COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

(Roundtable)

Reference: Health funding

TUESDAY, 23 AUGUST 2005

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Tuesday, 23 August 2005

Members: Mr Somlyay *(Chair)*, Ms Hall *(Deputy Chair)*, Mr Cadman, Mrs Elliot, Mrs Elson, Mr Georganas, Mr Johnson, Ms King, Mr Turnbull and Mr Vasta

Members in attendance: Mr Cadman, Mr Georganas, Ms Hall, Ms King, Mr Somlyay and Mr Turnbull

Terms of reference for the inquiry:

To inquire into and report on:

How the Commonwealth government can take a leading role in improving the efficient and effective delivery of highest-quality health care to all Australians.

The Committee shall have reference to the unique characteristics of the Australian health system, particularly its strong mix of public and private funding and service delivery.

The Committee shall give particular consideration to:

a) examining the roles and responsibilities of the different levels of government (including local government) for health and related services;

b) simplifying funding arrangements, and better defining roles and responsibilities, between the different levels of government, with a particular emphasis on hospitals;

c) considering how and whether accountability to the Australian community for the quality and delivery of public hospitals and medical services can be improved;

d) how best to ensure that a strong private health sector can be sustained into the future, based on positive relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in various levels of government; and

e) while accepting the continuation of the Commonwealth commitment to the 30 per cent and Senior's Private Health Insurance Rebates, and Lifetime Health Cover, identify innovative ways to make private health insurance a still more attractive option to Australians who can afford to take some responsibility for their own health cover.

WITNESSES

BURNINGHAM, Mr Ian, Group Executive, Risk and Treasury, MBF Australia Ltd 1

HARRISON, Mr Bruce, National Manager, Provider Relations, Australian Health Service Alliance Ltd 1

LEVY, Mr Bruce, Group Manager, Health Services, Medibank Private 1

MULCAHY, Dr Andrew, Chair, Economic Advisory Committee, Australian Society of Anaesthetists 1

NORRIS, Mr Angus, General Manager, Health and Benefits Management, MBF Australia Ltd............. 1

O'DEA, Mr John, Departmental Director, Australian Medical Association.. 1

ROFF, Mr Michael, Executive Director, Australian Private Hospitals Association.................................... 1

SCHNEIDER, Mr Russell John, Chief Executive Officer, Australian Health Insurance Association Ltd 1

SULLIVAN, Mr Francis John, Chief Executive Officer, Catholic Health Australia.................................. 1

TOBIN, Mr Patrick Dudley, Senior Policy Analyst, Catholic Health Australia 1

WAINWRIGHT, Dr Dana, Chair of Council, Australian Medical Association.. 1

Committee met at 9.34 am

BURNINGHAM, Mr Ian, Group Executive, Risk and Treasury, MBF Australia Ltd

HARRISON, Mr Bruce, National Manager, Provider Relations, Australian Health Service Alliance Ltd

LEVY, Mr Bruce, Group Manager, Health Services, Medibank Private

MULCAHY, Dr Andrew, Chair, Economic Advisory Committee, Australian Society of Anaesthetists

NORRIS, Mr Angus, General Manager, Health and Benefits Management, MBF Australia Ltd

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TOBIN, Mr Patrick Dudley, Senior Policy Analyst, Catholic Health Australia

WAINWRIGHT, Dr Dana, Chair of Council, Australian Medical Association

CHAIR (Mr Somlyay)—I declare open this roundtable public hearing of the House of Representatives Standing Committee on Health and Ageing for its inquiry into health funding. During the inquiry, the committee will explore how the Australian government can take a leading role in improving the efficiency and quality of the health care system. You are no doubt aware that the Council of Australian Governments meeting on 3 June agreed that senior officials would consider ways of improving Australia's health care system. The committee's inquiry should be seen as a separate but complementary process to the COAG process, as our inquiry gives organisations and individuals such as yourselves, outside of government, an opportunity to express your views in a public process. Indeed the public are welcome to observe this roundtable, and the transcript of evidence gathered today will be available on the committee's web site.

I remind you that members of parliament are acutely conscious of the pressures on our health care system, as we all receive a steady stream of people into our electorate offices with complaints, often about private health insurance premiums, gap payments and waiting lists. So we too have a vested interest in improving the system. This roundtable will be focusing on the role of the private health sector in the health system. The aim is to allow the committee to hear diverse and varied views from key stakeholders in a forum that encourages discussion and debate. All witnesses should have received guidelines for the conduct of the roundtable. These

guidelines ask that participants complete a Hansard witness identification form and that only one representative be seated at the table at one time, but that representative may be rotated.

I will shortly invite you all to make a three-minute opening statement. We will then discuss topics on a theme-by-theme basis and you will again be invited to make three-minute statements, but on a particular topic. Following these statements, members of the committee will have the opportunity to ask questions before I open the floor for general discussion on the topic. I will watch the time limits to ensure that everyone has an equal opportunity to put their case. Please also remember that, if you do not get all of your points across, you can put them in a supplementary submission at a later time.

All witnesses should be aware that, although the committee does not require you to speak under oath, these hearings are formal proceedings of the Commonwealth parliament and that the giving of false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. The evidence that you give today is covered by parliamentary privilege. I now invite each representative to make a three-minute opening statement, before we turn our attention to individual topics. Before we do that, I would like to compliment everybody who has put in a submission to this committee. I have been in parliament for 15 years and have served on many committees, many of them I have chaired, and I have never seen so many well-thought-out and well-presented submissions. The committee has received submissions of a very high quality, and I would like to state that the outset.

I invite Mr Michael Roff, on behalf of the Australian Private Hospitals Association, to commence proceedings with an opening statement.

Mr Roff—Thank you. I am the Executive Director of the Australian Private Hospitals Association, which is the peak body representing the interests of both for-profit and not-for-profit private hospitals and day surgery centres in Australia. I would like to thank the committee for the opportunity to appear today. We have provided a submission and some supplementary information to the committee. I do not intend to expand on that during this statement, but I am happy to take questions and to participate in the discussion. I would like to pass on apologies from Mr Pat Grier, the Managing Director of Ramsay Health Care, which is the operator of the facility we are in today. He wanted to be here to welcome the committee and participants but, unfortunately, he was otherwise detained.

