Private Health Insurance Branch
Medical Benefits Division
Australian Government Department of Health
Email: phiconsultation@health.gov.au

Dear Department

Thank you for the opportunity to provide feedback on the Department of Health Consultation Paper: Private health insurance reforms – second wave December 2020.

Catholic Health Australia (CHA) is the peak body for Australia's largest non-government grouping of health, community, and aged care services accounting for around 15 per cent of hospital-based healthcare in Australia. Our members provide around 30 per cent of private hospital care, 5 per cent of public hospital care, 12 per cent of aged care facilities, and 20 per cent of home care and support for the elderly. CHA not-for-profit providers promote the ministry of health care as an integral element of their mission and work to fully provide health care to the sick, the aged and the dying. This ministry is founded on the dignity of the human person, giving preference to the needy, suffering and disadvantaged.

Private hospitals fulfil an essential role in the Australian health care system – in 2018-19, private hospitals provided over 4.6 million hospital separations out of a total of 11.5 million across Australia – around 40% of total hospital separations. They provided nearly half of the day stay separations in Australian hospitals in 2018-19 (46%) as well as over 80% of inpatient rehabilitation separations and nearly 60% of mental health separations. Across the Australian health system, there is a heavy reliance on the private health care sector to care for millions of Australians and the effectiveness of the Australian public hospital system is heavily reliant on the effective operation of the Australian private hospital sector. However, of most relevance to this consultation, is that private hospital services are heavily dependent on the private health insurance (PHI) sector for their ongoing operations; and their vital contribution to the health of millions of Australians is almost entirely predicated on a viable PHI contribution to their funding.

Despite this inherent grounding in broader health policy, PHI in Australia is often considered, and indeed presents itself as, a market product. Doing so is problematic as it sets a framework for policy analysis and reform based on such concepts as market forces, profitability, and consumer choice and autonomy. None of these are applicable to PHI, at least to their full extent. Rather, the PHI industry is characterised by heavily regulated inputs and outputs which are designed for social policy purposes rather than to address an unmet need in a free market. In undertaking any reforms to PHI, it is far more helpful to see the PHI system as a conduit through which various public health outcomes could be achieved by

Government, and as the principal vehicle by which Australians contribute to the costs of their own health care.

This is not a criticism but rather an insight on the importance of the lens through which PHI is examined. And it is through this lens that CHA provides its response to this consultation paper – that is, how the proposed reforms contribute to an effective and efficient health system for all Australians.

In providing our consultation responses at Appendix One, CHA strongly recommends a further round of multilateral discussions and negotiations with key stakeholders to ensure that the critical issues and nuances pertaining to each proposal are not lost in these written submissions.

If you would like any further information on CHA's response, please contact Mr James Kemp, Director Health Policy at jamesk@cha.org.au.

Yours sincerely

Pat Garcia
Chief Executive Officer

8 February 2021

Appendix 1: Catholic Health Australia response to the Department of Health Consultation Paper: private health insurance reforms – second wave December 2020

Consultation 1: Increasing the age of dependents to 31 to encourage younger people, and also people with a disability, to maintain private health insurance.

Key Points:

- CHA supports this policy proposal and has been advocating for this change for a number of years.
- This proposal does have the potential to increase complexity for policy holders, with a wider variety of policy options. Clarity for policy holders is an important factor in maintaining PHI membership, and in fact was a key driver for the first wave of PHI reforms. Therefore, CHA recommends that the new age for dependents up to 31 years old be made mandatory, rather than discretionary, and that the criteria and definitions agreed through this consultation, in whichever form they take, should be consistent and universal.

This is a sensible policy which aligns the age of dependents on a family policy with the age at which the lifetime healthcover loading kicks in, thereby removing the 5 to 10 year gap in which PHI offers very little value for young people (statistically, they will be net contributors until they are around 55) and no penalties for not holding PHI (unless they are high income earners). Indeed, CHA has been calling for these reforms for some years.

These new allowances should not be voluntary for PHIs. All insurers should be required to offer policies for families with dependents up to age 31, and not be allowed to self-determine the age at which dependents are cut off from their family policy. This would otherwise create additional confusion in interpretation and understanding of insurance policies, and reduce the mobility of policy holders to change insurers.

Notwithstanding the need to make the changes mandatory to provide clarity for consumers, the particular policy questions on criteria and definitions (e.g. consideration of the eligibility of full-time versus part-time students) are best addressed by other stakeholders who have expertise is these areas. It is also important to recognise the effect on premiums, and modelling should be undertaken to understand the cost of premiums to families (i.e. would it increase and cause some families to drop out of PHI).

