The Pharmacy Guild of Australia

SUBMISSION

Submission to the Federal Government's Private Health Insurance Review

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Overview

The Pharmacy Guild of Australia (the Guild) is the national peak pharmacy organisation representing community pharmacy. It strives to promote, maintain and support community pharmacies as the most appropriate primary providers of health care to the community through optimum therapeutic use of medicines, medicines management and related services.

Purpose of Private Health Insurance

The principal purpose of private health insurance is to enable people to insure themselves to access hospital care beyond that which is provided through the government-funded public hospital system.

The Guild contends that government support for private health insurance should focus principally on enabling patients to insure themselves to help cover these hospital and related costs as well as larger unforeseeable medical costs that are not subsidised through the publicly funded health system, such as providing specialised non-PBS medicines for chronic and life-threatening conditions.

The reason that the Federal Government encourages and subsidises private health insurance is that patients accessing care through private hospitals reduce the overall demand on the public hospital system. The Government should focus its investment in private health insurance on reducing the burden on public hospitals, by encouraging patients to utilise the private hospital system and related services that are cost-effective in reducing hospitalisation and preventable use of the wider public health system.

Complexity

Patients need their health insurance products to be clear, understandable and to provide maximum certainty and peace-of-mind in relation to both their level of cover and their out-of-pocket costs.

The Government should consider the applicability of reforms that have been put in place in other markets such as financial services, general insurance and superannuation where the ability of consumers to make informed choices has been undermined by excessive complexity and a lack of clarity and transparency.

These reforms include no-frills policy options, model rules and standards, a requirement to ensure that policy holders are properly informed about changes to their policies that affect them, and clear and understandable statements of the benefits and out-of-pocket costs for policy holders.

The number of available products in the market make it very difficult for consumers to make valid comparisons across the full array of private health insurance policies. While there may be a need for some rationalisation, health insurers should be able to innovate and tailor their offerings to meet the diverse needs and circumstances of their policy holders.

Managing Risk

The incentive structure should work in a way that encourages health insurers to provide the level of hospital cover that meets their members' needs, whilst rewarding those insurers that are efficient and proactively manage their patient cohort to reduce their rates of hospitalisation.

At the same time, health insurers should have the ability to encourage and reward younger policy holders who are less likely to be at risk of hospitalisation and hence provide a greater ability for insurers to manage their overall levels of risk and maintain premiums at more affordable levels for the wider population.

There is a need for a thorough economic analysis of the complex interaction between Lifetime Health Cover, the Medicare Levy Surcharge and the Community Rating system.

Lifetime Health Cover and the Medicare Levy Surcharge effectively act as "sticks" to encourage younger and higher income individuals and families respectively to take out private health insurance. They have the twin objectives of reducing the burden on the public system and broadening the pool of privately insured policy holders beyond those most likely to require hospitalisation.

However, it is not clear whether either of these policies is effective in achieving these objectives or whether alternatives such as rewarding non-claiming policy holders and requiring higher income earners without private health insurance to make a financial contribution to their own public hospital costs would deliver better health and fiscal outcomes.

Such alternatives may also encourage health insurers to build longer term, health-focussed relationships with their policy-holders and reduce their current pre-occupation on managing issues of customer churn.

Community rating should be retained to ensure older, sicker patients continue to have affordable access to private health insurance. However the current risk equalisation system penalises health insurers that actively try to help their higher risk patients stay out of hospital.

A prospective risk-based capitation system would encourage insurers to invest in preventative health and chronic disease and medication management systems, incentivising their clients to make better lifestyle choices leading to better health outcomes and cheaper premiums. It would also add coverage and value to private health insurance products, reversing the current trend, and reducing the incentive to focus on offering highly exclusionary products.

There should also be changes made to the regulations to allow a broader set of chronic disease management programs and preventative and wellness programs to be included in a hospital product – currently many such programs are only possible in general treatment products. Private health insurers would then have more incentive to invest in such programs, because they would benefit from claims savings in the private hospital system. The Government would also benefit from the greater investment in these programs, from lower costs in the public system.

