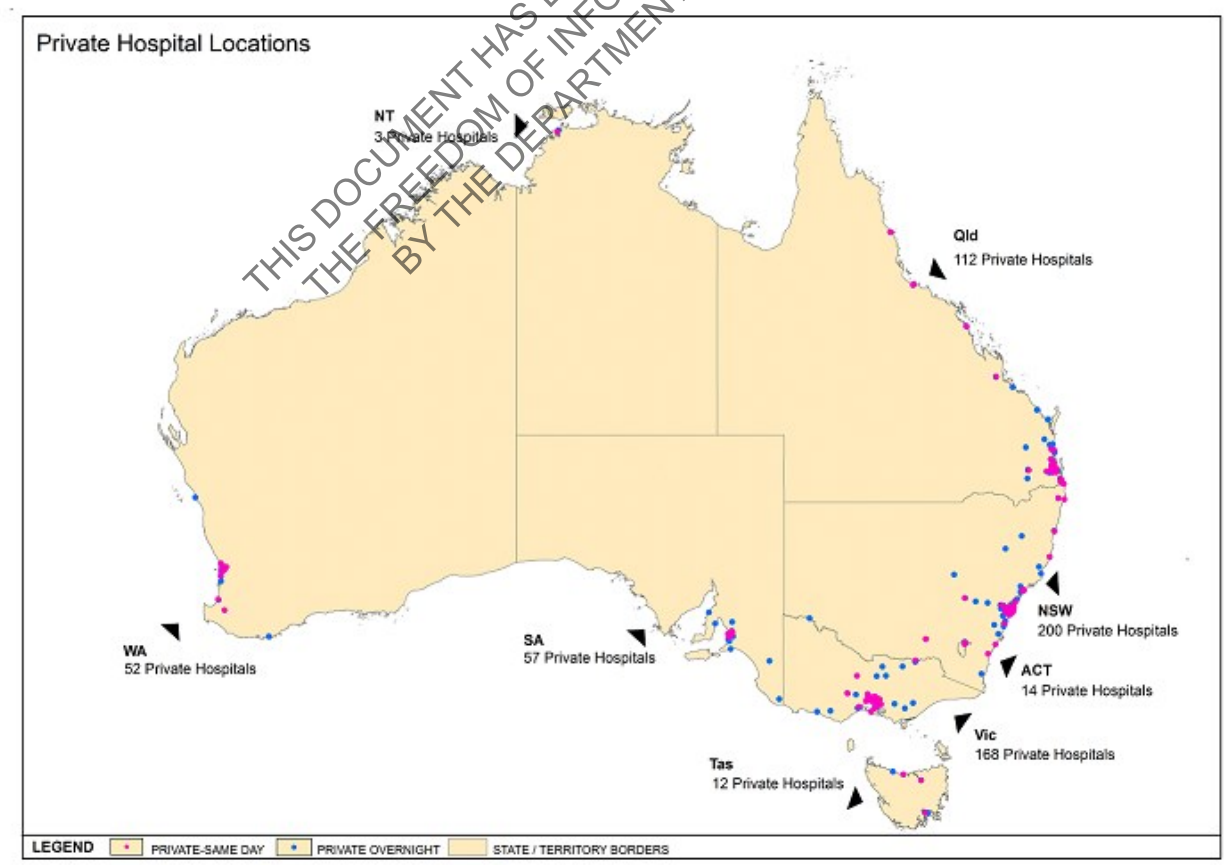


Figure 3: Locations of private hospitals in Australia, same day and overnight



Hospital separations

People in rural and remote areas have different patterns of service use compared with people in major cities. Public hospital separation rates increase according to remoteness area of usual residence. Table 2 shows that in 2014-15, the number of public hospital separations per 1,000 population was highest for people living in very remote areas and lowest for people living in major cities (585 and 220 per 1,000 population respectively).[11] Conversely, private hospital separation rates decrease with remoteness. For the same period, private hospital separation rates were lowest for people living in very remote areas and highest for people living in major cities and (92 and 180 per 1,000 population respectively).