CHA strongly believes that whatever criteria and definitions are agreed, they must be consistent and universal.

<u>Consultation 2</u>: Expanding home and community based rehabilitation care

<u>Key Points:</u>

- CHA supports the expansion of out-of-hospital care for rehabilitation as it increases the range of care options available to patients and clinicians and thus facilitates the right care, in the right place, at the right time. In order to make this work, and as outlined in the recommendations below, it is critical that funding is flexible and provides for the care required as prescribed in the patient's rehabilitation plan.

- In expanding OOH care, maintaining the quality of care provided is essential. Patients need to trust that the care they receive at home is as good as what they would receive within a hospital setting. This reform cannot be used to undermine the role of rehabilitation as a specialist field of medicine, and replace evidence-based models of care with community service models provided by private companies which are of lower quality and not governed by the same clinical standards and governance as those delivered through hospitals. The patient also needs to trust that the provider isn't in any way influenced by anything other than the interest of the patient. Therefore, CHA recommends that:
    - OOH programs funded through Private Health Insurance should only be delivered by a hospital, or under the clinical governance of a hospital; and
    - Funders i.e. Private Health Insurers, cannot provide these services, and cannot own providers of these services, except in partnership with hospitals.

- Investment in this model of care must be supported. A default rate for accredited providers will provide the surety and confidence to scale-up OOH services and ensure they are available for patients. A default rate will also ensure insurers, should they continue to be allowed to be both funders and providers, do not just channel patients through their own services and shut out other providers from delivering theses services.

Out of Hospital (OOH) care is an opportunity to ease pressure on the health system and provide patients with better, and more flexible, care. Compared to traditional in-patient care for medically stable patients, OOH care can often be more efficient and effective, with lower readmission rates, shorter length of stay, and decreased rates of mortality, and increased patient satisfaction.

The funding mechanisms which allow the private health system to operate – specifically, Medicare and Private Health Insurance legislation – work relatively well for care delivered in a physical hospital setting, but have not kept pace with innovations in healthcare. They are

unnecessarily prohibitive and OOH care has been left behind. As a result, OOH care is underutilised in Australia, and is now often described as the 'missing sector' of the Australian health system. Without reform, OOH care will continue to be fragmented, limited and falling well short of its potential.

In 2020, Catholic Health Australia undertook a comprehensive review of the barriers which are holding back OOH care, and proposed a number of changes and solutions which would allow OOH care to flourish.

Changes are required to the *Private Health Insurance Act 2007* and Medicare Benefits Schedule (MBS) to expand the range of care options available for patients. These reforms are about ensuring that each patient will receive the right care at the right place at the right time, based on their assessed needs and goals – for some patients, this will mean accessing in-home rehabilitation and for others with higher complexity and social needs, in-hospital treatment will continue to be the most appropriate mode of rehabilitation care for them.

Critical to this expansion in care options will be the implementation of governance and standards in OOH care. This means that the role of hospitals – and the quality standards and clinical governance they bring to care – has never been more important. This reform cannot be used to undermine the role of rehabilitation as a specialist field of medicine, and replace evidence-based models of care with community service models provided by private companies which are of lower quality and not governed by the same clinical standards and governance as those delivered through hospitals. We need to make sure that OOH care provides high quality care in the home and that patients can trust that is what they will receive. This requires national standards, and it requires reliable data for tracking.

This reform also requires teamwork. Even if these reforms were implemented, OOH care will not grow on its own. Clinicians, hospitals, primary care, health insurers, health departments, patients and carers need to work together to make sure the services are understood and embraced. This means the services must be expanded with the patient at the very centre of the design, and with their interests at heart.

The sections below outline the changes required to funding models, quality standards and care pathways in order to transform OOH care from the "missing" sector into a flourishing and highly effective sector which is a major contributor to health outcomes across Australia as well as the financial sustainability of our health system.

CHA Recommendations to enhance out-of-hospital rehabilitation care

Creating effective funding models for OOH care

The funding models for OOH care are generally underdeveloped and restrictive, particularly in the private sector. Creating and facilitating appropriate funding mechanisms, particularly through changes to the *Private Health Insurance Act* 2007 and Medicare Benefits Schedule (MBS), will increase the uptake of innovative and high quality OOH models.

Recommendation 1: The Government should amend the *Private Health Insurance Act* 2007, and the rules around its implementation, to enhance the capability of PHIs and healthcare providers to form collaborative arrangements that fund OOH health services.

Recommendation 2: The Government should extend the current minimum default benefit to OOH services provided by, or on behalf of, private hospitals.