General/Ancillary Treatments

Federal Government incentives for general treatment or ancillaries should be focussed on treatments for which there is evidence that they provide better health outcomes for the patient and are cost-effective in reducing hospital presentations and readmissions, taking pressure off public hospitals. Post-discharge medicine reconciliation in the community pharmacy is an obvious example as are diabetes care and point-of-care testing for at-risk patients with chronic health conditions. Preventative and wellness programs focused on areas such as smoking and obesity, which are proven to reduce the onset of preventable chronic conditions that put patients at high risk of hospitalisation should also be included.

Some current private health insurance ancillary services have little or no link to hospitalisation and arguably should not be subsidised by the Government. Government could encourage self-provision for the cost of these services through tax-effective health savings accounts. Private health insurers could offer these accounts with transitional arrangements put in place. Core ancillary services such as dental and optometry are well-established in the market and should be retained. Services for which there is little or no clinical evidence, and which are principally used by private health insurers to market to the young, fit and healthy, should not be subsidised by taxpayers.

The regulatory environment should not include barriers that prevent patients from accessing services through their private health insurers that will minimise their likelihood of hospitalisation. Rule 12 of the Private Health Insurance Rules is unnecessarily restrictive and should allow private health insurers to access health professionals such as pharmacists for the treatment of patients with chronic health conditions. This is particularly important given many of these patients have highly complex medicine regimens, and medication non-compliance is one of the principal causes of unnecessary hospitalisation and readmission after illness or surgery.

Role of Private Health Insurers in Primary Care

While private health insurers should be encouraged to proactively manage their patients to reduce unnecessary hospital admissions and readmissions, their role is not to establish an alternative primary health care system. Rather they should concentrate on financially enabling the delivery of services that are linked to their core hospital related purpose, working with existing primary care providers such as doctors, dentists, nurses, pharmacists and allied health professionals.

Facilitating a complementary privately financed market for these primary health care services which reduce the likelihood of hospitalisation will enable Federal and State Government to focus their attention on providing direct funding for the provision of similar primary health care services that reduce the unnecessary hospitalisation rates of non-insured patients, particularly the aged and socio-economically disadvantaged.

Private health insurers should have reasonable access to their policy holders' primary health care data to enable them to identify their risk of hospitalisation and to take proactive steps to minimise this risk by encouraging members to avail themselves of their general treatment options. The provision of this patient information could be facilitated through the My Health Record, with appropriate privacy and patient consent mechanisms.

Rural and Indigenous

Traditional in-hospital care is increasingly being provided from outside the four walls of the hospital precinct. This is particularly the case in terms of non-acute care, the provision of services such as chemotherapy and dialysis, in regional, rural and remote areas, as well as Aboriginal and Torres Strait Islander communities.

The regulatory environment should focus on enabling the most cost-effective and accessible delivery of traditional in-hospital services rather than the location from which these services are provided. In rural and remote communities, hospital related services and consultations should increasingly be provided remotely using video-conferencing facilities in sites such as community pharmacies, community health centres and remote Aboriginal health services, enabling better and more cost effective access to health professionals for the patient and less overall cost to the health system. Private health insurers should be encouraged to innovate in these areas for their clients.

Private Prescriptions

Patients should be able to insure themselves to access non-PBS subsidised, high-cost medicines required to treat chronic and life-threatening conditions. With the onset of complex, specialised and personalised medicines, the need to access these expensive treatments in the private market is increasing. Like hospital costs, they are treatments that many patients cannot reasonably be expected to access from their existing financial resources and should be insurable, possibly through a form of trauma insurance. At the moment, the current claim limits are totally inadequate in terms of meeting a reasonable proportion of the costs of these expensive, non-PBS subsidised medicines, which can be a matter of life and death for patients with rare cancers and genetic disorders.

Health insurers should provide greater transparency and certainty for patients regarding the medicines they cover and the level of cover. Patients should be able to insure themselves at levels that minimise the cost of these medicines and should have the flexibility to utilise their wider general treatment pool (and possibly their hospital pool in defined circumstances) to assist in the cost of the provision of these medicines.