Table 2: Separations per 1,000 population, by remoteness area of usual residence, public and private hospitals, 2014-15

	Remoteness area					
	Major cities	**Inner regional**	**Outer regional**	**Remote**	**Very remote**	**Total**[(a)]
Public hospitals						
Separations	3,795,177	1,235,751	682,486	117,937	111,489	5,980,338
Separations per 1,000 population	219.8	260.5	301.5	362.2	585.0	240.4
Separation rate ratio	0.9	1.1	1.3	1.5	2.4	
Private hospitals						
Separations	3,138,101	720,833	250,424	32,420	17,135	4,170,029
Separations per 1,000 population	180.3	143.1	106.7	98.6	92.3	164.7
Separation rate ratio	1.1	0.9	0.6	0.6	0.6	
All hospitals separations	**6,933,278**	**1,956,584**	**932,910**	**150,357**	**128,624**	**10,150,367**
Separations per 1,000 population	**400.1**	**403.6**	**408.2**	**460.8**	**677.4**	**405.1**
Separation rate ratio	**1.0**	**1.0**	**1.0**	**1.1**	**1.7**	

(a) Total includes separations for which the remoteness area was not able to be categorised.

The higher public hospital separation rates reflect what is expected – that is, due to poorer health and lower access to primary care, people in outer regional and remote areas tend to use hospitals to a greater extent than people in cities. People living outside major cities are also more likely to be admitted to hospital for conditions that could have potentially been prevented through access to non-hospital services.[12] However, the private hospital separation rates run counter to this.

[11] Australian Institute of Health and Welfare 2016, *Admitted patient care 2014-15: Australian hospital statistics*, cat no. HSE 172.

[12] Australian Institute of Health and Welfare 2014, *Australia's health 2014*, cat no. AUS 178. For 2011–12, the rate of potentially preventable hospitalisations was highest for residents of remote and very remote areas (56 and 67 per 1,000 population, respectively) and lowest for residents of major cities (27 per 1,000 population).

The lower separation rates for private hospitals in rural and remote areas could be attributable to:

a) reduced access due to lack of availability of services (which could mean members are receiving lower value for money from their private health insurance); and/or
b) fewer insured people in rural and remote areas and therefore a lower use of private hospitals (due to the lower proportion of people covered by private health insurance).

The data does show that in remote and very remote Australia, proportionally fewer people are covered by private health insurance. The available data also shows that the number of privately insured separations per insured person reduces substantially according to remoteness.

Table 3: Privately insured separations, by remoteness area of usual residence, public and private hospitals, 2014-15*

	Remoteness area					
	Major cities	**Inner regional**	**Outer regional**	**Remote**	**Very remote**	**Total**
Number of insured persons	8,505,496	1,796,712	846,245	130,279	50,979	11,328,577
Public hospitals						
Separations	527,724	187,351	85,956	9,149	2,141	812,321
Separations per insured person	0.06	0.10	0.10	0.07	0.04	0.07
Private hospitals						
Separations	2,638,631	583,346	199,530	19,742	7,479	3,448,728
Separations per insured person	0.31	0.32	0.24	0.15	0.15	0.30
All hospitals separations	**3,166,355**	**770,697**	**285,486**	**28,891**	**9620**	**4,261,049**
Separations per insured person	**0.37**	**0.43**	**0.34**	**0.22**	**0.19**	**0.38**

* Note: a number of assumptions were made in developing this table. The specific data should be treated with caution although the general trends are sound.

Rural and remote health care workforce

In 2014, rates of employed general practitioners (GPs) per 100,000 population were higher in remote and very remote areas (137) than in major cities (109). However, the overall rates of employed medical practitioners (including specialists) were lower.[13]

Recruitment and retention of allied health professionals is a recognised issue in rural and remote Australia. As with other health professionals (with the exception of Aboriginal health workers) the number of allied health professionals decreases with remoteness.

Table 4[14] provides full-time equivalent rates for the two largest professions (medical practitioners and nurses and midwives) plus dentists and optometrists. While this shows the difference in the number of health care professionals between major cities and non-city

[13] Australian Institute of Health and Welfare 2016, *Australia's health 2016*, cat no. AUS 199.
[14] Ibid.

areas, it does not account for population density – the more widely dispersed population outside cities further reduces access to the health workforce.

