Members Health Fund Alliance

Submission to the Department of Health's *Consultation paper: Private health insurance reforms – second wave*

8 February 2021

Members Health FUND ALLIANCE

Putting members' health before profit

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Re: Consultation on Private Health Insurance Reforms Second Wave

The Members Health Fund Alliance (Members Health) shares the Commonwealth Government's desire to improve the affordability, value, and attractiveness of private health cover particularly for younger Australians.

While Members Health broadly supports of the Government's Second Wave Reform initiatives, the feedback from our membership is that it fails to address the 'elephant in room', being the impact of the declining Australian Government Rebate. The decline of the Australian Government Rebate from 30 per cent to just 24.608 per cent overshadows all other Government reform efforts, damaging and eroding affordability of private health cover and forcing more Australians onto the overburdened public health system.

We note that despite massive increases in Commonwealth Government spending on State and Territory run public hospitals, public waits continue to grow and now extend well beyond a year for many procedures. The choice and value that private health cover offers to Australian families is indisputable and it remains our view that the best way to reduce pressure on the public health system is to assist consumers through the full restoration of the 30 per cent Australian Government Rebate.

Australia is fortunate to have a diverse and competitive health insurance industry with funds ranging from the very large to the very small, regional to national, not-for-profit to for-profit, listed to non-listed, Australian owned to internationally owned.

As a group, the alliance of Members Health funds maintain a close relationship with consumers, as demonstrated through high customer satisfaction and trust scores, and membership growth that is more than twice that of the rest of the industry. It is the health funds that know their members best and therefore it is vital that the Second Wave Reforms are underpinned by a philosophy and implementation approach that allows flexibility and sufficient time for insurers to develop and introduce products to market that are tailored to meet the particular needs and expectation of their memberships and communities.

We note the challenges of consultation occurring over the Christmas period and in the midst of the COVID-19 global pandemic. Our membership has uniformly stressed to us in the strongest and clearest possible terms that the implementation timeline proposed in the discussion paper for *'Consultation one'* is unrealistic and cannot be met by industry.

In the interests of achieving a smooth implementation for industry, government and consumers, we strongly advocate that the proposed implementation timeline be extended from 1 April 2021 to at least December 2021. Our submission notes that a 12 to 18 month implementation timeline will be required for the industry to introduce much of the changes. A delayed implementation date will provide industry with adequate time to adapt front and back office systems and process, develop new products, communicate with members and to train staff.

Following extensive consultation with our alliance of funds, the Members Health submission has sought to address all four policies and subsequent questions as set out in the Department of Health's Consultation Paper, released on 17 December 2020, as follows:

Consultation One:
1) Increasing the age of dependents to encourage younger people, and;
2) Removing age limits for people with a disability.

Consultation Two: Expanding home and community based rehabilitation care.

Consultation Three: Expanding funding to at home and community based mental health care.

Consultation Four: Applying greater rigour to certification for hospital admission.

In considering the proposed reforms, Members Health has suggested additional measures to best achieve the Government and industry's shared objective of improving the affordability, value, and attractiveness of health cover.

Members Health commends the Minister for Health on the first wave of private health insurance reforms in 2019. Likewise, we look forward to working with the Minister for Health and the Department of Health, as well as other industry stakeholders, on implementing this second wave of reforms to the private health insurance industry.

Yours sincerely

MATTHEW KOCE

CEO, Members Health Fund Alliance

About Members Health

Members Health is the peak industry body for an alliance of 26 health funds that are not-for-profit or part of a not-for-profit group, member owned, regional and community based. They all share the common ethic of putting their members' health before profit. Our funds represent the interests of more than 3.9 million Australians. All the Members Health funds enjoy close relationships with their membership, are highly trusted and are growing sustainably, including with younger policyholders.

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Consultation One

1) Increasing the age of dependents on family policies, and
2) Removing age limits for people with a disability

- Rising specialist fees, cuts to the Australian Government Rebate and adjustments to the MLS income thresholds remain the key drivers of affordability issues and declining participation, particularly among younger Australians.
- Members Health is supportive of the reform, believing it to be a useful tool in health funds' retention strategies for younger age cohorts.
- Of all the options on offer, Option 3 is the firm industry preference, allowing funds to appropriately price affected policies and manage any cross-subsidisation from the wider pool of insured persons.
- Implementation timing must be postponed to at least December 2021 so as to allow all funds and systems operators to familiarise with the legislation and rules once passed, and to avoid consumer confusion or undermine competition in the marketplace.
- Health funds should retain the right to set the definition of a "dependent". A standardised definition of "disability" should be drawn from relevant existing legislations, such as the National Disability Insurance Scheme Act 2013.

Members Health has undertaken extensive consultation with its 26 member funds and consistent with feedback received, broadly supports the Government's proposal to increase the maximum age of dependants and remove the age limit for dependants with a disability.

Affordability is considered to present a challenge for many younger Australians wishing to participate in private health insurance. Over the five years September 2015 to September 2020, the private health insurance industry has seen a 19 per cent fall in insured persons aged 25 to 29 on hospital treatment policies. Members Health has consistently worked with government and stakeholders to encourage positive reform and industry initiatives to arrest this trend, including the restoration of the full 30 per cent Australian Government Rebate, which has fallen to a historical low of just 25 per cent.

Alongside rising specialist fees and service costs, it is the declining Australian Government Rebate that has had the most profound impact on premium affordability, particularly among younger Australians. And while Consultation One reforms are worthy of consideration, we must also be mindful of the broader policy context and that it will not address the core issues impacting PHI affordability or participation – the declining Australian Government Rebate.

It is the Government that enforces the age limit of dependents, while health funds reserve the ability to determine dependents' qualification to remain on their parents' policy against a fixed criteria set by individual fund rules. The last time the age limit of dependents was potentially revised was prior to the *Private Health Insurance Act*'s passage in 2007 – now 14 years ago.

During that time, cost-of-living pressures that young people face in their formative years of financial and professional independence have shifted. Young Australians now take more time to reach key milestones, such as completing tertiary study, achieving stable employment in their chosen career, purchasing a first home, marrying or raising a family.[1] These milestones have long defined 'adulthood' and provided the foundation for Government policy.

Tracking more than 17,500 people across 9,500 households since 2001, the Melbourne Institute's *Household, Income and Labour Dynamics in Australia Survey 2020* found that in 2017, 56 per cent of men aged 18 to 29 lived with their parents, up from 47 per cent in 2001. More strikingly, the proportion of women aged 18 to 29 living with their parents rose from 36 per cent to 54 per cent.

