# Health Sciences Australia

Australian Council of Pro-Vice-Chancellors and Deans of Health Sciences

4 December 2015

Ms Janet Quigley
Assistant Secretary
Primary Health Care Advisory Group Taskforce
Department of Health

Email: PHIconsultations2015-16@health.gov.au

Dear Ms Quigley

**Submission – Private Health Insurance Consultations 2015-16**

I am writing in my capacity as Chair of the Australian Council of Pro Vice-Chancellors and Deans of Health Sciences (ACPDHS), in response to the consultation process announced by the Minister for Health, the Hon Sussan Ley MP, regarding concerns about Private Health Insurance (PHI) coverage. I understand the Department is accepting submissions on the issue as part of the consultation process.

ACPDHS is the peak representative body for Australian universities that provide pre-professional education in allied health sciences. Member universities, by their nature, are the health science heavy universities in Australia, and are proud in the fact that we take a whole of health systems perspective. Council members take a systemic approach and aim to make a positive and informed contribution. Council members meet regularly in a constructive dialogue with senior officials from relevant agencies, including the Health portfolio.

In launching the consultation process Minister Ley suggested the PHI process, and other areas of current reform (such as the White Paper on the Reform of the Federation, and the Government's reviews of primary health care and mental health) , *"should not (to) be seen as a series of isolated initiatives. ...Individually each is only part of the health puzzle."* The Minister also indicated the importance she places on *"ensuring that Australians have access to information, choice and affordable health care"*.

The Minister noted the $6 billion annual taxpayer investment made through the Private Health Insurance Rebate; the Medicare Levy Surcharge; and Lifetime Health Cover, and that this process seeks to identify how the effectiveness of this investment might be improved for consumers in particular. The engagement of Professor Graeme Samuel AC to assist the Department in this work is very welcome.

The Council's submission focuses primarily on issues that impact the relative value and effectiveness of PHI in our health system, especially in rural and remote Australia. The *Issues Paper* points to the relatively low take-up of PHI by people living in rural and remote Australia. Several factors contribute to this and need to be considered:

1. People with low income levels are less likely to take out PHI or to take it out above basic coverage requirements.
2. People living in rural and remote Australia have, on average, lower incomes than those living in metropolitan and urban Australia.
3. Many of the private hospital and other health services (for example ancillary services provided by private allied health professionals) available in metropolitan areas do not exist in many rural and remote communities, or are difficult, time-consuming and costly to access. Consequently, people tend to be more reliant on public health services.
4. Population health statistics (from MBS data, the Australian Institute of Health and Welfare (AIHW) and elsewhere) indicate people in rural and remote Australia have fewer interactions with the health system, and when they do it is more likely to be with a public hospital. Unfortunately, these figures also strongly suggest these people are more likely to delay or forego important treatment, leading to worse health outcomes overall.

Other factors combine to deliver poorer health access and outcomes in rural and remote areas. Some of these are structural issues. For instance, health workforce numbers are skewed toward higher population centres. This includes many allied health professions. If they work in rural and remote areas, allied health professionals are more likely to do so as part of the public system (in hospitals or community settings) because private practice is often not a viable commercial proposition. This serves to limit services and, in turn, reduce the benefits of private insurance. However, for holders of all-inclusive PHI, any reduction in ancillary benefits would further erode perceived PHI value and increase the load on public sector services.

Importantly, it is the combined effect of these factors that are likely to influence most people's choices. Recognising this, if a marked increase in PHI coverage among people living in rural and remote Australia is being sought, action needs to be taken to address the mix of underlying factors that constrain take up currently.

The value of PHI in the Australian context is based around the notion that people can access basic, quality health care and that PHI provides for something additional. This provides the incentive for people with the discretionary means to purchase PHI – for reasons of choice of health professional and facility, earlier treatment, treatment options (including those covered by ancillary benefits), peace of mind and so on – to do so. Where access to such health services is limited, many will see a decision to not take out insurance as rational. Arguably, even at higher income levels it may be that people who live in rural and remote Australia may take out PHI for different reasons (such as to avoid the Medicare Surcharge or due to concerns about severe emergency), than their metropolitan counterparts may be. This is a fundamental issue: why would people insure themselves for things they have little expectation of being able to access, even if eligible to receive a rebate if they do so?

Notwithstanding the need to improve, Australia is fortunate to have a world-class health system. We welcome the Minister's intention to see close integration of the health reform agenda.

This brings me to a final point: the Council is concerned that possible funding cuts in the Health portfolio will negatively impact the development of integrated care and distribution of appropriate health workforce. Any improvement in health service and outcomes in rural and remote Australia must include efforts to improve health workforce distribution.

Council members understand Ministers are considering savings proposals for the next Budget, or possibly beforehand. There is considerable uncertainty, for example, about whether the Health portfolio will continue to fund the Clinical Training Fund (CTF) and associated support for Integrated Regional Clinical Training Networks (IRCTNs). The CTF programme for example, has allocated around $78M per annum to support innovation and expansion in clinical placements. Positive clinical education experiences in rural settings increases the likelihood of people choosing to practice in those settings once they graduate.

Most contracted arrangements for these programmes cease at the end of this calendar year, and no advice has been provided as to whether they will continue. If CTF and IRCTN funding ceases it will ultimately have a negative impact on the health services available, especially people living in rural and remote Australia. It would certainly mean the loss of clinical education opportunities in rural and remote Australia including in practice settings such as aged care facilities and primary care settings where workforce shortages are particularly acute. This would reinforce some of the problems that currently constrain the take up of PHI in rural and remote Australia.

If you would like to discuss these or other relevant matters, please contact Allan Groth (Policy Adviser, ACPHDS) on 0448 293 245 or email allan.groth@jcu.edu.au, in the first instance.

Yours sincerely

Professor Ian Wronski AO
Chair
Australian Council of Pro-Vice-Chancellors and Deans of Health Sciences