Table 4: Health care professionals full-time equivalent per 100 000 population, 2014

Occupation	Major city	Inner regional	Outer regional	Remote	Very remote
Medical practitioners	437	292	272	264	264
Nurses and midwives	1,145	1,096	1,077	1,239	1,233
Dentists	63	43	38	25	25
Optometrists	19	15	12	8	8

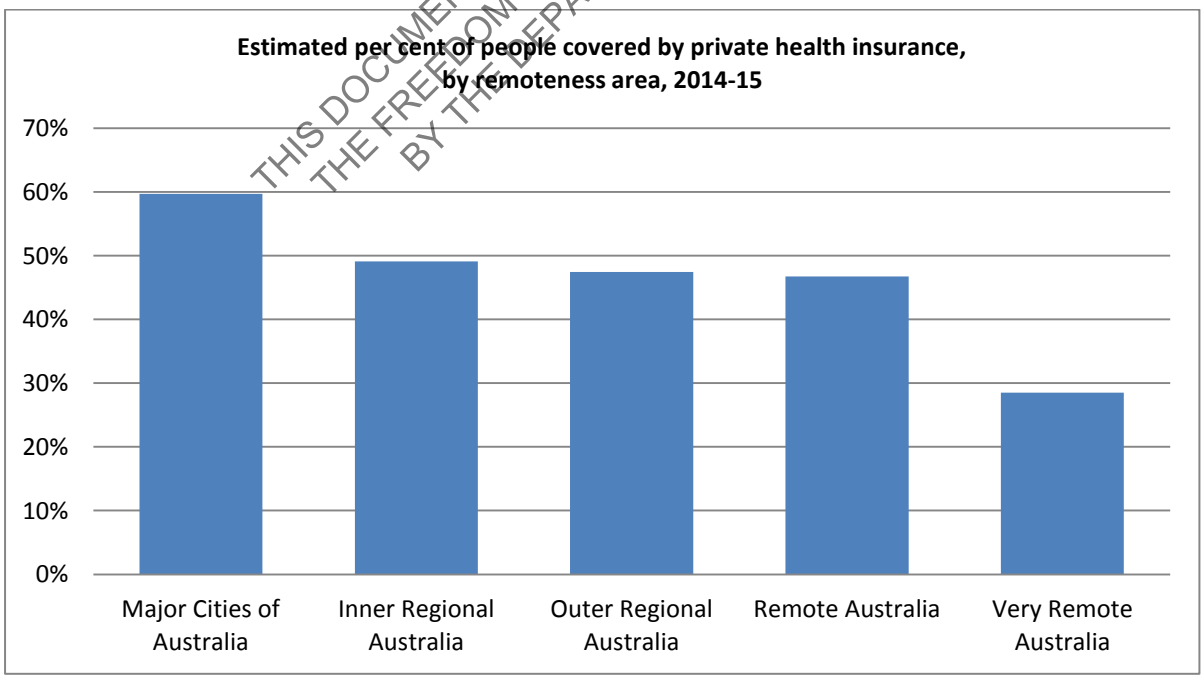
Private health insurance

Around 12 million Australians have private health insurance. Private health insurance coverage varies significantly by location. People in rural and remote areas are least likely to have private health insurance:

- around 60 per cent of people in major cities have insurance;
- around 49 per cent of people in inner regional Australia have insurance;
- around 47 per cent of people in outer regional and remote Australia have insurance; and
- around 28 per cent of people in very remote Australia have insurance.[15]

Figure 4 provides a breakdown of coverage by remoteness area.

Figure 4: Estimated per cent of people covered by private health insurance, by remoteness area, 2014-15



Note: this is for all types of private health insurance (hospital and general treatment)

[15] Calculations use data from Australian Bureau of Statistics 2016, *Regional Population Growth, Australia*, 2014-15, cat. no. 3218.0 and DHS postcode data as a proportion of total people with private health insurance according to PHIAC data, March 2015.

People in rural and remote areas may not take out private health insurance for a number of reasons:

- Cost of cover. People in rural and remote areas on average have lower incomes than people in metropolitan and urban Australia. The private health insurance consumer survey in late 2015 found that 67 per cent of respondents in remote and outer regional areas cited cost as a deterrent, compared with 58 per cent in major cities. Lower incomes also mean that people living in rural and remote areas are less likely to be captured by the Medicare Levy Surcharge.
- Perceived lower value for money due to limited access to services and/or benefits paid. Hospital services are far more likely to be public than private in rural and remote areas. Rural and remote consumers may also have less access to general treatment services (those that attract private health insurance benefits). Where they do have access, they may have travel and other out-of-pocket expenses which may not receive benefits. Rural and remote consumers may feel they are paying for services they have limited access to, and are subsidising people who live in major cities with better access. Of those with private health insurance, survey respondents living in remote areas were the least likely to feel that private health insurance provides value for money (15 per cent of respondents compared with 23 per cent in major cities).
- Existing public health care system. Feedback from the consumer survey found that compared with people in other areas, respondents in remote areas were most likely to believe that the public sector (Medicare) would provide them with the care they needed (46 per cent of respondents in remote areas compared with 31 per cent in outer regional areas and 34 per cent in major cities).