Mr Burningham—I am the group executive in charge of treasury and risk management for MBF Australia. MBF is the second largest health fund in Australia, and the largest non-government owned fund. We operate two private insurance funds. We also have previously made a submission. We would like to thank the committee for the opportunity to do that as well as to contribute today. Certainly, from the perspective of MBF Australia, these kinds of sessions are incredibly important. We think that the Australian health system is a very good one by world standards, and part of its strength is the balance between public and private health and the funding and financing of public and private health. As we go through the day's proceedings and we drill down into what is really the private funding side of that, it is important to remember that what the private sector does, at least in our view, is provide that balance to the public sector and provide consumers with choice.

We will be doing a bit of a tag team match. One of my colleagues will be joining me for specific themes. Again, thank you for the opportunity to contribute and participate.

Mr Harrison—I am the National Manager, Provider Relations with the Australian Health Service Alliance, which is generally referred to as the AHSA. By way of background, AHSA is a private company owned by its registered member health funds, which currently number 25. Our primary functions include hospital contract negotiations, administration of a known gap medical scheme with doctors, data compilation and industry analysis—all of which our member funds outsource to AHSA. We were formed in 1994 to assist some smaller restricted membership funds in hospital negotiations. We have grown a fair bit since then. Our membership now includes restricted membership organisations, open not-for-profit funds and open for-profit funds. Over the last 12 months, the combined membership of AHSA purchased in excess of $800 million worth of hospital and health care services on behalf of more than 1.6 million Australians.

As such, I think we are well placed to comment on some of the topics being addressed by this roundtable, particularly issues pertaining to contract negotiations and full financial consent. Projections that we have done estimate that demography and utilisation will increase fund costs by around four per cent per annum in the foreseeable future, while projections beyond five years are subject to increased uncertainty and indicate that the rate of increase in hospital charges due to a demographic change will steadily accelerate. Combined with an assumed average increase of between three and four per cent in hospital charges, the effect is a seven to eight per cent growth in fund expenses per year for the foreseeable future and a corresponding increase in premiums. This assumes that the membership base structure remains about the same.

These projections highlight a major issue facing the whole private sector. Private health fund premiums are being driven by factors related to demographic change and age standardisation utilisation that compounds the impact of any provider increases. It is a major concern to health funds and the industry generally that this could lead to a major reduction in health fund membership, and those remaining members will be those with above average utilisation resulting in a second round of premium increases. These sorts of figures are somewhat scary from my perspective and do little to ease the minds of governments and health administrators. This Commonwealth parliamentary inquiry, on that basis, is most opportune.

Mr Schneider—The Australian Health Insurance Association represents about 95 per cent of the insured community and represents 25 health funds ranging from very small to very large. One of the points we have made in the submission and on a number of other occasions is that health insurance is not a province exclusive to the rich and well-off; it crosses all levels of the Australian community. Many people are on very low incomes but they have quite deliberately chosen to make the sacrifices necessary to remain insured. In that context, with your indulgence, I would like to correct one part of our submission. On page 39 we erroneously said 1.6 million people in households earning less than $50,000 had private health insurance. The correct figure was 3.9 million people. I will not hold up the committee now by going into the detail of that. We also have to correct a graph where we said the number of people with hospital insurance should replace households. We have supplied a copy of the changes to the secretariat and perhaps those amendments could be noted.

One thing that I think is not always appreciated is the tremendous dilemma that faces people who administer health insurance funds, because every day they have to balance two often

conflicting requirements. Firstly, there are the requirements of the member who is a patient, and that member quite reasonably expects to have the best possible services and is not concerned about their cost. Secondly, health funds also have to represent the very large number of contributors who do not go into hospital frequently—or, in some cases, at all—but whose contributions cover the costs of those who do use health care services. This is a very difficult task to deal with. It is compounded even more by the fact that there is another interest in the equation, which is that of the people who provide the health care. Their interests are, quite naturally, to maximise their income. This creates an ongoing stress within the system which in most cases can be managed. But I do not believe that the difficulties involved in managing it are understood as well as they should be.

Finally, the one point that I would make which I think is key to our submission is that over the last 20 years the way health care has been delivered in Australia has changed quite dramatically, but the way we pay for it has remained rooted in the past. I think it is time we let this inquiry look at the extent to which we can make improvements to the methodology of payment for health care in the private sector. Thank you.

Dr Mulcahy—I am Chairman of the Economic Advisory Committee of the Australian Society of Anaesthetists. I would like to paint a picture of anaesthesia in Australia for the benefit of the committee—sometimes it is not well understood—and explain our role in the health sector and the relevance of health funding to anaesthesia issues. The Society of Anaesthetists is one of the older societies representing doctors in this country. It was founded in 1934. We represent over 2½ thousand anaesthetists, both specialists and general practitioners. That is more than 75 per cent of all anaesthetists in the country and probably more than 90 per cent of those who provide services in the private sector.

Just to demonstrate to the committee the scope of anaesthesia, approximately 1.6 million patients in Australia are anaesthetised every year in the private sector and probably the same number or thereabouts in the public sector. That is, 16 per cent of the entire population are anaesthetised every year. Most of those services, 90 per cent, in the private sector are provided by about 2,000 specialist anaesthetists. We concede that as a single specialty it probably impacts more on the Australian population than any other specialty. For example, any improvements in the delivery of anaesthesia services can provide benefits to a large section of the population. So small changes can provide for a large impact, hopefully positive, on the population.