[1] Australian Institute of Health and Welfare. *Australia's mothers and babies 2018: in brief*, p51 https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-and-babies-2018-in-brief/summary. Australian Bureau of Statistics, *National Marriages and Divorces by age*. 2019: https://www.abs.gov.au/statistics/people/people-and-communities/marriages-and-divorces-australia/

Raising the age limit of dependents is a welcomed, timely reflection of the changing times and has the potential to save younger people thousands of dollars a year. The median single Gold hospital treatment policy costs $2,520 per year before Government rebates. Over the course of five years, that equates to approximately $12,600, which young Australians could be saving or putting towards paying off HECS and university debt or a deposit for a first home.

The reforms proposed in this discussion paper will benefit consumers by providing additional opportunities for insurers compete on new products that focus on enhanced value to meet the diverse expectations of Australian families. The reforms will provide greater flexibility to tailor products that facilitate a smooth the transition from childhood through to young adulthood, helping younger Australians maintain their private health insurance cover without interruption and avoid paying Lifetime Health Cover loading, which commences at age 31. The reform also encourages younger Australians not to become dependent on the already overstretched public health system, where waits for surgery can extend well beyond a year and are expected to become much worse due to COVID-19 backlogs.

Consistent with past submissions to Government, Members Health firmly maintains that cuts to the Australian Government Rebate and adjustments to the MLS income thresholds have had a profound impact on private health insurance participation and that these policy changes are responsible for declining participation, particularly among younger Australians. Our position is that we are broadly supportive of the Government's proposal to increase the maximum age of dependants and remove the age limit for dependants with a disability as it will make a small but nevertheless positive contribution towards improving affordability, value, and attractiveness of health cover for younger Australian.

Timing of Implementation

The 1 April 2021 commencement date set by the Department of Health is unrealistic and cannot be met by industry.

The implementation timeline is dependent on the date legislation is passed and rules are set. If the rules set by Government are in place by no later than 15 March 2021, then the earliest possible implementation date for industry would be early December 2021. An early December 2021 implementation date is our preferred timing.

To accommodate these reforms, health funds will need to undertake complex and costly IT and software updates, as well as sufficient time for product design and pricing, staff training and member communications. Work on these updates cannot commence until new rules have been set by Government.

There is concern within the industry that further public Government advice on the April 1 implement date, despite the reform being voluntary, will leave funds vulnerable to media and consumer criticism. We can confirm that following the announcement of the reform in late 2020, some funds received complaints from consumers about the raising/removal of the age limits not already being in effect.

With that in mind, if the April 1 implementation date is pursued, we believe it will result in poor consumer outcomes and confusion and unwarranted media criticism of the industry, especially for the overwhelming majority (if not entire) of the industry that will not be able to implement the changes immediately.

While the reforms remain voluntary for health funds, it would be disadvantageous to all stakeholders to enforce an unrealistic implementation date that few if any health funds could meet and that will overshadow any positive benefits of the reform. A revised implementation date should therefore be clearly communicated publicly by the Government at the earliest possible opportunity.

Regulatory reporting

As noted above, to accommodate these reforms, health funds will need to undertake complex and costly IT and software updates, as well as adapt existing regulatory reporting process to accommodate the new insured groupings and products.

Members Health's preference for regulatory reporting these changes is in line with that of our industry partner, HAMBS: regulatory reporting should align with the new PHI reform data collection (HRF 605.0) or a new similar report and minimise any changes to the Statistical data by State report (HRF 601.0).

1) Increasing the maximum allowable age for dependents in PHI from 24 to 31 years

Following extensive consultation with member funds, Members Health supports Option 3, as outlined in the Consultation Paper.

> ***Creating a new category of dependent child and two new insured groups***
> *This option creates a new category of dependent child. The age range for the new dependent child category would be 25-31. This allows a dependent child to progress through infant dependent, to student dependent and/or non student dependent, to the new category of child dependent. In creating a new category of dependent child it is necessary to create a new single parent insured group and a new family insured group. This option:*
>
> - *increases the complexity of PHI by adding a new category of dependent and two new insured groups;*
> - *maintains the flexibility of insurers to define a lesser age range (between 25 to 31) and other requirements in their rules; and*
> - *allows for a three stepped pricing approach for insured groups with dependent(s), within a product.*

As noted in the Consultation Paper, this approach has the potential to increase the administrative burden on health funds. However, the benefits of the option outweigh the disadvantages posed by added complexity.

Foremost, with the flexibility of an additional age group, health funds will be able to more accurately price policies based on the service utilisation of the 25 to 31 age cohort.

Health insurers devote significant time and actuarial resources to examining the healthcare needs and trends of each age cohort to ensure appropriate and relevant coverage for hospital and general treatment services. Having a dedicated child dependent category for 25 to 31 year-olds will similarly enable funds to tailor products that reflect the dependent's healthcare needs and expectations.

Given the sustainability challenges facing our industry, the reform must allow funds the flexibility to provide affordable products for young adults, without requiring substantial cross-subsidisation of other age groups. Option 3, we believe, supports this flexibility and enables them to differentiate price points for parent's wishing to cover their 25-31 year old dependents (should funds wish to do so).

Another reason that Option 3 is the preferred approach over the alternatives, is that the added flexibility around pricing is likely to increase the number of funds participating. Given the reform is optional, if the Government does not give funds the option to charge a different price for over 25s or define dependants, some funds may choose not to participate.

Fundamental to all the Members Health funds is a shared mutuality ethos that drives their unwavering commitment to support policyholders throughout all stages of their life – from childhood through to adulthood and into old age. That commitment is highlighted through industry statistics showing that, as a group, the Members Health funds consistently lead when it comes to customer retention and growth across all age groups, including younger policyholders.

The consensus view across our 26 member funds is that Option 3 will allow health funds to develop improved longer term pricing philosophies that transition through the stages of young adult life. In combination with other optional incentives, such as age-based discounts, we are confident it would strengthen existing retention strategies to ensure a smooth transition from dependent membership to individual.

On the subject of precisely when a dependent will be required to exit their family policy, under the proposed higher age limits, Members Health is of the firm belief that this should be consistent with all

other age rules (21 and 25) which has the dependant coming off their parents cover on their, 21st or 25th birthday. Therefore dependents should come off their parents cover on their 31st birthday.