Recommendation 3: The Government should create a funding mechanism that covers OOH services through a combination of MBS rebates and PHI benefits (akin to the mechanisms used for in-hospital care), including:

- specific MBS items for development of the proposed Rehabilitation Plan, OOH care provision, coordinated clinical liaison and consultation (e.g. regular multi-disciplinary team meetings), including telehealth (for example, administration of intravenous antibiotics by a registered nurse), and
- episode of care-based payments, reflecting the services required to provide OOH care in place of traditional in-hospital admitted care, and which account for the use of consumables and multi-disciplinary teams (for example, post-surgery rehabilitation delivered primarily by an allied health team).

Recommendation 4: The Government should make specific provision to enable the scale-up and broad-based implementation of small-scale successful OOH programs from proof of concept into national or state-based programs, including seed or support funding until such programs become sustainable.

Promoting quality standards and improving data

The following solutions are proposed to improve consistency in the delivery of high-quality services, improve knowledge of service delivery models through data capture, and provide the necessary reassurance to consumers that the level of care they are receiving is at the same or better level of safety and quality as the care they would receive from in-hospital treatment.

Recommendation 5: The Government should ensure that there is consistency in clinical standards and regulations across OOH services, including staff and training accreditation requirements, patient assessment and monitoring requirements, and information and communication standards between providers, across hospital and community providers. This would bring OOH care into line with recent changes to guidelines for mental health and rehabilitation services, with the Improved Models of Care Committee recognising this work and agreeing these guidelines are a consistent starting point for a common framework in both hospital and non-hospital services.

Recommendation 6: The Independent Hospital Pricing Authority should develop a national definition of OOH care, for both admitted and non-admitted patients, and ensure it is used to inform consistent data collection requirements across all jurisdictions.

Recommendation 7: The Government, healthcare providers and PHIs should publicly promote the benefits of OOH care services, and the options available for consumers to access OOH care in the home or community.

Rehabilitation Plans: Sustaining Care Pathways and the right care, at the right place, at the right time

Recommendation 8: In implementing Rehabilitation Plans and patient benefits:

a. Specialist rehabilitation, and the accompanying patient benefits, should only follow from a referral to the admitting Consultant Physician in Rehabilitation Medicine or equivalent specialist.
b. Rehabilitation Plans must be made in collaboration with the patient and carers and the multi-disciplinary rehabilitation team, and should only ever be completed by a physician who has physically seen the patient (or the equivalent in a Medicare telemedicine consultation).
c. Plans should always include assessment risk factors for patients and providers to ensure that home based or centre based rehabilitation is suitable for the patient and safe for the providers to provide care in the home. When patients require high intensity MDT rehabilitation, it will continue to be provided in an inpatient setting.

Recommendation 9: Rehabilitation Plans must not be subject to input, negotiation or rejection by health insurers.

Recommendation 10: In order to be funded through insurance, OOH rehabilitation should continue to be delivered by, or under the guidance of, a hospital (as the legislation currently dictates). This will ensure the maintenance of quality, patient centred care.

Recommendation 11: Types of care should be flexible to allow for individual rehabilitation goals. The full range of location and mode of rehabilitation care should be as widely available as possible, including inpatient rehabilitation, pre-habilitation and same-day rehabilitation programs, with the ability to move the patient across the continuum of care as assessed on clinical needs and individualised rehabilitation goals. This means that funding sources should be flexible to facilitate this care (e.g. removal of the strict 3-hour rule for same-day rehabilitation programs when not prescribed in the rehabilitation program).

Recommendation 12: The regulatory burden of expanding models of care needs to be carefully considered. For example, currently the HCP data collection does not adequately accommodate reporting of outpatient or in home rehabilitation. Rather than trying to amend the HCP to accommodate outpatient / in home therapy, a new dataset needs to be created.

Consultation 3: Out of Hospital Mental Health Services

Key Points:

- CHA broadly supports reforms which increase the accessibility of high quality and effective mental health services for those who need them. In particular, the need for community mental health services is well-recognised.
- However, the primary consideration, and what is lacking in this consultation paper, should be to clearly identify the outcomes and services that we, as a society, are seeking, and then to determine the appropriate mechanisms to facilitate this.
- Without such a process, the leap to considerations of new funding opportunities for private health insurers – which is the primary focus of this paper - is futile and will inevitably lead to more services which are not linked to outcomes.

Catholic Health Australia recognises the significant gap in community mental health services, particularly services for young people, along the spectrum of mental health care provision. However, the consultation paper provided by the Department of Health does not adequately explore this gap and the reforms required to fill it, but rather the paper appears to approach the issue with the only consideration being what else can private health insurers fund in this space.