Australian anaesthesia prides itself on its record of safety and standards. We would argue that it is the best in the world, without exception. Certainly, that is the result of a rigorous training scheme, which is under the direction of the Australian and New Zealand College of Anaesthetists. We have a longer training period than other countries, we have higher standards, we have comprehensive maintenance of professional standards and we have a very thorough ongoing examination of professional practice. All of these things have led to a very low rate—by the crudest measure—of death from anaesthesia; it has halved every 10 years for the last 40 years to a very low level. But less crude measures are that complications have also been greatly reduced, allowing for many of the advances that we see in the practice of modern medicine today, particularly the fact that people go in and out of hospital on the same day at three times the rate that they did 20 years ago. Anaesthetists have greatly improved their productivity over that time and dramatically changed their methods of practice.

I will expand further through the day, but we have concerns about and an interest in the area of informed financial consent and patient gaps. It is an area you mentioned, Chair. We are concerned about the level of rebates available to patients for anaesthesia services; they are the lowest of any specialty. They have been for 30 years and continue to be to this day. Clearly, that must be a factor when looking at patient gaps. We are concerned about the nature of some of the health insurance products and how they can have an impact on gaps as well. Finally, we have a concern about the arrangements for funding through Medicare if one is trying to secure extra funding for what we believe is a worthwhile project. I will have time to expand on some of the difficulties later. Thank you.

Mr Levy—Medibank Private is a government owned health insurer. It is the only national health insurer, covering approximately three million lives across Australia. We purchase on behalf of our members approximately 1½ million bed days, so in many ways we are the same size as some of the large health departments. It is Medibank's view that we have one of the best health systems in the developed countries. An important reason for this outcome is the almost unique mix of public and private sector engagement in the Australian health system. However, we cannot sit back on our laurels; we need to accept that continual change to the dynamics of how the sectors work is a mandatory requirement if we are to continue with this leading position. We have to continue to apply best practice, if not set the standard for best practice in clinical and administrative innovation and in cost and clinical effective practices in the use of scarce health resources which will collectively maximise value for money for all stakeholders, in particular the consumer.

This continual change to the dynamics of engagement and intrarelationships and interrelationships in some cases may result in some noise across the system. However, we must avoid the temptation—if I can use the expression—of oiling the squeaky wheel and letting the natural dynamics of a system going through evolutionary change occur. Our goal must be for the private health sector to be sustainable and affordable for those who need and want to access it. It must be able to prove its value against what others may see as a free alternative. We need to offer better products that better reflect how health care is delivered today, through simpler processes that remove consumer uncertainty, meet expectations and better health outcomes, exemplify value and secure its position in the increasingly difficult decisions on the use of disposable income.

Government engagement and intervention should not be seen as a measure of failure, as the demands are many, the resources are finite and the delivery of health is complex. Medibank Private is committed to maximising the value and role of the private health sector in the Australian health system and will continue to pursue progressive and innovative change in the delivery of this commitment for the betterment of our members.

Mr Sullivan—Catholic Health Australia is the Catholic Church's contribution to health care and aged care. We run 65 public and private hospitals, 500 aged care services, seven major medical research institutes and five hospices across the country. With your indulgence I would like to read another statement that adds to our submission.

Towards the end of last year nearly 25,000 elderly people were waiting on public hospital lists for treatment. At the same time very well-off Australians, probably younger and fitter, received public subsidies to purchase private health cover, even though they would have bought it

anyway. The current system is inequitable. Despite the political rhetoric to the contrary, people with money do access health care more easily than the low-paid, and certainly more easily than the less connected, the less educated and the less well located in our metropolitan cities. In effect, the more money you have the more health care options you have.

Australia's public policy position runs counter to the usual mantra—that is, we have a two-tiered system based on a person's capacity to pay. Most people purchase health insurance for the assurance of being admitted to hospital at their convenience and with the doctor of their choice. This is a choice they pay for, but it increasingly is a choice Australians are taking because public hospital access is extremely problematic, particularly for people with chronic conditions, the mentally ill and children with complex diagnoses. We are facing a major challenge in Australia. Will access to essential health care remain a full entitlement for everyone, or will we see a slow but deliberate reduction in that entitlement, which inevitably will impact adversely on the poor, the sick and those less able to navigate the ever-increasing complexity of the health system?

As they presently stand, health services in Australia already extract fees from patients. The only exception is public hospitals, which have queues instead. But make no mistake, these fees are not price signals; rather, they are alternative sources of revenue for cash-strapped services. The political climate for too long has deluded the community into believing that quality health services can be delivered for relatively little outlay. Clearly, community discontent signals that this strategy has run its course.

We have a basic choice: Australia seeks either to maintain and strengthen the universal health insurance system or to shift the costs of health care onto privately organised insurance. Our view is that an appropriately balanced combination of the two is the most practical way forward. However, in an era when political populism seeks to reduce taxes, the durability of public services and entitlements becomes questionable. Likewise, where governments seek to construct price-competitive markets in health care, they must also recognise that consumers with complex conditions and difficult prognoses run the risk of being priced out of the private alternative. The danger we face is that, in the interests of reducing public expenditure on health care, we increase public liability as people fall between the gaps, fail to receive timely care, become less productive, and ultimately fall prey to the vagaries of the market on the one hand and the strictures of public rationing and regulation on the other hand.

Regardless of the financing system adopted, governments have a responsibility to alleviate either market failure or public program inadequacy. It is clearly not enough to set the parameters within which a price-competitive health market will operate and then withdraw to the sidelines to observe the fallout. Governments must intervene to guarantee the access for consumers they purport to offer. At the same time, it is plainly irresponsible for governments to proffer universal access to hospital care when that reality, for many sick people, cannot be met. This inquiry, coming after many similar ones before, can make a difference if it is prepared to consider a health system where patients come first, ideologies come last and practical solutions are embraced. Thank you.

CHAIR—Thank you. I now invite Dr Wainwright to speak.

Dr Wainwright—Thank you for giving the Australian Medical Association the opportunity to present here. I represent 38,000 doctors working in both the public and the private sectors and,

most importantly, their patients. Australia has a very good health system. Our citizens have very high expectations of access to quality health care, and by and large they get it, particularly in the private sector. Unfortunately, we have a failing public sector. Patients have access to good acute care but they do not have access to elective care.