Current initiatives supporting rural and remote Australians

There are a number of initiatives relevant to the rural and remote private health insurance discussion. These are mentioned below.

Travel and accommodation subsidies

Government programs

Each state and territory government has a Patient Assisted Travel Scheme (PATS) that subsidises or covers travel and accommodation costs for patients, and in some instances, their carer or escort, who must travel when they are referred by a general practitioner for specialist treatment. All jurisdictions have conditions attached to qualifying for subsidies, such as being a permanent resident of the jurisdiction and travelling over a certain number of kilometres to access treatment.

Support available varies between jurisdictions. For example, the Northern Territory provides a fuel subsidy of 20 cents per kilometre when a patient has travelled more than 200 kilometres one way or for more than 400 kilometres cumulatively in one week for renal or oncology treatment. In comparison, in New South Wales, eligible patients can claim a fuel subsidy of 22 cents per kilometre when a patient has travelled more than 100 kilometres

one way from the nearest treating specialist or more than 200 kilometres cumulatively in one week.

In terms of accommodation, jurisdictions offer on average $40-$60 per night for a patient staying in commercial accommodation and $10-$20 per night for a patient staying in private accommodation. Some jurisdictions only offer a subsidy for patients staying in commercial accommodation.

Benefits offered by private health insurers

From publicly available information, it appears that around half of all private health insurance funds offer benefits for travel and accommodation for members who must travel to access medical services. Generally, travel and accommodation are only able to be claimed by members with 'top' extras cover. The level of benefit varies from fund to fund, with some funds providing annual limits for travel and accommodation separately and some providing combined travel/accommodation amounts. The benefits paid vary as do annual limits which are paid either per person or per membership. Annual limits may be provided for travel and accommodation costs separately or as a total amount for combined travel/accommodation expenses.

In terms of accommodation, on average, private health insurers offer around $30-$60 per night for accommodation benefits, with annual limits ranging from $100-$350 per person or $400-$600 per membership. At the higher end of the spectrum, one fund offers $150 per night for accommodation benefits with annual limits of $600 per policy.

eHealth, including telehealth

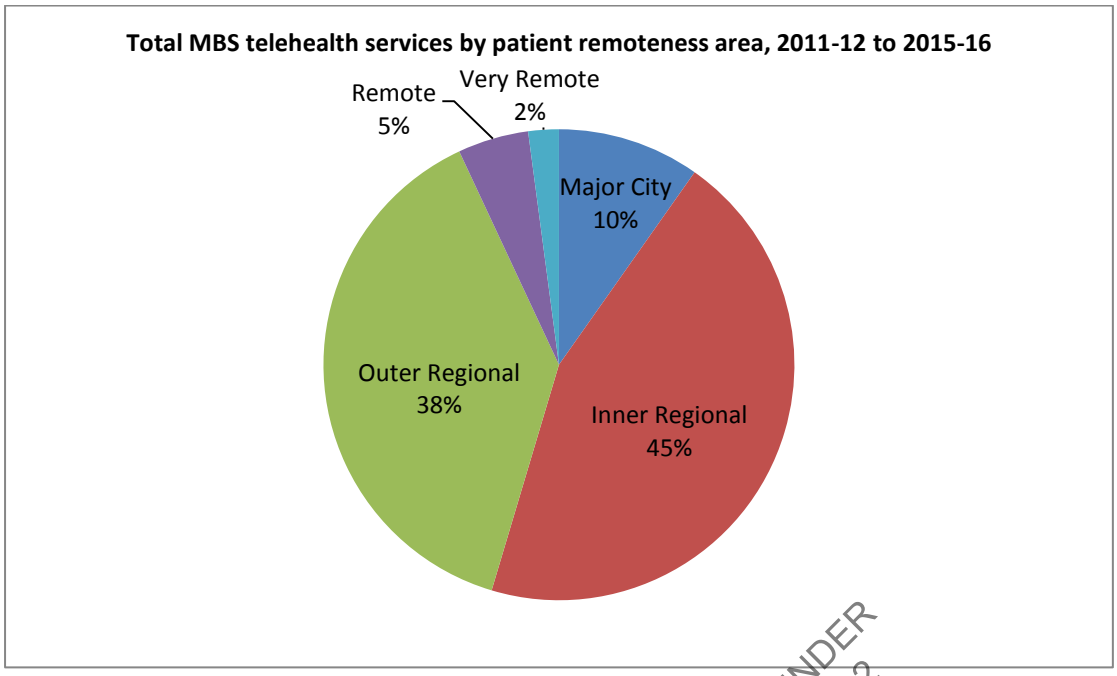
There are a number of ehealth initiatives relevant to the rural and remote private health insurance discussion. These are discussed below.

