Private Healthcare Australia

Better Cover. Better Access. Better Care.

Second wave private health insurance reforms

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About Private Healthcare Australia

Private Healthcare Australia (PHA) is the Australian private health insurance industry's peak representative body. We have 24 registered health funds throughout Australia as members and collectively represent 96% of people covered by private health insurance. PHA member funds today provide healthcare benefits for over 13.7 million Australians.

Dependents

Private Healthcare Australia welcomes the opportunity to offer products to allow dependents to remain under their parents/carers policy. PHA notes the intent of the government that this opportunity be voluntary for funds, and feedback from member funds is that they would like flexibility to offer a range of products.

Advice from the Department of Health suggests that it is not possible to leave the legislation open to funds to determine differing cohorts, so we recommend that a range of cohorts be contained in the legislation. While simplicity is important, the ability to offer a range of products depending on circumstances is more important for insurers. The less flexibility, the lower the number of offering that will be put to the market.

Member funds have noted the need to address issues such as age, student status and partnering status, as well as income and wealth when considering eligibility for dependence in various products. As much as possible should be contained in fund rules, with legislation defining cohorts where necessary. (PHA notes that the Department's discussion paper asserted that some existing categories were not used. Funds have disputed that assertion.)

For the cut off age, member funds have a range of views, with some preferring a set age of 30, and others preferring alignment with Lifetime Health Cover.

For people living with a disability, PHA recommends that the only acceptable definition is people in receipt of a National Disability Insurance Scheme package, combined with dependence. Other definitions are either self-assessed or not suitable. As the NDIS is an entitlement scheme rather than a welfare scheme, NDIS eligibility alone is insufficient. Many people with an NDIS package are independent and have significant incomes.

PHA does not recommend that the legislation include references to partnering for people living with a disability; there are a range of family types and many people with disability are married yet still living with and dependent on their family or carers. Similarly, references in legislation should not specify dependence on parents, many people living with disability live with and are dependent on other family members.

Out of hospital care

PHA is encouraged the government's policy direction to improve options for out of hospital care. However, taking a piecemeal approach out of the context of the overall regulatory structure will not produce the desired policy result.

There are currently very few regulatory barriers for funds to cover out of hospital care, but the existence of regulatory structures encouraging and rewarding hospital care (in particular, second tier default benefits) means that there is not a level playing field. Insurers have a strong incentive to contract for quality services. However, as the market is not allowed to operate fairly, providers have naturally gravitated to provide services which are rewarded by regulatory fiat rather than reacting to consumer need and market forces.

PHA have previously provided a paper to the Department of Health providing further information about second tier default benefits and the deleterious effects on out of hospital care.

Improving rehabilitation options

Our experience is that the majority of members undergoing procedures requiring post procedure rehabilitation have a preference for rehabilitation in the home rather than in the inpatient setting. The academic literature is very clear that home-based rehabilitation is better care in most cases.[1]

We note the government's policy priority to ensure that medical practitioners have flexibility for rehabilitation services and recognise that doctors making active decisions will improve patient care.

Everyone should have an after-care plan determined through a referral from the treating medical specialist to a rehabilitation physician, even if that plan does not require specialised rehabilitation services after surgery.

Instead of the department's current proposal that the legislation simply require a plan, PHA recommend inpatient rehabilitation benefits should be payable where:

- Services provided are consistent with Faculty standards (three hours a day five days a week minimum), **or**
- The patient has a written plan signed off by a rehabilitation physician for inpatient services where that plan differs from the faculty standards.

Most hospitals agree that discharge planning, including to subacute care begins at pre-admission. It is thus not a major change in accepted practice to require the plan be signed off by an appropriately qualified medical specialist and that it can be made available if necessary during clinical and financial audit processes.

It is vital that any regulatory creep that would force insurers to cover for services and suppliers who may not necessarily offer safe, effective or cost-effective services be avoided. PHA opposes the introduction of default benefits for out of hospital services as this would compound the problem existing with inpatient services (see previous paper).

Developing better out of hospital rehabilitation options is a priority for the sector. This should be evidence-based, determined by the patient's treating medical practitioner, and in most cases will involve multidisciplinary care from a range of professionals and support services. The most effective way to develop the sector is to ensure no barriers to entry (such as default benefits), freedom to

[1] See for example Buhagiar et al 2019, Assessment of Outcomes of Inpatient or Clinic-Based vs Home-Based Rehabilitation After Total Knee Arthroplasty: A Systematic Review and Meta-analysis, *JAMA Netw Open.* 2019;2(4):e192810. doi:10.1001/jamanetworkopen.2019.2810

contract quality services, and developing models that avoid out of pocket costs. It is critical admission to hospital is not seen as a mechanism to lower patient out-of-pocket costs. Removing the prohibition on insurers covering services outside the hospital (including where covered by MBS) would assist reducing out of pocket costs.

Patient-orientated mental health services

Similar to rehabilitation, there is a shortage of consumer-focused, evidence-based services in the private sector as older inpatient models of care are propped up by legislation. PHA's paper on mental health provided to the Department of Health in March 2020 outlines the issues and makes a number of recommendations.