The overall cost to GDP is relatively modest. A key ingredient is a highly trained and dedicated health work force, as Dr Mulcahy has said. They are dedicated to excellence and prepared to put the hard work in to achieve it. We have a complementary health system of both private and public and, with the right policy framework, we can do better and we must do better. We believe we have underinvested in health care and we continue to underinvest.

We would like to draw your attention to the following. There are extreme pressures on our public hospitals, reflecting years of malicious neglect and poor planning, which see too many people waiting for too long. There are too few beds in our public hospitals for the patients' needs, all because planners try to drive efficiencies. There is a serious shortage of medical practitioners in Australia and we need to adopt a number of strategies to train more and to retain our existing work force, without sacrificing quality. We have a failure to provide health resources, both funding and work force, appropriate to the needs of an ageing Australia. We have a very poor effort on mental health. We have a failure to make any material gains on the health of Indigenous Australians. I would like to point out, as Dr Mulcahy pointed out, the very high standard of our medical work force and that this must never be jeopardised by a political push to dumb down the training of our doctors or to substitute less well trained practitioners on their behalf.

Some interest groups advocate 'big bang' approaches to the health financing system. We do not want that. We suggest incremental change as the best case and the best strategy, instead of squabbling between Commonwealth and state. There are many aspects of the current health delivery and financing systems that stand in the way of seamless care. We need to change the way health departments and hospitals are managed. It is ridiculous that, at the moment in the public hospitals, four out of every five dollars are not expended at the coalface but are expended by managers and everyone else in the public system. Currently, we have too many managers pursuing economic rationalism and not health outcomes as their goal.

There is no shortage of ideas such as step-down facilities in hospitals, but there is a lack of political will to implement all these ideas. We do need to look at improving the interface between community and institutional care, acute care and subacute care. Above all, we need to improve our public hospitals. We need to maintain the value of private health. The ageing of the population is already throwing out challenges to the health system, and there are bigger challenges to come.

The AMA expects governments to try and shift more of the burden of health financing off budget. It makes it inevitable that private health insurance will have to be treated as a valued partner instead of a sometimes inconvenient adjunct to Medicare. Likewise, private hospitals need to be seen as a vital part of the health infrastructure. The reality is that without our private hospitals our public hospitals are so overloaded they could not cope with even a small drop-out of the private health people. We need to maintain the value of private health. We would like to see informed debate around initiatives such as health savings accounts and some further reconsideration of the respective roles of public and private health insurance. As we have heard,

private hospitals now cover 40 per cent of all admissions and do more than 50 per cent of all surgery.

Finally, we must not erode quality any more. There are lessons to be learnt from the events of Bundaberg. We do need to learn these lessons quickly and to avoid repeating the same mistakes. As I said, we need more local governance. We need political will to change the way we manage our public hospitals. We need a high-quality, efficient private health system to complement what we are doing, we need to maintain that value and, if the funding is required, we need to put it into both systems.

CHAIR—Thank you, Dr Wainwright. It was remiss of me at the beginning not to thank North Shore Private Hospital for providing this facility for us. The committee like to feel that they have a hands-on atmosphere in their public hearings, and I am sure we can achieve that in this context. We are running about five minutes ahead of time, so I might just ask: are there any members of the committee who would like to tease out anything put by the witnesses so far before we go on to the first topic?

Mr TURNBULL—Dr Wainwright, did I hear you correctly as saying that four out of every five dollars in public hospitals was spent on administration?

Dr Wainwright—In the whole health department, from the state health departments to the public hospitals, I understand from Mr Morris, who, as you know, is running the Morris inquiry. I would not dare to dispute his word that four out of every five dollars is spent not at the coalface.

Mr TURNBULL—By 'coalface' you mean doctors, nurses—

Dr Wainwright—Allied health.

Mr TURNBULL—allied health professionals, drugs and presumably pharmacists?

Dr Wainwright—Yes. I understand that that is so and I have no reason not to believe it. We are top heavy with managers in our public health system. Compare that to the private health system which is lean and mean as far as its administrators go, who actually do take part in clinical care. We have got the wrong approach.

Mr TURNBULL—How does that mesh with Mr Sullivan, who said the problem was that ideology does not come last? Mr Sullivan, your answer seems to be that the government should put more money into the system. You did not mention anything about efficiencies. How do you react to that? Clearly Dr Wainwright is raising a big issue about efficiency.

Mr Sullivan—I think Dr Wainwright might be raising a question about how the public hospital bureaucracy is organised. Is that right, Dr Wainwright?

Dr Wainwright—Yes, that is correct. Unfortunately, they drive efficiencies and they are involved in economic rationalism; they do not look at health outcomes.

Mr Sullivan—And that has been a longstanding critique.

Ms HALL—And that is not at odds with what you were saying, is it? You were not commenting on that.

Mr Sullivan—I was not actually going to that in what I said. I was talking about the fact that an inquiry today which is primarily looking at hospitals and hospital insurance, be it public or private, also needs to examine the fact that insurance is meant to get you to care when and where you need it. We have problems on both sides of this debate. One is an entitlement insurance which, for many Australians, does not work suitably in a timely manner, particularly, as I mentioned in our opening statement, for people with chronic conditions. I think Dr Wainwright made the point, and I concur, that the health system is not just about the hospital; it is about community care and backup in chronic care, particularly for the elderly. Second, in any price competitive market, if insurers are placed in competition with each other to drive down the price of providers, then some users of the system get priced out, and we can see that happening in private health care—again, it is usually people with chronic conditions and complex diagnoses. That is the import of what I was saying.

Ms HALL—Dr Wainwright, could you comment on what Mr Sullivan said and whether or not that is at odds with what you were saying?

Dr Wainwright—No. I think both sides are for the patients. It is the patient who is suffering in both our public hospitals and private hospitals. I should point out I am a practising general physician, mainly at the Royal Brisbane Hospital. I am also in private. I advocate for patients on both sides. Patients with chronic complex diseases are the ones who are missing out in both the public and private spheres. As this is mainly about private, they are missing out in the private sphere, and we need some new insurance models that look after these people in the community. Some talks are already going on to try and achieve that.