Government initiatives

Medicare rebates are available for video consultations between specialists and patients in telehealth-eligible rural and remote locations throughout Australia. Rebates are also available for clinical services provided by a health professional located with the patient during the video consultation.

Between 2011-12 and 2015-16 the Department of Human Services processed over 475,545 telehealth services provided to over 144,400 patients by over 13,815 practitioners. As Figure 5 shows, ninety per cent of these services were provided to patients outside major cities.

Figure 5: Total MBS telehealth services by patient remoteness area, 2011-12 to 2015-16



Private health insurance programs

Some private health insurers offer telephone and online health services that provide members with access to clinicians for health advice. For example:

- HCF's *My Health Guardian* service provides online health services that allow access to clinicians for advice on personal health matters such as diet, health and fitness.
- HBF Coach is a telephone coaching program that provides support for members with cardiovascular disease or diabetes to help manage their conditions.
- Medibank provides a range of health support services for members including telephone triage, health advice and referral, telephone health coaching, mental health telephone programs and chronic disease management.

These services are available to all members regardless of their location, so are not a particular benefit for rural and remote consumers.

Options to improve value of private health insurance for rural and remote Australians

There is no 'one size fits all' approach to improving access to and the value of private health insurance for people in rural and remote areas. Rural and remote communities are diverse and there are limitations as to what private health insurance can do to assist. For example, structural issues such as the location of hospitals and the availability of the health care workforce are outside the scope of these reforms. However there are options that can be explored which may improve rural access to private health cover and deliver better value for money for rural and remote consumers.

This section considers possible options for change, and pros and cons of each. The options presented are intended to guide and encourage discussion, they are not exhaustive.

Option 1 – Rural and remote specific private health insurance product

Description

Design a product to provide better value for money for consumers living in rural and remote areas who currently have limited access to private hospital services. Features could include:

- Lower premiums due to less access to services.
- Increased access to travel and accommodation benefits for patients and carers (i.e. not only available with 'top' level cover).
- Travel and accommodation as part of a hospital package (i.e. not an additional general treatment benefit).
- Increased benefit paid for travel and accommodation costs to link more closely to actual costs.
- Ability to claim for telehealth services and remote monitoring devices.
- Ability for consumers to claim travel and accommodation benefits prior to receiving treatment so the consumer avoids up front out of pocket costs.

Pros

- Consumers living in rural areas may perceive that they are getting lower value for money from their private health insurance compared with urban consumers due to lack of available services. A tailored product may go some way to addressing inequity because consumers will only be paying for what they feel they need.
- Private health insurance may cost less for rural and remote consumers if the product is providing access to fewer services. Consumers may view this as better value for money, which could lead to increased product take up in rural and remote areas.
- Consumers may be more inclined to use services if they are paid a benefit in advance.

Cons

- Could be more expensive than regular insurance, which may lead to less take up of the product.
- A specific rural and remote product would impact the community rating principle.
- May affect the balance of the risk equalisation pool if new product results in high volume of high-cost claims.

Other considerations

- How would a rural and remote specific product fit in with new classifications of insurance products, e.g. gold, silver, bronze?
- Would there need to be more than one 'rural and remote' product to allow consumer choice?
- Would there need to be more than one product to reflect the diverse needs of rural and remote regions? E.g., will there need to be a 'rural' product and a 'remote' product?
- How would eligibility for the product be defined?
- How would such a product be priced? What evidence/experience is available to base a price on?

Option 2 – Modify existing products

Description

Change existing products to include additional services/benefits that will be of use to rural and remote consumers. Features could include:

- Travel and accommodation extras available at a lower level of cover.
- Increased benefit amounts available for travel and accommodation.
- Telehealth access for allied health services such as psychology, nutrition, speech pathology.
- Higher benefits paid for individuals in rural and remote areas.
- Lower excess for rural consumers.