We reiterate that along with these changes would come an administrative burden to funds. Industry will require sufficient time to adapt IT systems and products, based on the rules approved subject to legislation, to allow for the added dependent category and insured groupings.

Finally, we would like to point out that several health funds currently use two insured groups (Rule Reference 5(1)(c)(i) and 5(1)(c)(ii)) to construct a Young Adult Support Plan (YASP) as a mechanism to increase participation and conversion of young adults. These insured groups are described as "not in use" within the Consultation Paper, however, that is incorrect as they are currently in use. Therefore, these two groups cannot be removed from the list of insured groups (as suggested in the Consultation Paper). These groups must be preserved in the updated Rules so that health funds can continue to operate these policies post April 1 2021.

1.1. Consideration of the Age-Based Discount (ABD)

If Option 3 is adopted, Members Health supports the retention of the optional age-based discount for individuals exiting their family policy for the first time at age 31.

The ABD allows funds to offer people a discount of 2 per cent per year that they were covered between the ages of 18 and 29 years – to a maximum discount of 10 per cent.

We acknowledge that this approach would require wider consideration from IT and regulatory systems operators, and potentially add complexities for business processes. Nevertheless, the consensus view of our constituent funds is that they be allowed the option to retain the ABD for individuals exiting their parents' policy at age 31, as an additional incentive to encourage young Australians to remain covered into their adulthood.

Allowing health funds the option to apply ABD will assist them to further develop coverage pathways and communications strategies that seek to achieve the shared industry and government objective of improving affordability, value, and attractiveness of health cover for younger Australians.

1.2. Statutory definitions of Dependent

The position of Members Health is firmly that health funds should retain the right to set the definition of a dependent.

The Government's reforms to the maximum age of dependants provides an opportunity for private health insurers to compete on the breadth and flexibility of their private health insurance offering. Members Health strongly supports an approach to implementing the reforms which allows private health insurers the greatest degree of flexibility (to the extent contemplated by the Government's announcement) to bring products to market which respond to the particular needs of their members.

As the *Private Health Insurance Act 2007 (Cth)* currently stands, private health insurers have flexibility to determine the circumstances in which young adults (those aged over the aged of 18, but less than 25) will be treated as dependent children. The approach proposed in this submission preserves that flexibility in respect of young adults aged less than 31.

Having a strict, standardised definition for dependent, we believe, could bring about unintended consequences both for health fund revenues and for policyholders as it would incentivise any member within the age bracket – irrespective of income, marital or lifestyle status – to drop coverage and return to their parents' policies. Such a scenario could cause younger aged policy numbers to plummet, and drive up prices for other age brackets – contrary to the stated objective of improving the affordability, value, and attractiveness of health cover, particularly for younger Australians.

2) Removing age limits for people with a disability

Members Health supports the Government proposal to remove age limits on family policies for dependents with a disability, subject to a firm and reliable definition of "disability" as agreed by industry.

2.1. Statutory definitions of Disability

Members Health supports the need for a standardised definition of "disability" to ensure each fund applies the same criteria for determining eligibility under a family policy.

In the interests of portability and avoiding the introduction of further complexity, having a standardised definition will ensure people can switch confidently between health funds without having to satisfy another set of criteria.

We note the Department's preferred approach for the definition and eligibility of "disability" to be drawn from the National Disability Insurance Scheme:

> *A person meets the disability requirements if:*
> - *(a) the person has a disability that is attributable to one or more intellectual, cognitive, neurological, sensory or physical impairments or to one or more impairments attributable to a psychiatric condition; and*
> - *(b) the impairment or impairments are, or are likely to be, permanent; and*
> - *(c) the impairment or impairments result in substantially reduced functional capacity to undertake, or psychosocial functioning in undertaking, one or more of the following activities:*
>   - *i. communication;*
>   - *ii. social interaction;*
>   - *iii. learning;*
>   - *iv. mobility;*
>   - *v. self-care;*
>   - *vi. self-management; and*
> - *(d) the impairment or impairments affect the person's capacity for social or economic participation; and*
> - *(e) the person is likely to require support under the National Disability Insurance Scheme for the person's lifetime.*

While we support the adoption of the above standard definition for the purposes of this reform, it would also require an element of assessment based on individual conditions and circumstances.

In order to support portability in private health insurance, we suggest firstly that health funds be allowed to require people to meet the standard definition of disability, while also assessing their eligibility against the criteria (set by the fund) of a dependent – such as being financially dependent and living with parents.

Moreover, the onus would fall on parents top provide the necessary NDIS registration documentation in order to apply for this change to their policy.

This would provide funds with greater flexibility and control over eligibility criteria, and so encourage participation in the reform.

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Consultation Two | Expanding Home and Community Based Rehabilitation Care

- This reform reflects good clinical practice, but should include additional measures to improve the likelihood of engagement from practitioners, better outcomes for patients and improved efficiency.
- All rehabilitation plans should be developed, documented and consented to by patients before they are commenced.
- Members Health estimates that 12 to 18 months are required to implement the reforms.
- The reform requires significant amendments to existing provider arrangements, regulatory reporting and product systems.
- Mandate the capture of outcomes through tried and tested measures, allowing performance evaluation and the dissemination of best practices.

Members Health is generally supportive of the proposed change requiring development of a rehab plan by an appropriate and responsible medical practitioner, and that such a plan would always include consideration of out-of-hospital rehabilitation where relevant.

It is our belief that this reform reflects good clinical practice which, given the variance in utilisation of rehab between public and private, and across the private sector, suggests it is not currently widely in place. With that in mind, such policy change should also come additional measures to improve the likelihood of engagement from practitioners, better outcomes for patients and improved efficiency for the health system overall.

Members Health believes all rehabilitation plans should first be developed, documented and consented to by patients before they are commenced. There should also be a general understanding, embedded in the policy reform, that rehabilitation plans require flexibility as patient circumstances change.

This includes not only the option of having non-hospital-based rehabilitation as part of the overall rehabilitation plan, but also the option of having no specific rehabilitation (where rehabilitation is multidisciplinary). Each plan should be accompanied with sufficient detail and reasoning regarding the options discussed and developed with the patient.

We believe that by mandating such options, the default approach by practitioners in developing a rehabilitation plan will be to consider all options for each patient, making the process systematically and transparently patient-centric.