CHAIR—One of the weaknesses so far of this inquiry has been that we have had no submissions from consumers, from the patients. We have sought to remedy that by speaking with the Ombudsman, who will be giving evidence to us at a later date. The figure I use for the amount of money spent on administration in the public sector is 20c in the dollar going to the patient. What do you think is a fair figure that should be achieved? Morris speaks about cutting down administration bureaucracy. What is a fair amount of money that goes to the patient and what is that figure in the private system?

Dr Wainwright—I have no idea. I am no economist but I do know that it is the way we manage. It is not just the money that goes to bureaucracy; it is the fact that they measure activities like biscuits in a production line instead of measuring whether the patient actually got better. They measure throughput and they give bonuses and penalties for that throughput, and they need managers to manage it. I do not know what the correct amount is. Maybe we could go back some years and look at how the bureaucracy was not top heavy in those days and where we at least did the best we could.

CHAIR—Does anyone have a view?

Mr TURNBULL—I make just one observation. If 80 per cent of the dollars are not going to the coalface, then a 25 per cent reduction in the administration costs would allow a 100 per cent increase in the money that is spent on patients. So the dividend from operational efficiencies

could be enormous. I think part of the problem—and this is the core of the problem—is if, say, you compare funding for schools and funding for health, the demand for health is potentially unlimited. At some point, in a school system, if every child has a school they can go to, a classroom and a teacher there, then if you build another school you will not be able to fill it. But the difficulty with health is that you either allocate services by a market mechanism where price is the signal or you have a system where you basically have caps and queues, and that is essentially the public system. I would be interested to know what the alternative is because demand, with no price signals at all, is obviously limitless.

Dr Wainwright—That is very true, but we need honesty from our politicians stating the true state of the nation with regard to waiting lists, for example. We have a hidden waiting list with hundreds of thousands on it, which never hits the press, yet we measure a very false figure of waiting. We need honesty and the community needs to be involved in the debate of where the very scarce health dollars go, particularly in the public sector.

Mr TURNBULL—Do you not think that part of the problem is that people do not understand what health costs? The costs are hidden, either through the public system or through insurance, and there is a lack of understanding of what exactly health is costing us, what procedures cost and what hospitals cost. We have a big debate about health but the raw material for that debate—that is, information, is sadly lacking.

Ms HALL—I have news for you. In my electorate those who want to see a doctor or need to get treatment in a hospital are not going to sit down and gaze at their bellybutton and think about the health costs. They want to know that they can get into hospital when they need to, and we need to ensure some equity in the system. I would like to hear your comments on that, rather than on something as esoteric as people sitting down and considering the economic consequences of the health system when they are sick and cannot get their hip replacement operation when they need it.

Dr Mulcahy—I would like to support Dana’s call for honesty in the debate. The general public cannot even enter the debate if they do not understand the problems. Frequently, in every state, you hear talk of the routine eight-week closedown over Christmas and six weeks over Easter. This is because they do not have the budget to fund services through that time. They are not routine at all. They may be now. They have become routine, but they should not be. Until we actually say to the public, ‘We do not have enough money to do all the hip replacements, therefore, the waiting list will be three years,’ the public cannot even have the debate because they do not understand the problem. Once they understand, they can then have the debate and decide whether more resources need to be devoted through increased taxation or taking it from some other area.

Mr CADMAN—Would Mr Roff like to make a comment on the proposal that the private health funds, private and public hospitals, medical practitioners and other health professionals form a group known as the Australian private health council to consider the importance of the private health industry?

CHAIR—I think we will cover that in the topics as we go on. This is a general discussion on the opening statements. I will close discussion on that and move on to our first theme, the contracting arrangements between private hospitals and private health insurance funds, which

has been the topic of discussion, media comment and correspondence between the funds and the hospitals. Mr Sullivan, would you like to make some brief opening remarks on that?

Mr Sullivan—Our comments on this are global in the sense that this system of contracting between hospitals and health funds has been running now since at least the early part of the 1990s. We have been, as a hospital group, relatively supportive of that change. As I said in previous statements, the difficulty is that, particularly if you want to run not-for-profit private health, part of your reason to run not-for-profit private health is to try to offer a comprehensive range of services, not necessarily wanting to provide niche services—not to discount those who do. We have found over the period that, in some aspects of the contracting arrangements, with less lucrative patients who come with more complex caseloads and therefore are going to be more expensive to treat, you run the risk, as a hospital, of ending up servicing those patients beyond the reimbursement period. This is the high-risk end. The difficulty is that at a public policy level I do not think we have proper information to see what is happening for the longer stay patient and whether those services are beginning to vanish from the private health sector and in turn are shifted back to the public sector. This is counterproductive, given the government's subsidy arrangement which is trying to encourage the use of private rather than public facilities. That is the first point.

The second point is that the contracting relationship between hospitals and health funds is slowly maturing. It has had its difficulties. I understand that it could have been titled 'noise', but it has had its difficulties. In particular we have seen consolidation in both sectors and the Catholic hospitals have been very prominent in that. We have created bigger companies. Most of our private hospitals are in four major groupings and this has been a deliberate response to the structure of a price competitive market. I think that has assisted in the relationship with funders. The committee needs to be mindful of the fact that the contracting environment has necessitated a major capital investment on the side of both insurers and hospitals in the area of IT so that people can know their costs, negotiate appropriately and contract the costs efficiently—which goes to your previous question. I think I will leave it at that. There are other aspects to this but I am sure they are going to be picked up by others.

