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HEALTHSCOPE SUBMISSION: PRIVATE HEALTH INSURANCE REFORM – SECOND WAVE

Healthscope thanks the Australian Department of Health for the opportunity to provide feedback on the consultation: private health insurance reforms – second wave.

While we have responded in good faith to the consultation paper, Healthscope notes the consultation period during COVID has not been optimal for the type of industry consultation that should accompany such important reform. Our hospitals are still being impacted by COVID through regular policy changes and changing state conditions due to new cases.

We would welcome further opportunities to engage collaboratively with others in the sector, beyond insurers who appear to have had significant input over a longer timeframe, to ensure reforms impacting a highly complex system that may change the underlying economics of the sector, have sufficient consideration by all stakeholders.

BACKGROUND

Healthscope is a leading private healthcare provider in Australia, comprising 43 private hospitals nationally, with a presence in all states and territories. We provide care to more than 600,000 patients annually. We place the highest priority on quality clinical outcomes, transparency of reporting and elevating the overall patient experience.

Most patients seen in private hospitals fund their stay through private health insurance (83% in 2018-19, according to the Australian Institute of Health and Welfare), making Healthscope a key stakeholder to this consultation.

We have raised the issues we foresee in the implementation to the suggested reforms. In doing so, we are following a core set of principles we think are pertinent across all health reform;

- The **primacy of clinical independence** is a central tenet for any health reform proposal in this country which must be fiercely protected. Clinical decision making must remain with the overseeing clinician, and there should be no undue influence on the clinician or patient in any way by health insurers or service providers.
- The **critical role of the private hospital sector in the Australian health ecosystem** must be protected**.** This role is significant and necessary for the effective functioning of the health system overall. Private hospitals perform two in three elective surgeries in Australia[1], and although the case-mix of public and private hospitals are fairly different, they also complement and need each

[1] Australian Institute of Health and Welfare, Admitted patient care, 2018-19, Table 6.16.

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other, as COVID has demonstrated. Any reforms impacting private service delivery, funding or private hospital infrastructure, or transfer of risk or cost between players within the system, need to be considered through the lens of their impact on the long-term sustainability of private hospitals which, like public health infrastructure, has a high demand for capital and a long-term investment profile.

- All private health reform needs to improve **the sustainability of the health sector as a whole**. Reform which simply transfers cost between players in the sector is not addressing the long-term viability of the sector or its relationship to the cost of public health provision.

CONSULTATION 1

Increasing the age of dependents to 31, and removing the age limit for dependents with a disability.

Healthscope is broadly supportive of this proposal.

We are concerned with the falling participation rates in private health insurance in Australia, and we welcome the Australian Government's attempts to address this. We note, however, these reform changes are voluntary for the private health insurers to implement.

We suggest the Department of Health monitor both the uptake by private health insurers of this voluntary reform and the subsequent retention or uptake of private health insurance in the relevant age categories through data from the Australian Prudential Regulation Authority.

CONSULTATIONS 2 AND 3

Expanding home and community based rehabilitation and mental health care.

Increasing the availability of home and community care in Australia presents significant opportunities, and the innovation of models of care in home or community settings could be beneficial to patients for whom this is clinically approved and appropriate.

Whilst Healthscope is largely supportive of increasing the availability of different models of care to those patients for whom home or community care is clinically appropriate, there are a number of risks and potential unintended consequences in implementation we wish to highlight.

These include:

- moving away from the primacy of clinical expertise as a driving principle
- breaking the private health sector through allowing anti-competitive behaviour, including through third or full line forcing and prohibitive rates in contracting
- moving Australia towards a US style 'managed care' model
- seeking to influence patients under the guise of patient choice.

Healthscope also offers the Department of Health some implementation suggestions below through mandated accreditation standards and default pricing for accredited providers.

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Primacy of clinical advice

Healthscope holds serious reservations around private health insurers providing healthcare services, given the fundamentally different incentives driving an insurer versus a provider in healthcare.