In conjunction with such a patient-centric approach to rehabilitation plans, it is important to also pay consideration to the fact that medical practitioners have differing access to public and private funding, and consequently have varying out-of-pocket costs. These costs do, and will continue to, materially impact patient decisions regarding rehabilitation plan options and care.

It is to be expected that, all other things being equal (especially on expected clinical outcomes), patients will choose the option with the lower out-of-pocket cost.

We believe that providing health funds more flexibility to fund medical practitioners who provide out-of-hospital care (including when those services might be MBS eligible) will to some degree permit the dissolution or diminution of out-of-pocket costs as a material factor in rehabilitation plan development.

Finally, capturing the outcomes of home- and community-based rehabilitation care plans should be considered equally as important as the development stages of the process. Members Health believes the reform as proposed by the Government should also mandate the capture the outcomes through tried and tested measures, allowing performance evaluation and the dissemination of best practices.

Timing of Implementation

In addition to complex and costly updates to their systems, regulatory reporting, product design, pricing and staff training to accommodate these reforms, health funds will need to negotiate significant resourcing and funding arrangements with practitioners.

It is also expected that this reform will trigger changes to the electronic claiming of outpatient medical services at both the insurer end, and the Services Australia end.

Members Health estimates that 12 to 18 months are required to implement the reforms.

Questions raised in the consultation paper

Q. Which procedures and/or MBS item numbers should have a rehabilitation plan?

- The need for a rehab plan should not be limited to specific procedures or marked by specific MBS item numbers. The requirement for a rehab plan should apply to any patient deemed by his/her appropriate and responsible medical practitioner to require rehabilitation care.

Q. How prescriptive should the plan be, regarding the type of care services to be included? What exemptions if any should be available?

- The rehab plan should be sufficiently comprehensive and detailed such that the patient (the patient's carer/s if consented to by the patient) and clinicians participating in the care of the patient can clearly understand what rehabilitation care is required by the patient and expected to be delivered to the patient (including the settings of care).
- Additionally, the estimated timeframe and frequency of care services; and the targeted goals for those care services along with the overall goal for the rehabilitation plan should be documented.
- The patient's informed consent to the plan should be documented.
- As described above, the plan must also document deliberations regarding non-hospital-based rehab and no rehabilitation options and when such options are not agreed to, the plan should document the reasons as to why those options were not appropriate for the patient.
- As described above, the rehab plan (noting that it can be amended after its initiation) should be documented and consented prior to commencement of any rehabilitation care.

Q. What mechanisms should be in place to ensure compliance with developing and reviewing a rehabilitation plan?

- As proposed in the consultation paper, insurer funding for rehabilitation care requires there to be a documented rehabilitation plan.
- As proposed, given that the process of developing a rehabilitation plan requires an appropriate and responsible medical practitioner to consult with the patient, a specific MBS item number (in lieu of a general consultation MBS item number) could be introduced to serve as a marker regarding the performance of development of a rehab plan.
- With the MBS item number as a marker, it would also permit targeted compliance measures such as periodic compliance audits by insurers or DoH where documented rehab plans are reviewed

Q. It is expected that the plan would be developed in consultation with the patient and potential rehabilitation providers. Which parties should the rehabilitation plan be made available to once created?

- The plan ought to be readily available to all clinicians attending to the patient including the patient's general practitioner. Of course, the plan should also be available to the patient as part of the process of its development, through to obtaining consent from the patient and as part of tracking and monitoring the delivery of the plan over the course of rehabilitation
- The plan ought to be able to be made available to the Department of Health on request as well as on request to health insurers. Such a process places a stewardship obligation and expectation on medical practitioners regarding prudent use of hospital-based rehabilitation.
    - As described above, a specific MBS item number specifying the activity of development of a rehabilitation plan by an appropriate and responsible medical practitioner facilitates subsequent compliance activity by the Department of Health

Q. What arrangements, if any, should be in place to assist medical practitioners identify appropriate home or community based rehabilitation services and oblige insurers to fund these services?

- Medical practitioners ought to be assisted in development of rehab plans by the hospital, allied health staff and other clinicians. They can assist in bringing to the awareness of medical practitioners appropriate home or community based rehab services that are accessible to the patient.
    - Given the generally better utilisation of community based rehab services by public hospitals, medical practitioners in the private sector may consider similar referral pathways for their patients.
- Should the policy changes described in the consultation paper be adopted, health insurers are likely to engage additional providers of home and community-based rehabilitation services in order to enable access to such services by their policyholders.
- Some private hospitals are also well placed to either provision home and community-based rehabilitation services or procure such services through alternative funding arrangements with insurers
- The Department of Health, or assigned body such as the Australian Health Practitioner Regulation Agency, should manage the issuance of service provider numbers and accreditation. If it is expected that facilities will be classified as hospital substitute facilities, then the Department could issue a provider number and undertake the relevant checks similar to the process they use currently for hospitals. For other service providers that do not have a provider number issued by Medicare, then it may be more appropriate for another body, such as AHPRA to undertake this task.

Q. What transition arrangements and timeframe would be appropriate to implement this reform?

- Estimate that 12-18 months are required to implement the reform. This time is required to:
    - Have providers of home and community-based rehabilitation increase their resources to attend to likely greater demand; and,
    - Have additional and modified funding arrangements between insurers and providers and between health care providers established; and,
    - Have medical practitioners modify their practices to include the routine consideration for and development of rehab plans; and,
    - Implement changes to systems to capture and report on utilisation of and outcomes from home and community based rehab.
    - It is expected that changes will be required to the electronic claiming solution, ECLIPSE, provided by Services Australia. Currently only inpatient medical claims can be submitted to health insurers. A change to this transaction type would potentially

require industry consultation, changes to the Services Australia solution and then once they are made, changes to both provider and insurer systems.

- Insurer systems may need to be updated to calculate outpatient medical claims correctly, as the Medicare benefit portion is different to inpatient i.e. 85% vs 75%. An interim option of manual claiming would add a significant processing overhead to health funds.

Q. What are appropriate metrics for measuring the impact of this proposal?

- Measures of utilisation of rehabilitation in different settings.
- The Australasian Rehabilitation Outcomes Centre (AROC) already provides national benchmarking systems to improve clinical rehabilitation outcomes in both the public and private sectors. Through the systematic collection of outcomes information, using standard measures, the AROC has the infrastructure to develop clinical and management information reports that could assist in the review of home- and community-based rehabilitation programmes for all stakeholders.
- Though PROMs and PREMs would add additional value in assessing the patient impact from implementing changes as proposed, it is acknowledged that existing infrastructure may not be in place to support this in the near term.

