Australian Government

Australian Government response to the Select Committee on Red Tape:

Effect of red tape on health services

Interim report

November 2018

RECOMMENDATION 1
The committee recommends that the Australian Government publish without delay the red tape reduction reports for 2016 and 2017.

Response: AGREE

The Government published the Annual Regulatory Reform Report: 1 January 2016 – 30 June 2017 on the Department of Jobs and Small Business website on 28 May 2018.

RECOMMENDATION 2
The committee recommends that the Department of Health investigates the merits of allowing private health funds to fund out-of-hospital care.

Response: NOTED

In October 2017 the Minister for Health announced a package of reforms designed to make private health insurance simpler and more affordable. The package included the establishment of the Improved Models of Care Working Group (IMOC) to advise on potential changes to private health insurance regulation to ensure that services funded by private health insurance are both clinically effective and delivered efficiently.

IMOC will focus on private health insurance funding of mental health and rehabilitation services, including consideration of the current regulatory regime, models of care, funding arrangements and options for possible change including the funding of services provided in alternative settings. IMOC will also consider the suitability of any new models of care applying to other clinical areas.

IMOC is expected to conclude its consideration in late 2018.

RECOMMENDATION 3
The committee recommends that the Australian Government review cost drivers for private health insurance, to identify and better manage the ongoing effects on the cost of private health insurance.

Response: NOTED

The private health sector is subject to the same cost drivers as the public health system. These cost drivers are well-known and include: technological advances and increasing costs of treatment and services; increased utilisation; an ageing population; and an increase in chronic and complex conditions. Private health insurers meet these increasing costs through higher benefit outlays funded by health insurance premiums.

Regulatory burden is not a major driver of the cost of private health insurance. The private health insurance industry had average management expenses of only 8.8 per cent of premium revenue in 2016-17.

In October 2017 the Minister for Health announced a package of reforms designed to make private health insurance simpler and more affordable. The package includes:

- The establishment of the Improved Models of Care Working Group to examine opportunities to ensure that services funded by private health insurance are both clinically effective and delivered efficiently.
- The establishment of the Ministerial Advisory Committee on Out-of-Pocket Costs to develop best practice models to make information on out-of-pocket costs more transparent and to help consumers with private health insurance better understand out-of-pocket costs.
- An agreement with the Medical Technology Association of Australia. This agreement is in place until January 2022 and specifies a range of Prostheses List reform activities aimed at reducing the cost of prostheses and cutting red tape.
- From 1 April 2019, allowing insurers to choose to offer discounted hospital cover products to people aged 18 to 29.
- From 1 April 2019, preventing insurers from offering insurance cover for a range of natural therapies which have limited evidence of clinical effectiveness, such as Bowen therapy or Rolfing.

RECOMMENDATION 4
The committee recommends that the Australian Government considers ceasing regulation of the prosthesis market, apart from maintaining standard consumer protection.

Response: NOT SUPPORTED

This recommendation is contrary to recent reviews of the Prostheses List arrangements:

- In January 2016, the Industry Working Group on Private Health Insurance Prostheses Reform (IWG) was established to examine opportunities for reform of the arrangements governing prostheses and devices access in the private health insurance sector. The IWG supported the continued operation of a Prostheses List, both in terms of listing devices for reimbursement, and setting the level of benefit.
- In May 2017 a Senate Enquiry into Price Regulation associated with the Prostheses List Framework was conducted. One of the recommendations was that the Department of Health undertake further analysis and consultation, including with consumers, to determine the most appropriate benefit setting model or models, and that this analysis include investigation of the introduction of outcomes based categorisation of items on the Prostheses List, and the option of the government purchasing devices directly.

Previous experience with deregulating the Prostheses List in 1999 saw benefits per prosthesis almost double between 2000-01 and 2002-03. This resulted in the Australian Government agreeing, in 2003, to a package of reforms to private health insurance that included new arrangements for listing prostheses products.

In October 2017, the Government entered into an agreement with the Medical Technology Association of Australia. This agreement is in place until January 2022 and specifies a range of Prostheses List reform activities aimed at reducing red tape and providing savings of approximately $1.1 billion to private health insurers over the life of the agreement.

RECOMMENDATION 5
The committee recommends that the Australian Government, through the Council of Australian Governments, streamline the identifiers issued to healthcare practitioners for practice purposes.

Response: NOTED

The Government recognises that health care professionals must successfully complete a range of application processes to be credentialed, registered to practise in their profession, obtain employment and, where appropriate, register to work under the Medicare system. In some cases, a health professional may be required to be re-credentialed once they complete a postgraduate health or medical qualification so that their newly attained level of clinical expertise is reflected in their practising rights.

