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PRIVATE HEALTH INSURANCE

A wintry fleece

Pharmacy consumers aren't the only ones getting fleeced. Health fund members were told this month that their premiums would be increasing by, on average, 7.96%. The health funds and the Government were quick to put the blame on other service providers. Doctors' costs had risen by 19% over the last year (largely through all of the gap cover schemes), prostheses costs had increased by over 18% and hospital costs by around 10%. The question nobody was asking, though, was why? How is it that service providers just put up their costs, the health funds just pay them and then pass the costs on to consumers? Why aren't the health funds out there, negotiating hard on behalf of their members?

There are two reasons why it seems as though premium increases are likely to be a permanent fixture. First, negotiating with service providers, especially doctors, is likely to be difficult and uncomfortable for health funds. Whenever the health funds have mentioned cost control in the past the Australian Medical Association (the doctors' union) has kicked up a huge fuss, claiming that the funds are going down a path of Americanised 'managed care' where quality care is compromised because of unrealistic cost controls imposed by the health funds. These campaigns have been successful in the past as most people are more comfortable having their doctor rather than their health fund determine what type of care they get. The AMA also argues that

attempts to control costs will limit consumer choice, and on this issue they may have a point.

Private health insurance is marketed as being all about choice — choice of doctor, choice of hospital and choice of time as to when you undergo the procedure. Unfortunately, cost control is just not compatible with unlimited choice. If health funds negotiate contracts only with the lowest-cost providers then some providers will not have contracts with funds. Some costs will therefore not be covered and will have to be met by consumers.

The other problem that health funds face is a change in their age profile. While young people have been leaving private health insurance, older people have been joining. Since September 2000 around 366,000 people aged under 55 have left private health insurance and 284,000 'over 55' have joined. In the last quarter alone there was a net gain of 34,000 — 31,000 of whom were aged over 55. Coincidentally, 55 is about the age when people stop being contributors to health insurance and start being beneficiaries — that is, they take out more than they pay in premiums.

In some ways the health funds can't win. They can't negotiate too hard with doctors because they just don't have the political clout. And when it comes down to it, it is far easier to pass the costs on to consumers than to have a public fight with the doctors' union. The Government has set policies that make it more likely that older and more expensive customers will join health insurance putting more upward pressure on premiums.

To meet growing costs, health funds have a choice of increasing premiums or cutting benefits. According to the Private Health Insurance Ombudsman they are doing both. "There are also signs that, in their efforts to keep premium increases to an acceptable level, some funds are delivering their health insurance products by reducing benefits or other conditions and allowing more patient gaps." All of these factors make private health insurance a pretty unenticing product for consumers. While the Government has been very good at getting people to take out private health insurance they have not been so good at ensuring that consumers who have bought the product are actually getting value for money. In fact current policy settings make the whole system unstable. Until there is a broad ranging evidence-based review of the whole system it seems consumers are doomed to high premiums and decreasing value from their health insurance.

OUR OBJECTIVE

To ensure that consumers with private health insurance receive full product information and value for money.