Q. What is the regulatory burden associated with this proposal?

- Additional documentation obligations with medical practitioners to consult on, develop and record rehabilitation plans.
- Requisite changes to regulatory reporting, potentially including both APRA and claims statistics via Hospital Casemix Protocol (HCP). Changes to provider and insurer systems to capture data on use of non-hospital-based rehabilitation care and administer funding – e.g., use of the non-admitted HCP2 designation – noting that, in order to evaluate outcomes appropriately, the data systems would need to be structured to be able to link acute care to hospital-based rehabilitation or home/community-based rehabilitation.
- Additional funding arrangements will need to be established with a broader range of providers of home and community-based rehabilitation including modified arrangements with private hospitals

Q. Service providers: what services would you deliver under this proposal?

- Question pertains to service providers and is not appropriate for Members Health to answer.

Q. In the context of this proposal, what changes do you intend to make to your current funding arrangements for home and community based rehabilitation care and in hospital care, and the timing of these changes?

- Question pertains to individual funds' product strategy and coverage.

Q. What is the anticipated change in the number of rehabilitation services delivered in and out of hospital?

- There is a high variance of utilisation of hospital-based rehabilitation services in the private sector. It is anticipated that this variance will reduce and it is anticipated that most of the reduction in variance will arise from reduced utilisation of hospital-based rehabilitation where such utilisation is high with patients deciding in consultation with their medical practitioners

to either have home or community-based rehab instead or deciding with their medical practitioners not to have any rehab.

    - It is also anticipated that changes will include a shortening of hospital-based episodes of rehab care as patients undertake a greater proportion of their required rehab in a home or community setting.

- Anticipated change will be different according to the different patient conditions attended to by rehab. For example, it is anticipated that the change in rehab services delivered in hospital will have a larger reduction for orthopaedic rehabilitation than for other patient conditions such as neurological rehabilitation following a stroke.

Q. What is the anticipated impact on your overall premium revenue if you implement this proposal?

- Difficult to estimate as a key unknown and significant driving factor of impact on overall premium revenue is the potential volume of new policyholders to a fund arising as a result of implementing the changes as proposed in the consultation paper.

Q. What will be the expected impact on the number of people and/or polices covered if you implement this proposal?

- As noted above, Members Health believes this reform reflects good clinical practice, however requires additional measures to improve the likelihood of engagement from practitioners, better outcomes for patients and improved efficiency for the health system overall.
- Ensuring practitioners develop rehabilitations that are systematically and transparently patient-centric, and providing health funds more flexibility to fund medical practitioners who provide out-of-hospital care will all contribute to improved engagement.
- However, the potential volume of new policyholders to a fund arising as a result of implementing the changes remains a key unknown.

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Consultation Three | Out-of-hospital mental health services

- Members Health believes the changes appropriately reflect the issue that timely access to secondary and tertiary prevention mental health services is inhibited by regulatory constraints on insurer funding.
- We support the mandated inclusion of a medical practitioner (e.g. general practitioner or psychiatrist) in a patient's care and care plan.
- Establish an appropriately positioned system of accreditation for providers of non-MBS eligible out-of-hospital mental health services and treatments to provide greater assurance to all stakeholders of appropriate minimum quality and safety standards.
- Members Health estimates that 12 to 18 months are required to implement the reforms.

Members Health is generally supportive of the proposed three-part policy change in the Department's Consultation Paper. We believe the changes appropriately reflect the issue that timely access to secondary and tertiary prevention mental health services is inhibited by regulatory constraints on insurer funding towards clinically and cost effective out-of-hospital services.

For many patients, mental health conditions can be insidious in their development. Such conditions vary widely per individual, in severity and complexity. They have co-modification factors, such as impacts on physical condition, the provocation of environmental stressors and carer issues.

Many are chronic in nature and can travel a long, relapsing and remitting course with widely variable periods of remission. And finally, there is no single pathway for treatment, with a wide range of evidence-based options available in the wider health care system.

On a societal level, mental health has surfaced as one of the greatest challenges to Australians' personal and economic progress in recent times. This enhanced focus on the country's mental health and wellbeing has, for private health insurers, led to a shift in understanding – and achieving – members' expectations of coverage.

Over the five years to July 2019, expenditure on mental health-related services by health insurers grew more than 43 per cent to more than $584 million. The trend is further pronounced over the past two decades, with private health insurer expenditure on mental health-related services trebling by more than 360 per cent.[2]

Despite health funds' best efforts, Members Health believes that existing funding constraints continue to inhibit a more patient-centric, clinician-led, integrated mental health care system. That is to say, the current regulations prohibit insurers from truly investing in the mental health of their consumers.

The Australian Government's Productivity Commission, in 2020, agreed that health funds play a vital role in supporting the large number of people who suffer these conditions – both personally and financially. The Commission correctly called for the Australian Government to review the regulations that prevent private health insurers from funding community-based mental healthcare activities, and permit insurers to fund mental health treatments on a discretionary basis.

> *"The private health insurance regulatory framework should recognise and leverage the fact that private health insurers face strong incentives to prevent avoidable hospitalisations among their insureds …*
>
> *"Current regulations are designed to permit some preventative care, but are not aligned toward doing so for mental healthcare. The restrictions in place prevent private health insurers from funding services outside of hospitals that are eligible for MBS rebates (irrespective of whether the rebate is claimed or not)." – Productivity Commission Inquiry into Mental Health, Final Report: Action item 23.9*

Most notably, we believe funding gaps for secondary and tertiary prevention services act to curtail development of supply of services. Meanwhile, out-of-pockets continue to act as barriers to access of

[2] Australian Institute of Health and Welfare, 29 January 2021: Mental health services in Australia: Expenditure on mental health services. Data Table Exp.34: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/expenditure-on-mental-health-related-services

out-of-hospital mental health services – including MBS eligible care from psychiatrists and other clinicians.

Members Health suggests that enabling insurers to flexibly fund, from hospital tables, a broader range of out-of-hospital mental health services that are not MBS eligible will enable access to effective and more cost-effective care. This could reduce existing access barriers such as relative costs (from a patient's perspective) between hospital-based services and out-of-hospital services, and make available additional insurer funding for current and future providers to sustainably deliver more out-of-hospital mental health services and treatments.

However, sustainably increasing services and improving outcomes across the board through further insurer funding, while achieving a more integrated, patient-centric, clinically and cost effective mental health system, requires complementary changes to the proposed reform.