Mr Levy—A health consumer's entitlements to private hospital services comes from their hospital insurance cover. However, the cover that a member obtains from this exceeds just hospital services and also includes medical services and the fees charged for those medical services. It includes prostheses, and the fees charged for those which are often set by government processes, pharmaceuticals and also diagnostic technology. The first point to remember is that, when going through a hospital contracting arrangement, the funds that are available for a fund to meet those services go beyond merely the services provided by the hospital. The funding for these entitlements is finite. It comes directly from the consumers premiums. There is substantial evidence to show that when those premiums increase at the rate of two or three times the CPI the consumer not only changes funds but also often leaves the industry in its entirety. So the use of those funds has to be judicious and has to recognise that efficiency is driven by what we would call commercial and competitive realities which are important to help balance and use the scarce health resources across the sector.

Similarly—and this is a point which we will no doubt be discussing during the day—the traditional form of those contracting arrangements which deal with services, as we loosely call them, within the hospital world needs to change. Much of the health care delivered now for our

members is beyond the hospital world. If we can make arrangements to pick up those services and ensure that our members can access them in an efficient way, we believe that the use of those resources will be a lot more effective.

Dr Mulcahy—I think the interest of the Society of Anaesthetists, and probably the medical profession, in this issue is where the contracting arrangements can have an impact on patient standards. Our main concern would be that standards of care are not affected by these arrangements. Clearly, both insurers and hospitals have to remain viable. As has already been stated, health care costs are continuing to rise and certainly at a greater rate than the CPI. New technology is expensive. Pharmaceutical costs are increasing and there is no sign that that is going to abate in the near future. So this is obviously a major problem for the private health industry.

Be that as it may, the patient must remain the focus of this issue and there must be a maintenance of standards. I can give examples of where some of the squeeze being put on hospitals at the moment, and the efficiencies they are striving for, has had a direct impact on patient care. Increasingly, patients are being asked to come into hospital closer and closer to the time of their planned procedure. That has some benefits, but if an appropriate time and mechanism for a proper patient assessment is not allowed or is not built into that process, when we look at three million patients every year, that is going to lead to some bad, avoidable outcomes. We know that for a fact.

Another area in which we have seen a change recently in the private sector is step-down units between intensive care and ward care. These are common in public hospitals; they are called HDUs. They used to be common in private hospitals. Because of a lack of appropriate funding arrangements for the hospitals, most hospitals are no longer able to provide those services. Patients are now going to the ward when they perhaps are not ready to. Again, that will have a direct impact on patient care. From the point of view of patient care, that is our main concern on this issue.

Mr Schneider—There are a couple of things I would like to point out. I would like to go into the history of contracting. One of the problems we have in the whole private sector debate is a concept that many years ago I described as a cargo cult mentality on the part of providers—that is, the fact that one provides care automatically entitles one to a third party reimbursement at a level determined by the care provider. Unfortunately, that is not practical in the real world because, as I said earlier, the payer has to take into account the interests of those people for whom they act as an agent, not all of whom are patients at any given time.

The other point that is possibly a little relevant in the context of Dr Wainwright's comment about the percentage of money that goes to care is that, in the private sector, 90 per cent of the health insurance dollar, give or take a little bit, goes to providers in one form or another. I am not going to try to put myself in a position of comparing apples with oranges because I accept that it may not be directly relevant to the public sector. There may be some administration costs in respect of private hospital providers but 90c in the dollar goes from the health fund contributor to the provider of care, which is not bad.

The history of contracting I think, is useful to see to get things into context. Up until about 1994, we were in an environment in which hospitals determined simply what they would

charge—often based on recommendations from their state association—and health funds would be expected to match those benefits. There was nothing to stop hospitals charging whatever they liked, nor is there today. We had a gap appearing between what the hospital charged and what the health fund was able to pay, based on what it could raise from its contributor base.

This led to considerable dissatisfaction on the part of consumers who found that, if they did go to hospital, the liability they had was unknown, and that might not be covered by insurance. The result of that was that the then government agreed to introduce legislation encouraging the development of hospital purchaser provider agreements or contracts, and similarly tried to deal with medical gaps, which were also a problem and remain so. They introduced legislation allowing the development of medical purchaser provider contracts.

The problem, I guess, in terms of perception even at that time, when there was considerable underutilisation of private hospital resources because of the small insured population in those days, was that there was a view that every provider should be entitled to a contract as of right. Contracting really is not about that. The concept of contracting is to allow a proper negotiation—a commercial negotiation—between a person who is paying a bill and the person who is providing the services with a view to striking a mutually acceptable arrangement. I say 'mutually acceptable', not necessarily liked by both sides, because everyone who is paid believes they are underpaid and everyone who is a payer believes they are paying too much. But the concept is to try to come up with a mutually acceptable arrangement whereby the patient is fully covered if they use that particular hospital. Theoretically, the hospitals that benefit from that should also enjoy the advantages of increased volumes. In most businesses that I am familiar with, an increase in volume usually does allow you to reduce your unit margins. So that was how contracting came about.

Since then there has been a substantial increase in the insured population. That substantial increase has led to a small increase in private hospital beds, but not one of the same percentage, by any means. Private hospitals that once upon a time had empty beds and were very anxious to take a contract at virtually any price are now in a position where their beds are very close to being full, in some cases, although some hospitals still have occupancy problems. To a certain extent that has shifted the commercial power relationship between the two sides. But I come back to my original point: contracting was never intended to guarantee every hospital a contract to the health fund for 100 per cent of the time. It is natural enough that there will be times when one side or the other falls out of contract.

We hear a lot about the threat of contracts being broken, but we should also remember that the threat to break a contract can itself be part of a negotiation and we should not get too excited about that. One of the biggest problems in trying to evaluate the significance of contracting and its impact on the provider is the lack of transparency. Any of you can simply go to the report issued by the Private Health Insurance Administration Council and find extremely intimate details of the financial position of every health fund in Australia. You cannot do the same thing with hospitals. So if the discussion about contracting and the impact of contracting on providers, particularly hospital providers, is to be meaningful, we really do need to see much more information about the financial position of hospitals, and I strongly urge that that be considered by the committee and, indeed, picked up in your report.