Whilst there are already a number of these services in place and increasing rapidly, the Department of Health should not endorse a system where patients are only allowed to access care provided by the health insurance company they are a customer of. This is an unacceptable imposition on clinical independence and a concerning shift in the Australian health system towards United States-style 'managed care'.

We strongly oppose health insurers becoming involved in clinical decision making. Clinical decisions and care planning are between the patient and their treating physician, and should be fiercely protected. Health insurers should not be allowed to direct or incentivise care of a patient in any way. It is our concern private health insurers enter the health provider market in order to funnel patients to their preferred care pathway, and may do so based on cost rather than clinical best practice or patient wishes. We are already seeing health insurers purchase stakes in private hospitals and then offer financial incentives to doctors to funnel patients to lower cost models of care at these facilities.

It must be left up to clinicians in consultation with the patient on who would benefit from alternative models of care. It is Healthscope's position private health insurers must not be involved in any clinical decisions and Hospital Purchaser-Provider Agreements (HPPAs) must not be allowed to contain terms and conditions contradicting this.

Potential anti-competitive behaviour by private health insurers and patient choice

Private health insurers already have dangerous competitive levers in their HPPAs seeking to impact clinical independence and their move into owning providers steepens that slope.

Private health insurers must not be allowed to drive contrary terms through HPPAs such a rehabilitation transfer targets, as these are punitive and redundant given it is the specialist or general practitioner who is the custodian of the clinical decision for rehabilitation intervention type (the private health insurer or the hospital).

While allowing for more home and community care providers to enter the market appears to encourage competition, where the providers are owned by private health insurers, the market becomes distorted (through vertical integration) as private health insurers seek to exclude other providers, including through full line forcing and prohibitive clauses contained in HPPAs. It is already the case that health insurers refuse to fund services provided by us, while publicly advertising the same services (e.g. mental health programs) they provide themselves.

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Private health insurers cannot be the gatekeepers of who can access in- and out- of hospital care in a managed care scenario. This undermines the primacy of clinical advice which must remain the driver of determining what model of care is recommended, in consultation with the patient. Therefore, the provision of home and community care services needs to be available to a wider set of providers, in order for specialists and general practitioners to present their patients with genuine choice. Incentivising doctors or other providers to direct care to insurer-owned providers influences that provider in a way that may not be in the interest of the patient. Patients should ultimately be allowed to choose the care they want based on the best clinical advice provided by medical specialists – and this should include in-hospital services if that is the most appropriate care pathway.

Private hospitals already have the infrastructure, expertise and accreditation to provide patients with the care they require, and are well placed to translate this infrastructure and these credentials to home and community care where appropriate.

Healthscope recommends Government imposes a blanket ban on third line and full line forcing in the home and community care markets to ensure competition is healthy, above board and on an even playing field.

Sustainability of the private sector

Whilst Healthscope agrees it is good to remove barriers to alternative models of care, private health insurers must be compelled to work with rather than around private hospitals to ensure continuity of care and enhance patient experience, or risk fragmenting or breaking the private health system.

Each time low-complexity care moves out of the hospital, and fewer complex procedures remain, the per-episode cost of in-hospital care increases further. Private hospitals are able to accept current pricing for hospital services because of this mix of complexity, although insurers continue to challenge these cost structures in a downward manner out of step with the reality of rising health delivery costs. This is ironically similar to the argument some health economists use to describe the situation insurers face, with an increasingly small number of members needing to fund about the same value of claims. If less complex services move out of hospitals, providing complex services at the current price point becomes unviable.

Unfortunately, the existing competitive market between insurers and hospitals is not suitable to fix this viability issue, as the core leverage hospitals have is to choose to go “out of contract” with a funder, which of course makes the viability problem worse in at least the short to medium term.