Those changes include:

- Mandated inclusion of a medical practitioner (e.g. general practitioner or psychiatrist) in a patient's care and care plan (including referral directly to services or by way of a patient-specific care plan). This would improve the likelihood that insurer-funded out-of-hospital mental health services and treatments remain clinically appropriate and integrated with other aspects of a patient's mental health and other health care. Directly linking patients with a medical practitioner supports the doctor-patient relationship for the purpose of ongoing mental health care and encourages informed discussions regarding mental health care requirements.
    - In practice, patients would nominate their chosen medical practitioner, who would then document assent to keeping oversight of the patient's out-of-hospital mental health services and treatments. Patients would be able to change their nominated practitioner, but such changes should require a new medical practitioner document assent.
    - In order for a medical practitioner to be appropriately engaged, the scope of insurer-funded mental health services need not include primary prevention.
    - Insurer funding would be contingent on the out-of-hospital mental health service provider providing the identity of the nominated medical practitioner to the fund.
    - Insurer funding should be allowed to be made to a medical practitioner for serving as the patient's nominated medical practitioner (including in circumstances where such services are MBS-eligible).
- An appropriately positioned system of accreditation for providers of non-MBS eligible out-of-hospital mental health services and treatments to provide greater assurance to all stakeholders of appropriate minimum quality and safety standards.
    - Industry can develop and institute a set of guidelines specific to out-of-hospital mental health services to augment the system of accreditation.
    - Accreditation requirements and obligations should be set according to the form and scope of clinical service/s provided and the size and sophistication of the service provider.
    - Accreditation requirements should be set such that they are not a significant barrier to entry for qualified, safe and effective providers of out-of-hospital mental health services and treatments.

Members Health reiterates its support for the three-part policy proposal subject to complementary changes as listed above. If Department's three-part policy is instituted as described solely in the Consultation Paper, Members Health believes there could be a material risk of perverse outcomes, including:

- Amplification of the existing fragmentation and duplication of health services applied to mental health care; and,

- Dilution of doctor-patient relationships and continuity of care; and,
- Rather than reducing or substituting higher-cost or less efficient mental health care, additional benefit outlays without adequate medical practitioner participation may simply add to the funding of higher cost, less efficient care.

Timing of Implementation

In addition to complex and costly updates to their systems, regulatory reporting, product design, pricing and staff training to accommodate these reforms, health funds will need to negotiate significant resourcing and funding arrangements with practitioners.

It is also expected that this reform will trigger changes to the electronic claiming of outpatient medical services at both the insurer end, and the Services Australia end.

Members Health estimates that 12 to 18 months are required to implement the reforms.

Questions raised in the consultation paper

Q. What additional mental health services funded by insurers under this proposal would be of value to consumers?

- MBS-eligible mental health services as well as non-MBS-eligible services should be allowed to be funded by insurers. This includes MBS-eligible mental health services provided by medical practitioners. Out-of-pocket costs or gap payments for out-of-hospital MBS-eligible services are a material barrier to consideration of and access to out-of-hospital mental health services. Such gap payments distort patient and clinician decisions that result in over-utilisation of hospital-based mental health services
- The breadth of out-of-hospital mental health services permitted to be funded should extend from early secondary prevention (e.g., funding of symptom-triggered early diagnostic mental health services) through to complex tertiary prevention services (e.g., crisis management services, Chronic Disease Management Programs) and treatments.
    - Mental health conditions are varied and patient treatment requirements, individually and as a population, can be broad. Under the proposal, rather than implementing a prescribed list of treatments and services for which insurer funding is permissible, it is preferred that regulation utilises an approach comprised of general rules and criteria.

Q. Should an expanded list of allied health services available for direct PHI benefits as part of a CDMP be limited to only mental health conditions?

- No. Limitation to only mental health conditions should not be instituted. Patients who qualify for and benefit from CDMP may have multi-morbidity, which may include required treatment of early or more significant mental health conditions. Patients with more chronic diseases, of greater severity and longer duration have higher likelihoods of developing or having depression and anxiety.
- Additionally, patients with chronic mental illness are more likely to have one or more chronic physical conditions. Attempting to limit an expanded list of allied health services to only mental health conditions is likely to result in confusion as to applicability of insurer funding to CDMP patients with multi-morbidity.

Q. To be eligible for direct CDMP related funding from insurers, should professions have additional requirements, such as accreditation standards, professional memberships or educational levels?

- Yes, appropriate accreditation standards should be required to be eligible for insurer funding but the requirements should be set according to the form, scope and complexity of clinical services to be provided.
- At a minimum, there would need to be minimum relevant education and professional qualifications for providers of single modality services in sole-practitioner or small group practices.
- The additional requirements should thus be titrated according to the services to be provided and not act as a barrier to providers who are qualified, safe and effective.
- The industry has learnt from the alternative therapy provider accreditation process that not having one single source of truth for the industry adds a significant burden to all parties in the end-to-end registration and claiming process and makes it confusing for the consumer. Government and industry should endeavour to get this right from the outset, leveraging off the capability and services offered by AHPRA for these provider types.

Q. How should the definition of coordination and planning be expanded to best support the funding of out of hospital, non-MBS related mental health services?

- As outlined above, patients with mental health conditions can present with a spectrum of requirements and the course of their condition can follow a variable course including a relapsing and remitting course with variable tempo and intensity. As such, the definition should require coordination and planning to:
    - Permit (or require if indicated) changes to services and their amounts according to patient needs.
    - Specify the frequency of review including permitting changes to the frequency of review according to the course of the patient's mental health condition.
    - Specify the criteria or trigger points by which additional services or required or at which services can be withdrawn or limited.
    - Specify the treatments and care required to achieve durable remission and maintain durable remission.
- The plan should include as a requirement the identity of the patient's nominated medical practitioner as described above and the plan should be provided to and accessible to the patient's nominated medical practitioner

Q. Are there any mental health services insurers should not be permitted to fund?

- Primary prevention services such as general, non-specific wellness-type services (e.g., mindfulness training, general wellness programs) or general mental wellness education services should not be funded by insurers.
- Mental health services that do not include the identity of the patient's nominated medical practitioner, as described above, should not qualify for insurer funding.
- As described above, the principle of having providers obtain the identity of the patient's nominated medical practitioner and confirming this status with the patient's nominated medical practitioner increases the likelihood that the mental health services are delivered in an integrated manner with the patient's other health services.