CHA contends that a better process for effective policy development is as follows:

1. Determine what mental health outcomes we would like to achieve as a society, and how these can be measured and evaluated.
2. Consider what services need to be provided in order to achieve these outcomes.
3. Finally, consider the most efficient and cost-effective way to fund these services.

In making these determinations, a number of principles are critical:

- Australia needs to continue to aim for an integrated health system that responds to the needs of the patient, and our community more broadly – not to facilitate the sustainability of insurers and service providers.
- Patients need to trust that their care provider isn't in any way influenced by anything other than the interest of the patient, and therefore an insurer should never be the funder and provider of care. This separation needs to be distinct and transparent.
- Regulation is required to ensure that PHIs are only funding services which are evidence-based and represent value for money. It should preclude organisations without appropriate clinical governance as their ability to consistently achieve high-quality and cost-effective service provision is undermined. The risk of doing otherwise is ultimately lower-quality and higher-cost care, and higher premiums for insurance holders.

- Increasing benefits for mental health service provision, and thus the cost base, for PHIs should come with the expectation of higher premiums rather than cuts to other areas of PHI funding.

Consultation 4: Applying greater rigour to certification for hospital admission

Key Points:

- The premise of this proposal – that more rigour is required on certification for hospital admission due to inappropriate use by clinicians – belies the fact that the process is overly burdensome and administratively costly for hospitals and that the vast majority of admissions are entirely medically appropriate. Policy reform must be appropriate and measured, and does not need to add to administration load.
- CHA supports the development of rules (not guidelines) by the relevant medical groups and colleges that outline which Type B and C admissions are generally medically appropriate. The subsequent certification of admissions which come within these rules should then become redundant. The first reform, which could be implemented immediately, is that no overnight medical admission requires a Type C certificate, or indeed any certification.
- A key principle in determining the ongoing need for any type of admission certification should be whether the patient is insured for the condition for which they are being treated, not the location of the services performed. In some cases, the only place such services can be accessed in rural and regional areas is the hospital facility.
- Should a health insurer have a concern of inappropriate admissions by a particular provider, that matter can be referred to an independent umpire for review, rather than continuing the current practice of widespread and arbitrary investigations by the insurers themselves and the ongoing withholding of legitimate benefits.
- Ultimately, these changes will create more certainty of coverage, and payment of benefits, for patients.

The need for certification of certain patient admissions has become problematic for clinicians, hospitals and health insurers, diverting costs into administration and away from frontline care. Ultimately, patients are negatively impacted due to uncertainty over what they are covered for, and, while relatively marginal, the additional administration cost ends up costing the patient.

CHA strongly supports the development of rules by medical groups which outline which Type B and C admissions are generally medically appropriate. These rules should be comprehensive enough to cover the majority of current certification disputes between hospitals and health insurers, thus reducing the administrative burden.

In developing these rules and applying new billing protocols as a result, the following considerations should be taken into account:

- The first principle for whether a patient should receive benefits for their care needs to be whether the patient is insured for their condition; not where the service is

performed. A critical consideration for the rules will be allowing for continuity of care – that the patient should continue receiving care in the same facility where it would be clinically inappropriate to change locations due simply to funding rules.

- Given the HCP data provided by law to health insurers, which includes ICD coding, the need for additional certification for admissions which fall within the rules should be negligible.
- The rules should consider rural and regional factors, including the fact that certain procedures are only available in hospitals. To allow otherwise would deny access to care for insured patients.
- The developed rules need to be recognised by both hospitals and health insurers, otherwise the entire exercise will be futile.

Should a health insurer have a concern of inappropriate admissions by a particular provider, that matter can be referred to an independent umpire for review, rather than widespread investigations by the insurers themselves and the ongoing withholding of legitimate benefits.

Further to these rules, CHA suggests improved transparency in the listing of Type B and C procedures by the Department, with input from clinicians and providers at this early stage of the process to guide decisions as to whether a particular MBS code describes an admissible patient. This may avoid, for example, certain procedures being classified as Type C when they are not available outside of hospital – thereby creating a service void. A guiding principle in making these decisions should be where in the majority of cases a service is performed in a hospital setting then it should not ever be declared Type C.

Type C – Medical admissions are becoming increasingly problematic from a billing perspective, as Health Insurers are tending to review all medical admissions as a Type C admission due to the fact that the only MBS Item that will be submitted is the doctor's consultation fee. This is despite the fact that HCP data would clearly indicate the legitimacy of the admission. Hospitals (and doctors) should not need to justify medical admissions for patients with conditions such as pneumonia, and this is one example of where the administration is becoming overly burdensome and distracting. One change, which should be implemented immediately, is that no overnight medical admission should require a Type C certificate.

[ends]