This is particularly so when the financials of private hospitals need to take into account the long-run cost of capital necessary to maintain major critical health infrastructure for the Australian community (unlike insurers who don’t face these capital costs and appear to be targeting

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investment at lower capital, lower value care such as general practice clinics and day surgeries). If the end result is complex care can no longer be done in private, it will fall to the already strained public sector to carry the load of all complex care and ultimately challenges the long-term viability of the private health hospital sector.

Furthermore, lower cost settings are only clinically safe where higher cost settings are available as a 'back up', i.e. as a safety net were things to go wrong. Yet this unfunded benefit of the acute hospital constitutes a hidden cost; indirectly enabling low cost settings. The proposed model of home and community care is not recognising the safety net of complex hospitals: the hidden cost of moving patients to lower cost settings that need complex hospitals as a 'back up' is not remunerated to the complex hospital.

Private hospitals have critical community infrastructure already in place, and the private hospital sector is an essential part of the Australian health ecosystem. Healthscope recommends the Department ensures private health insurers must not be allowed to undermine the sustainability and clinical safety of private care in the process of vertical integration.

Continuity of care

Continuity of care and having a genuine choice of service provider and care pathway are important for patients across the health sector. Care is best provided where there is a specialist or general practitioner overseeing and coordinating a patient's interaction with the health system. In the private hospital sector, patients are admitted under the care of a specialist, and although a multi-disciplinary team may provide the care, the specialist will devise the best care pathway in consultation with the patient.

The importance of continuity of care is particularly highlighted in mental health care. A patient's relationship with their psychiatrist and care team is paramount, and interruption of care can be detrimental to recovery. If home and community care continues to grow, yet private hospital psychiatrists who have an existing relationship with patients are not included in the provision of home and community care, they will no longer be able to maintain primacy of clinical care. Patients will risk 'bouncing around' the system without a focal point of an overseeing specialist. This will be detrimental across the private hospital system, and particularly so in psychiatry, where every interaction with mental health care providers was another exercise of familiarisation and building trust.

Healthscope sees this as another reason for Government to ensure there is a breadth of providers available in the home and community care sector who are able to access funding from health insurers, rather than a narrow subset of providers owned by health insurers.

Issues specific to rehabilitation care

Orthopaedic joint surgeries are high volume procedures in Australia, and this will continue to grow with an ageing population. At these high volumes, efficiency of operational processes is

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critical, and orthopaedic specialists and private hospitals already have strong incentives to drive efficiency.

To impose a new care plan layer with disruptions into every one of these orthopaedic procedures will add workload and administrative burden across the private health sector. As the current consultation reads, it is likely each care plan, drafted by either the treating specialist or general practitioner (or whomever else is creating the plan), will also require input from the hospital, the health insurer and the surgeon, as well as family input with an overlay of an independent external community provider seeking to secure a preferential referral to their service.

Furthermore, it is difficult to ascertain from the consultation paper how clinicians or health insurers will be able to separate when a care plan will apply and when it doesn't. Ultimately it is likely to apply for all joint replacement patients to ensure it becomes embedded as required practice. This in turn is likely to create additional work for more than half of patients who currently go home after surgery and don't have specific rehab care requirements. So we will be adding in a layer of work with no return and, once again, the effort will most likely be with hospital staff to complete these tasks. Worse, many of the orthopaedic patients who currently go home after surgery without further care necessary may in future be assigned or expect care, and in fact add cost to a separation where previously there was none.

Solutions

Healthscope recommends the following to address some of the concerns we have raised:

- **Recommendation 1: Accreditation of providers**
  Home and community based care providers need to be regulated and require accreditation equivalent to care models in hospitals. Safety of the patient and quality of care need to remain at the centre of any health services provided, whether it is delivered in hospital, at home or in community settings.

- **Recommendation 2: Implementation of standards and guidelines**
  Standards and accreditation need to be fit for purpose and patient-centric. Furthermore, such standards and accreditation frameworks should be industry-led. Having said that, we do not recommend reinventing the wheel; in fact, we note there are industry-developed and agreed national standards for mental health services (from 2010) and guidelines for recognition of private hospital-based rehabilitation services (from 2016) which could be adapted for this purpose. Whilst the latter is for hospital-based care only, the former already contains a framework for community based care.