Q. How should the relevant patient cohort be identified as eligible for services?

- By requiring that insurer funding cannot be put to primary prevention, the patient cohort, at a minimum, would have a symptom or other defined clinical condition that triggers eligibility for insurer funded mental health services.

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- Additionally, the requirement to have the identity of the patient's nominated medical practitioner (as described above) provides a further level of assurance regarding a patient's eligibility for insurer funded relevant mental health services.
- Clinicians would need to assess a patient's clinical requirement and eligibility for services and ensure that, at a minimum, inform the patient's nominated medical practitioner of the services being provided by the provider to the patient.
- Of course, the assessment of a patient's clinical requirements for services could be made by the patient's nominated medical practitioner who then refers the patient to or prescribes the required mental health services.

Q. Who should identify relevant patient cohorts and should insurers set criteria for which members would be eligible?

- A clinician including the patient's nominated medical practitioner should identify and refer to or prescribe the appropriate and relevant services for the patient after consulting and discussing with the patient.
- Insurers should be permitted flexibility as to which providers or classes of providers to establish agreements or arrangements with and this should include the scope of services covered in the agreements or arrangements and the related terms and conditions that need to be met in order for the provider to qualify for payment from the insurer.

Q. What are appropriate metrics for measuring the impact of this proposal?

- The most appropriate and patient-relevant measures are standardised patient reported outcome measures (PROMs) and patient reported experience measures (PREMs). Ideally, such metrics will be captured before introduction of the proposed changes. It is acknowledged that the infrastructure is not readily available to implement such metrics at a national and population scale.
- In the near term, the most appropriate metrics are utilisation metrics (by geography and per appropriate unit of insured population) to track and gauge uptake of non-hospital-based mental health services and track and gauge impact on utilisation of hospital-based mental health services.
- If the additional change suggested above is adopted permitting insurer funding of MBS-eligible mental health services provided by medical practitioners, measuring the change in volume and mix would also be an appropriate metric in the near term.

Q. What is the regulatory burden associated with this proposal?

- Amending fund rules to expand scope of cover of hospital tables.
- Establishing and administering commercial agreements and arrangements with a larger array of providers of non-hospital-based mental health services.
- If insurer funding is permitted for MBS-eligible services provided by medical practitioners, insurers will also need to establish arrangement for these services.
- Extending existing administration systems to transact with the larger array of providers.
- It is expected that changes will be required to the electronic claiming solution, ECLIPSE, provided by Services Australia. Currently only inpatient medical claims can be submitted to health insurers. A change to this transaction type would potentially require industry consultation, changes to the Services Australia solution and then once they are made, changes to both provider and insurer systems.

- Insurer systems may need to be updated to calculate outpatient medical claims correctly, as the Medicare benefit portion is different to inpatient i.e. 85% vs 75%. An interim option of manual claiming would add a significant processing overhead to health funds.
- Any system changes required for regulatory reporting purposes will also need to be accommodated.
- If the proposal for a patient nominated medical practitioner requirement is adopted, providers will need to establish new processes and modify systems to routinely capture, document and communicate this information and communicate information with medical practitioners as and when required or called upon.
- For insurers, the most resource intensive item to accommodate the changes in the proposal is that of establishing commercial arrangements with a larger array of providers of mental health services:
    - The other items listed above to accommodate the proposal will consume significantly fewer resources (including time) to fully implement

Q. In the context of this proposal, what changes do you intend to make to your current funding arrangements for mental health services and the timing of these changes?

- Not appropriate for Members Health to answer as it pertains to individual health fund product strategy and coverage.

Q. What will be your likely approach to pricing products with expanded mental health service benefits?

- Not appropriate for Members Health to answer as it pertains to individual health fund product strategy and coverage.

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Consultation Four | Applying greater rigour to certification for hospital admission

- Members Heath believes the three-part policy proposal in the Consultation Paper provides the greatest opportunity for industry to resolve the issues raised to the Department.
- Terms of reference of the Panel should be clear and drafted by an independent party (or the Department).
- Panel should develop an independently drafted Code of Conduct or Practice regarding certification.
- Panel must include hospital and insurer representation, clinician representation, one or more DoH advisory members and an independent Chair with mediator experience.
- Panel should be sufficiently equipped with administrative resources, and a means to publish and archive determinations.
- Panel determinations should be used to continuously update and maintain the Clinical Guidelines.

Members Health is broadly supportive of all three parts listed under the proposed changes for *Consultation Four: Applying greater rigour to certification for hospital admission*.

We acknowledge that the overwhelming majority of hospital episodes requiring type B or C certification are resolved without friction. However, due to the sheer volume of hospital episodes that require such certification, having even a small proportion of those triggering disputes does reflect a significant number. We also note that many of the issues that frequently arise in the certification process, do so repeatedly.

Having considered all three parts of the policy change proposed in the Consultation Paper, Members Health makes the following additional suggestions:

1) Establishment of a self-regulated industry panel (the Panel)

- From the outset, the terms of reference of this Panel should be clear and drafted by an independent party (or the Department).
- Both the Panel and the Professional Services Review (PSR) should be provided a mechanism to inform the Type A/B/C classification process for MBS item numbers.
- An initial objective of the Panel should be to develop an independently drafted Code of Conduct or Practice regarding certification, which:
    - Covers how stakeholders interact with each other to provide type B/C statements; share information; assess and review the type B/C statements; move certification issues to resolution via the Panel; and interact with patients when certification disputes arise.
    - Outlines the principles of referral of disputes to the Panel and how Panel rulings and recommendations are to be considered by each stakeholder.
    - If there is evidence of unreasonable failure to comply with the code of conduct/practice, an option should be retained to legislate enforceable code provisions.
- Along with hospital and insurer representation, the Panel should include:
    - An independent Chair with mediator experience, as well as Clinician representation.
    - Given the risk of bias across the various stakeholders, the function of the Panel would likely be assisted by equal number of members representing insurers, hospitals and clinicians.
    - Capacity to refer focused matters to external advisory bodies (e.g., specialist colleges).

- Initially, one or more DoH members as advisory members (or observers) to maintain the Panel's awareness and understanding of the regulatory framework and intent of the type B/C certification provisions.

  NB. The history of other industry bodies designed to self-regulate matters in the private health sector indicate that the presence of the DoH in the deliberation of such bodies makes them more effective. As the panel matures in its function, the DoH can transition off.