Mr Harrison—My comments follow very closely to what Russell was just saying—for a second, I thought he was reading my notes. As I said at the beginning, AHSA has been involved in contract negotiations since 1994 and, since that time, the landscape has changed. We have seen health fund amalgamations, private hospital closures and the formation of large private hospital groups. At the same time we have seen rebates for the privately insured and the introduction of Lifetime Health Cover, which generally have all been positive for the industry. We have also seen a shift in the power base between private hospitals and the health funds. Traditionally, health funds have been portrayed as the ogre of the industry, with the all-powerful health funds dictating to private hospitals. That is certainly no longer the case, and we look at the high occupancy levels within private hospitals. Certainly the large geographic spread of private hospital beds and the large hospital groups has levelled that playing field.

One of the issues that Russell raised is an indicator that perhaps the playing field is not so level, and that has come back to the financial reporting aspects. If you have a look at the private health funds you will find they are subject to almost unheard of scrutiny in terms of their PHIAC reporting. Their financial performance indicators are published for everyone to scrutinise, their gap schemes are up on web sites for public scrutiny and they are subject to television current affairs programs in terms of comparing product prices and so forth. I think that is probably a good thing; it has driven greater efficiencies through the private health fund sector through the benchmarking that occurs as a result of all that. So that is actually something that, I believe, the health funds encourage and should encourage, because it has a positive impact.

As Russell said, there is really no transparency at all in the private hospital sector. The public companies publish their results, but there is really no benchmarking that can come out of that from an individual hospital perspective. As part of the negotiation process we seek to get financial data from private hospitals. Generally that is not forthcoming. The response to that question is generally one of, 'We don't have to provide that; it is none of your business.'

Mr Norris—I head up negotiations for MBF across the full suite of services we purchase—hospital, ancillary, medical and everything else. I would like to try and take a slightly different tack, even as a health insurer. If we were to read the purpose statement we could maybe translate it to read slightly differently in that a strong private sector can only be sustained into the future when health funds, private and public hospital operators, medical practitioners and all other stakeholders finally realise they are part of the same industry and that they need to work together to deliver quality health care services at an affordable price in the most appropriate setting. That is the objective behind any contracting that MBF is now pursuing. Contracting is about achieving change; it is not about arguing over unit cost increases. We must find the efficiencies within the system and reward and penalise with our contracting arrangements.

The private health care sector comprises three distinct significant operators: health funds, hospitals and doctors. The relationship between health funds and hospitals, whilst at times tense—as it should be in any commercial arrangement—ranges from minimal to extremely positive. The relationship between the health funds and the hospitals with the medical profession on matters of sustainable affordability is almost nonexistent. It is the relationship with the medical practitioners that holds the key to a vibrant, quality, focused sustainable private sector.

Health fund hospital contracting has matured over the past decade. I noted that Francis stated that, and I believe it is one of the key things that we need to bear in mind. The private sector 15

years ago was a cottage industry. We are now a significant player in health care and I think all parties are starting to find their place in it. Most health funds are setting their purchasing objectives around addressing the key drivers of escalating health care costs, which in 2003-04 grew by $575 million. The private sector is now paying $7.6 billion. That is a lot of money and we are a significant player. But the drivers of health care costs, as everyone knows, are increasing utilisation, ageing population, advances in technology and the rising cost of prostheses.

I believe it is only fair and right to point out at this time that some hospital operators have accepted this approach and share our concerns over the unsustainability of the current funding arrangements. Hospitals are coming to the table and embracing change. In order that we can drive change which challenges the inpatient-centric mode of care, we need hospital operators with us and they need to be adequately rewarded for their efforts. It should be understood that hospitals drive the revenue from inpatient admissions, so why would they actively work to reduce their inpatient throughput? Health funds must be able to reward hospitals for the prevention of inpatient admissions, for substitutional care to acute hospital care and for outpatient programs which either reduce inpatient length of stay or mitigate the need for inpatient care altogether. For this to happen, health funds should not be penalised through the current reinsurance arrangements whereby health care costs for non-inpatient services cannot be included in the reinsurance bill.

As previously stated, hospitals must be rewarded for being change agents by ensuring that their financial viability is not put at risk. We recognise this. The current second tier arrangements in place are a significant barrier for this to occur. That a health fund should have to pay to a hospital that does not want to enter this new paradigm of health funding 85 per cent of what we pay a contracted hospital is perverse. It is our position that second tier arrangements should be withdrawn, or relooked at and fixed, in order to coincide with any changes to the expansion of out-of-hospital services delivered by hospitals and allowable to be paid by health funds. We believe that these two things must go together.

Mr Roff—I will start by picking up on a point made by Mr Schneider in relation to an assertion that there is an expectation that every health fund will have a guaranteed contract with every hospital. That has never been the position of this association. I wanted to put that on the record. As we stated in our submission, we believe that the contracting environment is flawed. I agree with some other speakers that it has matured over time, but we still believe it is flawed. It does not take place on a level playing field. This has been evidenced by a decline in hospital margins from up around nine per cent in 1995, when contracting became widespread nationally, to around six per cent today—and that is the average across the industry, so there are a lot of people existing on a margin of less than six per cent. The health funds might say that that is a good thing and is evidence that contracting has been successful, but in our view it particularly jeopardises the ongoing viability of the independent part of the private hospital sector, which does not have any countervailing market power against the health funds.

It also jeopardises investment in education and training. Allen Consulting conducted some research earlier this year that shows there is a least $35 million being spent annually by private hospitals on training doctors, nurses and allied health professionals. That is not from any external funding source, so that comes out of the operating margin. It also jeopardises ongoing capital investment. Last year’s Australian Bureau of Statistics figures showed there was a 35 per

cent decline in capital investment in private hospitals, and that raises some issues about the ability of the sector to meet the increasing demands of the ageing population that we heard about earlier today.

I would like to pick up on the point about the second tier. We believe that the maintenance of the second tier benefit is essential. In the space of a year it has gone from around 30 hospitals to 130 hospitals that have now received eligibility for second tier benefits. There is another meeting tomorrow to consider a further 60 applications. That is probably further evidence of the flawed contracting environment, but it is also evidence that the second tier default benefit needs to remain. I also note that Medibank Private have decided to pick up the second tier methodology as their off-contract payment methodology for any hospitals they do not contract with as a result of their current process. So at least one health fund seems to think it is an appropriate mechanism.