  We also note the National Safety and Quality Health Service Standards, which have already been adapted to settings other than hospitals, should either by applied or an equivalent should be developed for home and community care settings. This is to ensure patient safety, quality of care, and a level playing field for providers.

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Healthscope is willing to assist with the development of accreditation and guidelines should further consultation be needed on these matters.

- **Recommendation 3: Default pricing structure**
  Healthscope recommends a default pricing structure for accredited providers of home and community care is explored to circumvent anti-competitive behaviour designed to restrict patient access and benefit only the private health insurer. Such a default pricing structure would need to legislate payment of accredited services, regardless of what the hospital provider's HPPA may say, and whether the home or community provider has an HPPA with the insurer. This default pricing safety net has a precedence in second tier pricing in private hospitals.

  Healthscope is willing to work with the Department and other stakeholders on how such a pricing structure (or an alternative) might be developed and maintained.

- **Recommendation 4: Include telehealth and videohealth in home and community care**
  Healthscope recommends home and community care includes telehealth or videohealth where this would be an appropriate clinical pathway for patients, especially in mental health services. Again, these types of services should also be deliverable by hospital providers, and funding mechanisms must be in place to ensure private health insurers fund these services and cannot 'pick and choose' to direct funding to either their own services, or on their own terms. Insurance funding should be agnostic of the provider.

  Healthscope has recent examples through COVID-19 restrictions where care offered to patients was identical to pre-COVID care, with the same psychiatrist, the same time frame and the same care provided, however, health funds have declined to fund the care due to the mode of delivery being telehealth. The patients were thus unable to maintain their continuity of care with their preferred psychiatrist because of the COVID-19 restrictions, when this care was readily available. (At the same time, the insurer was publicly advertising mental health services, not revealing that this meant their preferred or owned services, and not those provided by hospitals or our specialist clinics).

CONSULTATION 4

Applying greater rigour to Type B and C certificates for private hospital care

Healthscope supports lowering the administrative burden of certification in the private health sector. Annually, Healthscope completes a total of 15,000 certificates (about 10,000 Type C and 5,000 Type B), which is about 40 certificates a day. This involves an administrative burden for both the clinician who completes the certificate and the hospital.

Whilst this administrative burden is accepted as part of the funding model in private healthcare, there has been a recent increase of scrutiny of certification by the private health insurers. This has been a trend coupled with their increasing auditing of private hospitals. We estimate about

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10-20% of certificates are regularly disputed by private health insurers, further adding to this administrative burden. A 'dispute' over a certificate will delay payment to hospitals whilst further information is sought. Sometimes, the hospital will have the necessary information on file, other times we need to seek this information from the treating physician.

For each 'disputed' or 'audited' certificate, additional time and cost is necessary to resolve the dispute. Where no resolution can be found, it is either the patient who bears the cost through out of pockets, although more often than not, this out of pocket cannot be passed to the consumer either due to the time lag or because the cost had not been flagged at time of financial consent. The hospital then bears to cost of the episode.

Healthscope supports the development of guidelines by the professional bodies for what would constitute 'agreed clinical reason' for certification of a patient, with an understanding by hospitals and private health insurers that patients falling into the categories of the guidelines cannot or should not be disputed or audited. We believe this would resolve some of the contention around certification. Two of the main issues to flag, however, would be

a) How does the clinical society/association address significant disparity of opinion within their own specialty?
b) How do hospitals address certification for a patient whose clinical need for certification falls outside the listed reasons in the guidelines?

We appreciate the opportunity to provide a submission to the proposed private health insurance reforms and look forward to further consultation on these changes. Should you have any questions or would like to discuss our response, please don't hesitate to contact me.

Signed,

Steven Rubic,
CEO,
Healthscope