- Panel should be sufficiently equipped with administrative resources, and a means to publish and archive determinations (while protecting individual patient/provider privacy) in a transparent, searchable online format (to be utilised for reference by stakeholders).
- Panel determinations should be used to continuously update and maintain the Clinical Guidelines, allowing previous findings (precedent) to be overridden due to their being rendered obsolete or incorrect based on changes to evidence-based clinical practice (or by changes to MBS item descriptors).
- Include mechanism for panel findings and recommendations to be referred to the Department of Health, where there is relevance to Type A/B/C classification of MBS item numbers (as described above).

2) Development of clinical guidelines

- Given that the guidelines pertain to type B/C certification – a regulatory construct that governs health insurer funding – it is important that the guidelines are developed not solely as a clinical matter. Many clinicians are not informed of the regulatory context regarding private health funding and type B/C certification.
- The guidelines should therefore be developed upon the input of hospitals, insurers, specialist colleges and representatives from the Department of Health to ensure they align and are consistent with the regulatory context affecting private health insurer funding.

3) Escalation pathway to PSR

- Code of conduct should be structured to ensure that escalation pathway to PSR is used appropriately and sparingly. The Chair of the mediation panel will be important in this regard.
- Escalation pathway should include referral to PSR and the Department of Health if the mediation panel finds instances of systemic concern with the use of one or more MBS item numbers.
- There should be a mechanism by which the PSR are permitted to freely pass their findings back to the mediation panel.

Alternative options

Members Heath believes the three-part policy proposal in the Consultation Paper provides the greatest opportunity for industry to resolve the issues raised to the Department, being:

- Confusion and lack of awareness of certification requirements resulting in a lack of detail or incorrect information provided by hospitals and medical practitioners to insurers; and.
- Rejection of the medical conditions or special circumstances outlined in the certification documentation by insurers.

The alternative option to introduce more standardised forms for certificates, we believe, is far less likely to remedy the above issues relating to type B and C matters. Clinical variety and variance can be high in matters regarding qualifying type B and C certification. Developing standardised forms will

add an unnecessary administrative burden in accommodating for each specialty area or each sub-specialty area.

Questions raised in the consultation paper

Q. Should an industry mediation panel be established to resolve hospital certification disputes?

- Yes, as outlined above.

Q. If an industry mediation panel is established, what process should be undertaken to establish it, including determining membership?

- The means and process of its establishment could be undertaken by DoH or by an independent party/entity (assisted by a DoH-selected independent chair) tasked with doing this by DoH.
- The independent party/entity could also be tasked with establishing the initial administrative resources required to support he Chair and the panel
- Its funding ought to be by way of a hypothecated levy placed on insurers and hospitals to ensure that funding of its operations cannot be held hostage or placed in jeopardy by any stakeholder group. We anticipate that any funding impost by way of a levy will probably be offset by reduced costs of handling disputes incurred by hospitals and insurers (and clinicians).

Q. What parties should be involved in the development of advice on the appropriate criteria for certification?

- As stated above, initially there should be co-development of guidelines – not just specialist colleges, but also hospitals, insurers and DoH.
- Once established, the panel can oversee the maintenance of guidelines (and the Code of Conduct)
- Additionally, as stated above, a process should also be instituted to permit recommendations to be put to DoH regarding potential changes to the type A/B/C classification of MBS item numbers.

Q. Should PSR, or another regulatory body, provide a regulated and enforceable process for reviewing Type C certification?

- PSR should be part of an enforceable escalation process from the panel.
- The referral criteria should be established by the panel to ensure appropriate utilisation of an escalation process (and to ensure that the cost impacts to the function of the PSR are kept manageable) – the Chair of the panel and an agreed Code of Conduct will be important in this regard.
- Initial observer members from DoH on the Panel would be useful in this regard. There may be consideration in having one or more permanent DoH members on the Panel to advise on referrals to PSR

Q. Should there be a specified list of 'special circumstances' allowable for Type C certificates?

- The findings and determinations from the Panel should be made transparent. When categorised and aggregated appropriately (perhaps by the Chair and by agreement of the Panel), findings may function as guidance for 'special circumstances' to allow for Type C certificates.

- Care will be required to ensure that such a list does not result in perverse outcomes, such as forms of over-servicing. With oversight by the Panel and its administrative resources, however, such perverse outcomes can be addressed either through amendment of the set of 'special circumstances' or through a PSR escalation process.

Q. Should hospitals be potentially liable for Type C certificate statements, and if so, in what circumstances?

- Primary responsibility for completing Type C certificate statements should continue to reside with the responsible medical practitioner as the determination regarding use of the hospital for the treatment specific to the patient's circumstances resides with the responsible medical practitioner
- The hospital has contributory responsibility in ensuring the information provided in the Type C certificate statement aligns with the clinical records held by the hospital and are factually correct.

Q. What is the likely impact upon premiums of this proposal?

- Likely net impact on benefit outlays is estimated to be small and, therefore, the impact on premiums will be insignificant.

Q. What is the likely impact on the number of people and/or policies covered of this proposal?

- Given this reform's minimal impact on premiums and benefit outlays, it is likely to have an insignificant or nil impact on people and or policies covered.

Q. What are appropriate metrics for measuring the impact of this proposal?

- Initially, volume of episodes referred to the Panel for deliberation and the volume mix of outcomes from the Panel:
    - The volume of episodes referred should also be measured as a proportion of all episodes requiring type B or C certification.
    - Over time this ratio is expected to fall as more episodes are satisfactorily resolved between insurers and hospitals (and clinicians) without referral to the Panel.

Q. What is the regulatory burden associated with this proposal?

- There will be initial engagement activity required from stakeholders to establish that which is proposed. Thereafter, we expect further regulatory demands upon stakeholders to be minimal as most of the ongoing administrative maintenance and improvement activity will be carried out by the Panel.
- The funding requirement for that proposed, if borne by all stakeholders across hospitals and insurers, will be a very small financial burden.
- The net impact on the current regulatory burden on type B/C certification should be a reduction in resources applied as there should be fewer disputes proportionally over time and when there are disputes, the resources required to move the dispute through to resolution will be shared with the Panel.

Q. Are there any other reform options that should be considered?

- As outlined above

- Code of conduct/practice should be developed and instituted; and,
- Along with a process of escalation to PSR, there should also be a process of input or recommendations to DoH regarding categorisation of MBS item numbers to type A/B/C.

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