These assessment requirements and related identifiers exist to ensure health professionals are capable of providing the legislated standards of care to consumers, particularly if working in independent private practice. For those assessment processes applied by the Government when determining Medicare Benefits Schedule (MBS) eligibility, the identifiers assigned to health professionals serve an important compliance function. The assessment processes ensure that MBS items and prescribing rights are correctly applied to providers, particularly medical practitioners, when entering the health system.

The Government, through the Department of Human Services (DHS), has streamlined the Medicare provider number application process for providers who are not subject to restrictions through their medical registration. This includes the online Provider Digital Access (PRODA) system, which allows many unrestricted health professionals, including medical practitioners, to receive new Medicare provider numbers in real time. Work is continuing to incorporate new business rules to expand eligibility to apply through PRODA to additional segments of the health workforce.

The Government, as part of the 2018-19 Budget, announced proposed legislative changes to the *Health Insurance Act 1973* to reduce administrative burden for specialist general practitioners to access higher Medicare payments. The proposed changes will mean that DHS will directly utilise registration data in the Australian Health Practitioner Regulation Agency data repository to make these determinations.

RECOMMENDATION 6
The committee recommends that the Australian Government, through the Council of Australian Governments, develop a standard template and associated guidelines, including reasonable timeframes, to streamline ethics and governance approval process for clinical trials across Australia.

Response: SUPPORT IN PRINCIPLE

A number of initiatives are underway to improve the environment for clinical trials in Australia, including efforts to streamline ethics and governance approval processes.

In March 2017, COAG Health Council agreed to a revitalised reform agenda that had been collaboratively developed with all jurisdictions, to streamline the conduct of clinical trials in Australia.

The *Encouraging More Clinical Trials in Australia* measure in the 2016/17 Budget provides funding of $7 million over four years to support activities aimed at achieving national consistency of clinical trial systems. The initiative was a Coalition Election commitment announced in December 2016, which has served as a reference point for the COAG Health Council revitalised clinical trials agenda.

A Project Agreement with states and territories was executed in March 2018 to implement this Budget measure. This will provide important stimulus funding towards the establishment of jurisdictional central coordination units to streamline trial operations and improve trial outcomes, in keeping with the COAG Health Council revitalised agenda.

The Australian Government is also seeking to explore the concept of an Australian National Clinical Trials Front Door, in collaboration with states and territories.

These discussions will build on the outcomes of a Review of the Australian and New Zealand Clinical Trials Registry, to explore options that could best meet the needs of patients, researchers, sponsors and administrators, to enhance our attractiveness as a preferred clinical trials destination.

Under two previous budget measures, the National Health and Medical Research Council (NHMRC) developed a number of tools and frameworks to improve ethics review efficiency and streamline research governance for clinical trials. This included the development of the Human Research Ethics Application (HREA). The HREA is a simplified and efficient electronic form that supports nationally consistent ethical review and site-assessment for all human research. HREA is able to be used in all major research management platforms, which use a free, licensed version of the HREA.

Other activities NHMRC undertook to streamline ethics and governance approval processes included:

- The development and piloting of the *Good Practice Process for Site Assessment and Authorisation of Clinical Trials* which can reduce the start time of clinical trials by over 100 days.
- The development of a refined list of standard items associated with clinical trials to further increase the transparency for costing of clinical trials. These items were costed by the Independent Hospital Pricing Authority.
- Working with the Therapeutic Goods Administration (TGA) to revise a series of Clinical Trials Guidance documents and developed guidance for *Safety Monitoring and Reporting in Clinical Trials Involving Therapeutic Goods* to streamline reporting requirements for sponsors, investigators and Human Research Ethics Committees.

Through its *National Certification Scheme of Institutional Processes related to the Ethical Review of Multi-centre Research*, NHMRC developed template resources for certified institutions and ethics committees to use.

NHMRC continues to work with the states and territories through a National Mutual Acceptance Working Group to streamline ethics and governance process, and supports effort by the Working Group to develop a national site-specific assessment (SSA) form – a key governance document.

Information about these initiatives can be found at the following link:
https://www.nhmrc.gov.au/research/clinical-trials/nhmrc-clinical-trials-initiatives

RECOMMENDATION 7
The committee recommends that the Australian Government place licensing requirements for the supply, ownership and operation of diagnostic imaging equipment on the agenda for consideration by the Council of Australian Governments.

Response: NOTED

Radiation licensing requirements are the responsibility of individual states and territories. While the Commonwealth regularly nominates agenda matters for consideration by the Council of Australian Governments, possible nominations are considered alongside competing priorities.