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Department of Health
GPO Box 9848
Canberra
ACT 2601
phiconsultation@health.gov.au

Consultation Paper: Private Health Insurance Reforms – Second Wave

The Australian Society of Anaesthetists (**ASA**) is the peak body representing the professional interests of specialist anaesthetists. Its mission is to support, represent and educate Australian anaesthetists, in order to assist them to provide best possible patient care.

The ASA thanks the Federal Government's Department of Health (DoH) for the opportunity to respond to its Consultation paper "Private Health Insurance Reforms – Second Wave". The ASA certainly supports efforts to encourage private health insurance take-up by Australian citizens.

Specialist anaesthetists constitute the largest individual specialty practising in the private hospital sector, and as such the ASA is an essential stakeholder in efforts to reform the private health insurance (PHI) industry. Not all of the specific reforms being considered here are relevant to anaesthesia practice, however, and the ASA will highlight such instances where they occur.

Consultation 1: Increasing the age of dependents to encourage younger people and also people with a disability to maintain private health insurance

The ASA certainly agrees with the basic premise behind this concept – that encouraging younger people to maintain PHI membership will contribute to improved affordability and sustainability of the sector.

The ASA agrees that the increasing the allowable age of dependents to 31 by the least complex method is appropriate, particularly if this allows for a lower premium for younger people.

The ASA does not have specific expertise in the care of those with a disability, but supports the general concept that removal of the age barrier to PHI coverage here, is appropriate.

Consultation 2: Expanding Home and Community Based Rehabilitation Care

The ASA agrees that options for non-admitted post-operative rehabilitation care should be explored. However, the ASA also submits that decisions on the specific healthcare needs of each individual patient must be left to the treating clinician. Private health insurers have a vested interest in containing costs, in order to maintain financial profitability. They must not be given the power to override the opinions of expert specialist clinicians, whose primary focus is best care of the patient.

The ASA does not have specific expertise in rehabilitation *per se*, but an essential component of post-operative care is analgesia, especially in major orthopaedic surgery, which is specifically identified in the DoH consultation paper. Anaesthetists are intimately involved in the provision of post-operative analgesia in the inpatient setting, and for this reason should certainly be involved in the planning of early discharge and outpatient-based post-operative care.

A classic example would be the use of a local anaesthetic nerve block (LANB) catheter for post-operative analgesia after major orthopaedic surgery such as joint replacement. Here, the anaesthetist would certainly need to be involved in post-operative care in the case of early discharge to home. Even where the patient is discharged to home after less major surgery, or after a LANB catheter has been removed, ongoing analgesia will be an issue.

Specialist anaesthetists and pain medicine physicians (many of the latter also being specialist anaesthetists) are recognised experts in post-operative pain management and as such should certainly be involved in any reforms in this area. The ASA would be pleased to recommend specific specialist anaesthetists/pain medicine physicians with recognised academic expertise in this field.

Consultation 3: Out of Hospital Mental Health Services

The ASA does not have expertise in this area and will not offer opinion.

Consultation 4: Applying Greater Rigour to Certification for Hospital Admission

Again, the ASA emphasises that private health insurers must not be given the power to override the decisions of expert clinicians. The decision-making process as to where an individual patient, with his or her own unique requirements, will receive best care, must be left to clinicians, not insurers.

DoH states:

"*The Department has been made aware of issues relating to the inappropriate certification of type B and type C procedures by a small number of providers.*"

Without actual statistics this statement has no merit. What percentage of these certificates are issued "inappropriately"? How was this judged? If the number is indeed "small" why is there a need to make major changes? The ASA believes that education of this small number of practitioners would be more efficient and cost-effective.

DoH also highlights the issue of "disputes" between insurers and private hospitals, resulting in delayed payments by insurers. DoH indicates that insurers have, on some occasions, received "insufficient information" in this regard. It is important that this issue is resolved, in order to provide certainty to consumers about the level of their insurance cover, and potential out-of-pocket expenses. Once agreement is reached on how clinicians may formally certify the need for overnight admission in the case of type B procedures, or inpatient treatment in the case of type C procedures, insurers must not be permitted to delay hospital payments.

It is essential to note that clinicians providing care for type B procedures fully intend their patient to be admitted on a same-day-discharge basis. However, unforeseen findings requiring further treatment or complications may arise, requiring overnight admission. Difficult to control post-operative pain, difficult to control post-operative nausea and vomiting, or unexpected delays to emergency cases taking priority and bumping lists, later than expected procedural finishing times are typical examples of such unpredictable events. In these circumstances there is often no time to

go through approval processes, and the approval might be having to be requested later in the evening / after hours. The treating clinicians' judgements are paramount and no attempt by private health insurers to circumvent this should be allowed.

Proposed policy part one: Establishment of a self-regulated industry panel to manage disputes

The ASA agrees that such a panel might appear useful at first sight. However, the statement that private health insurers may "challenge the use of type C certificates they perceive to be contrary to accepted medical practice" is of significant concern.

Private health insurers do not have the expertise to make such decisions. Their motives are purely financial. Again, insurers must not be given the power to overrule clinicians' decisions. If agreement can be reached on how a clinician can formally certify that a type B procedure requires overnight stay, or a type C procedure requires inpatient care, insurers should have no power to override this, and a dispute resolution panel would not be necessary.

Proposed policy part two: Encouraging the development of clinical guidelines for type C procedures requiring hospitalisation by medical colleges

The ASA agrees that the medical Colleges, Associations and Societies should be intimately involved in the development of such guidelines. This is the safest and most effective way to develop the formal certification process for type C procedures, referred to by the ASA above. Again, it is imperative that once such agreed certification has been provided by the treating clinician, private health insurers must not have the power to override this.

Proposed policy part three: Escalation of disputes or severe breaches to the Professional Services Review for decision

As DoH correctly states, the role of the PSR is to "*protect the integrity of Medicare and the PBS*".

The ASA submits that the PSR has no role in the decision-making process regarding a patient's admission to hospital. Nor should it. Medicare and the PBS are not involved in funding at this stage. There will certainly be Medicare funding for medical practitioners' services during such admissions. The use of PBS-listed medications will also be needed in the majority of cases. However, these sources of funding will be required regardless of whether a type B procedure requires overnight admission, or a type C procedure requires inpatient care.

The PSR's role must be confined purely to correct claiming of Medicare items, and appropriate prescribing practices for PBS-listed pharmaceuticals. It should have no role in deciding when and where care is provided. "*Expansion of the PSR's authority and functions*" in this way is inappropriate.

The ASA submits that where there is concern about "*inappropriate certification for hospital admissions*", the correct approach is to refer the case to the Medical Board of Australia. Only the Board should have the authority to discipline practitioners for "*egregious behaviour*" in this area (again noting that DoH has provided no evidence as to how frequently such "*egregious behaviour*" actually occurs).

If you require any further information or would like to discuss further, please do not hesitate to contact Ms Jacintha Victor John, Policy Manager on (02) 8556 9720 or via email jvictorjohn@asa.org.au in the first instance.

Yours sincerely,

Dr Suzi Nou
President
Australian Society of Anaesthetists