Pros

- Recognises the current inequities that rural and remote consumers experience due to less access to services by geographic location.
- Potential for better health outcomes if consumers are able to claim for telehealth allied services.
- Potential to reduce burden on health system due to better access to preventative health and/or health maintenance services. This could provide savings to the health system.

Cons

- Increase in premiums for policyholders.
- There may be some difficulty in justifying why certain benefits are only available to rural and remote consumers (e.g. a person in a major city who has complex comorbidities may also benefit from being able to receive a benefit for telehealth services).

Other considerations

- What is the incentive for private health insurers to include or increase the scope of their products (i.e. travel and accommodation, telehealth)?
- If extras like travel, accommodation and telehealth services are added to existing products will these be restricted to rural and remote consumers or would all policyholders have access to them? What impact would this have on premiums, affordability and sustainability?
- A lower excess would only benefit rural and remote consumers who are admitted to hospital.

Option 3 – Increase private health insurance rebate based on location

Description

On top of the current private health insurance rebate, an additional rebate would apply dependent on rurality.

Pros

- Recognises that rural and remote consumers experience less access to services by geographic location and provides an additional rebate which, in effect, reduces their premium accordingly.

Cons

- It could be hard to justify an additional rebate for a certain population group in preference to other population groups.
- Reduces the net premium of consumers in rural and remote areas, but does not directly address issues of access.
- Potential for rorting by consumers who primarily reside in an urban location, but also have property in a rural location and claim on the basis of their rural address.
- Impact on Commonwealth budget.

Other considerations

- Eligibility and rebate levels would need to be determined.

Option 4 – Improve access to allied health services

Description

Access to allied health services in rural and remote areas could be improved in a number of ways, for example:

- Private health insurers could contribute to chronic disease prevention and management in rural and remote areas through access to multidisciplinary allied health providers. Incentives would encourage these multidisciplinary allied health workers to encourage a consumer centred approach with an emphasis on client outcomes.
- Health professionals working part time in the public sector could register as a provider for private health insurance to improve the financial viability of private practice and increase access to services.
- Benefits paid for telehealth consultations with allied health professionals such as psychologists, nutritionists, speech pathologists.

Pros

- Better health outcomes for rural and remote policyholders.
- Providing health services in the primary care setting may reduce the need for hospitalisation later.

Cons

- May result in increases to premiums.

Other considerations

- What critical mass would be needed to make this work?
- How can Primary Health Networks and insurers work together?

Option 5 – Alternative models of care, including outreach services

Description

Invest in alternative models of care, for example outreach services (mobile clinics offering health checks, monitoring of chronic conditions, etc), telehealth, remote monitoring, hospital in the home services. Non-policyholders may be able to access services via a co-payment.

Pros

- Provide services to areas where access is usually limited.
- Reduces the need to travel to access services.

Cons

- Increased cost to deliver services (possibly offset by reduced hospitalisations).

Other considerations

- It is important that this does not undermine any existing private services in a community.
- There are no identified regulatory barriers to prohibit insurers from currently undertaking such activities.
- A critical mass is required for service viability. There is potential for insurers to collaborate to achieve critical mass to offer services.

Option 6 – Change the risk equalisation scheme

Description

Modify the risk equalisation pool in such a way to lower premiums for rural and remote consumers.

Pros

- Insurers are more likely to offer products to suit the needs of rural and remote consumers because they are receiving financial benefit.

Cons

- Depending on changes to the scheme, this could impact on community rating and therefore be inconsistent with other private health insurance reforms.
- Potential for rorting by consumers who primarily reside in an urban location, but have a rural property and use their rural address as their primary address of residence in order to pay a lower premium.

Other considerations

- If other changes to the risk equalisation scheme are required, this could be done as part of that process.

Option 7 – Second tier default benefit arrangements for rural and remote areas

Description

Higher second tier default benefits for hospitals operating in rural and remote areas.

Pros

- May provide an additional incentive for private hospital operators to provide services in rural and remote areas as they are guaranteed a minimum level of income.

Cons

- May not be favourably looked upon by some stakeholders who may perceive this as preferential treatment.

Other considerations

- Is related to the broader question of whether changes should be made to second tier default benefit arrangements more generally.