There are two broad cohorts of patients – those with chronic and severe mental health conditions that are being treated in hospital, and a much larger group of members with conditions that can be managed in an outpatient setting. The academic literature is very clear that community-based care is better care in most cases for the first cohort, although for some people inpatient care is required. Recent work by the Victorian Royal Commission, the Productivity Commission and the RANZCP all highlight the need to improve care options.[2] [3] [4]

Funds need more flexibility in mental health care and in prevention, but we are concerned the government is looking to add additional rules rather than increase funds' flexibility. For example, it would be a mistake for government to try and shift existing general treatment options into a hospital-substitute framework.

Mental health care is less exact than most other areas of medicine, and the context of patients' lives has a much greater bearing on their condition. Flexibility, rather than rigid protocols, is a growing feature of the evidence base.

PHA supports the first part of the government's proposal to offering preventative services to consumers who are identified as meeting a set of criteria. Those criteria should be set by funds rather than legislated, as funds will be in the best position to determine the costs and benefits of particular options for their customers. Clinicians would then refer their patients to a range of programs.

PHA supports the second part of proposal so private health insurers could be explicitly allowed to directly fund the mental health services of a wider range of allied health professionals as part of a Chronic Disease Management Program.

The most effective way to ensure this is to remove the existing list of practitioners, rather than to add to the list. Some professions that should be on the list for unusual circumstances (eg orthoptists) are not included. New professions are being developed (eg lactation consultants) and having a list means that some consumers could be disadvantaged by not being to access new and/or specialised services. Not having a list ensures flexibility and future-proofs the legislation. The Act already requires providers to be adequately qualified/accredited.

PHA supports the third part of proposal that funds be allowed to pay for a wider range of services, such as subscriptions to mental health applications. A broad statement of intent should be determined in legislation, rather than seeking to list individual services. Prescribing a list would stifle

[2] See https://rcvmhs.vic.gov.au/
[3] See https://www.pc.gov.au/inquiries/completed/mental-health#report
[4] See https://www.ranzcp.org/news-policy/news/%E2%80%9Cthe-time-is-now%E2%80%9D-psychiatrists-call-for-mental-he

innovation, as government is not best placed to pick winners. Ensuring no prescribed services also future-proofs the legislation.

Further, PHA recommends that inpatient hospital second tier benefits should not be payable where the patient is admitted to hospital but not assessed by a psychiatrist. While rare, it appears some providers are taking advantage of the loopholes in the legislation that allow for any hospital to receive second tier default benefits.

Certifications

Private Healthcare Australia supports changes to improve accountability and transparency for certifications under the *Private Health Insurance Act 2007*.

False, fraudulent or otherwise problematic declarations under the Act are very rare indeed. The vast majority of providers act with integrity and provide certifications which are reasonable and necessary to improve patient care.

However, there are a tiny minority of providers who appear to base their business model on using certifications to bolster their income without demonstrating an assessment of individual patient need. The existence of second tier default benefits means these business models can be viable while avoiding quality assurance activities enforced by contracting. This poor behaviour from a very few resonates across a broader cohort as funds seek to protect member funds; the actions of a few mean than providers doing the right thing are under greater scrutiny. Although the numbers are small, it is possible for health funds to lose a very large amount of members' funds over a short period resulting from fraud and inappropriate practice in this area.

Currently there are few sanctions for poor behaviour. Hospitals are not accountable as doctors are legally responsible for their decisions, even though additional funding goes to the hospital. Disputes are time consuming, and the only real sanctions available are through the Medical Board of Australia or the police.

PHA supports each of the Department's recommendations but suggests that the development of clinical guidelines is the most important action. Where clinical guidelines exist, disputes are minimised. Hospitalisations are clinical decisions, and clinical guidelines provide a level of surety (while noting there will always be unusual circumstances that cannot be covered by guidelines).

Clinical guidelines for certifications would also allow the department to reduce the upwards pressure on banding procedures. The evidence is clear that more health care should occur in the community rather than in hospitals, and guidelines should give the department more confidence to tend towards lower banding in line with government policy to promote out of hospital care.

The proposed mediation panel may prove useful to help the industry gain an understanding of common practices and could help provide guidance to funds and to providers. It could not be a determining body without certification by the ACCC. In many cases, disputes are around clinical matters, which the proposed committee would not be qualified to judge.

The third proposal that certifications may be examined by the Professional Services Review is supported. Our view is that this pathway would be very rarely used, but the mere existence of the pathway may help moderate outrageous behaviour as there is a more tangible sanction mechanism, and one that will be meaningful to clinicians, enabling them to push back on any inappropriate pressure from providers.

It is important that the industry continue to work in the best interests of patients, both by ensuring people needing hospitalisation are covered and ensuring that the 13.7 million Australians paying premiums are getting value for their investment. We will continue to work among ourselves to clarify processes and reduce the administrative load of certifications.