A couple of people have also referred to the change in the landscape and consolidation within the private hospital sector. That has been travelling quite quickly and moves as we speak. There will probably be further announcements about that later this week. One of the key drivers behind private hospital consolidation has been the contracting environment. Whereas health funds can band together, for example, in a health service alliance to negotiate jointly, the only way hospitals can do that is under a formal corporate structure. That is why we have had the emergence and expansion of hospital groups. It has happened in both the for-profit and the not-for-profit sectors, with the Catholic groups and Uniting HealthCare in Queensland as well. It has been a direct response to the contracting environment.

One of the key problems is that the benefit increases paid by health insurance companies do not keep pace with the cost increases incurred by hospitals. I want to emphasise that the cost increases are happening in both the public hospital sector and the private hospital sector. That is recognised in the indexation arrangements built into the health care agreements, but it is not recognised in the benefit payments that come to private hospitals. I know it is very difficult to try to balance the perceived need to keep premiums down or keep premium increases to an acceptable level with, on the other side, a guarantee of timely access to quality care in the private sector. But that is really the balancing act that we have to try to undertake in this industry. I was interested to hear Mr Norris’s comments in relation to a new approach, and we would be happy to engage on those sorts of issues. He talked about penalties and incentives. I would like to see some further incentives across the industry in relation to improvement of quality of services in the private sector under a pay-for-performance model.

I think the issues in relation to transparency that have been raised before cut both ways as well. The health insurance companies have to be open and transparent with their membership about what it is they are providing, because through the contracting regime they have been subtly limiting services through financial incentive and disincentives both to specific types of services and total services. We have seen that in Medibank’s current approach with some of their efforts to try and cap volume.

Ms KING—Why?

Mr Roff—In relation to Medibank’s attempts to try and cap volume, which at the end of the day is not determined by the hospital, they are trying to put in some financial disincentives for

hospitals to increase volume, which we have heard is going to happen anyway because of the ageing population. So I think there really needs to be some honesty and transparency from the health insurance companies about what it is they offer. If we are going to move down this road of rationing and capping—well, fine, but let us be open about it.

Dr Wainwright—These issues are mainly for the hospitals and the health funds. From our perspective it is very important that standards are maintained if any of the rationing and capping occurs, as Dr Mulcahy said. It is very important that patients retain choice—choice of provider and choice of hospitals. It is very important that patients with chronic diseases are not excluded from treatment, either as an inpatient or an outpatient, because the current bulk payments do tend to exclude or preclude patients with chronic diseases or the elderly from accessing inpatient care.

With regard to outpatient care, we are currently negotiating or talking with many of the health fund providers about looking at alternative products that could keep patients out of hospital but not in a managed care environment. So we want to see maximum stability in the sector and we want the second tier default benefit retained, just as Mr Roff has said. Our private hospitals are already overloaded, particularly in winter. If the second tier default benefit goes and the hospitals go to the wall, our poor public sector is going to be even more overloaded and coping even less. As we said, it is a complementary sector.

In relation to gap cover schemes, which have not been touched on very much, we think there should known gap cover schemes available from every health fund. We are going to discuss shortly the no gap arrangements, portability and informed financial consent. We will go more into that in the next session. We think it is very important that the contracting arrangements are transparent as well. I would concur with Mr Roff on that.

CHAIR—Mr Norris, you mentioned the cost drivers. Mr Roff, I thought you were going to speak about that as well but in the general discussion. Do you agree with Mr Norris on what the main cost drivers are? I do not think wages were mentioned as a cost driver? Did you mention wages?

Mr Roff—I think Mr Norris was talking about cost drivers for the insurance sector.

Mr Norris—That is correct.

CHAIR—There is quite a bit of mobility in staff between the private sector and the public sector.

Mr Roff—Yes, but certainly wages are a key cost driver in private hospitals—60 per cent of a hospital's cost base is in staffing and the majority of that is in nursing wages. They have increased quite considerably around the country and tend to follow a state-by-state pattern. If New South Wales gets a 15 per cent increase, Queensland will get one the following year. There is also competition between the public and the private sectors in relation to the nursing work force. It is a highly mobile work force. There are still nursing shortages, although the situation is not quite as dire as it was perhaps three or four years ago. But that is still a major part of the cost base of private hospitals.

Another issue that plays in there is in relation to volume increases. Mr Schneider talked about the possibility of reductions in unit price with increasing volume. Private hospitals have very high variable costs, particularly nursing wages. If you have more patients in your hospital, you need more nurses to be able to provide that quality care. That costs money.

Mr Schneider—I concur with all of that. I think the important part about this is that work force, and the work force capacity, is the real sleeper in the health reform debate. Having enough people to do the job in the medium term is a big issue and, obviously, wages will be driven up because of that. We have found, particularly where hospitals are not located in metropolitan areas, that it is very difficult to acquire staff. If you also have a private hospital near a public hospital there is intense competition around wages. Finally, if you are an organisation that provides broader health care than just hospital provision—in other words, you are also providing residential aged care or home nursing services—it is very difficult to attract nurses away from the hospital. The whole issue around wages and work force is probably our biggest headache.

Ms KING—I particularly want to focus on the issue of smaller hospitals that both Mr Sullivan and Mr Roff have alluded to. What is happening to smaller hospitals at the moment? I am thinking in particular of the Victorian case. You have seen that Freemasons have just gone on the market with claims that they have not had a lot of money to invest in capital over a long period of time. What are your comments about what is happening with smaller hospitals?

Mr Roff—I think they are finding it increasingly difficult. If nothing changes, I think we will find that in a couple of years time there are not many small hospitals, either because they have become another type of facility or they have been incorporated or consolidated into a large group to try and get the economies of scale and market power in balance.

Ms KING—I want to ask about the relationship between contracting and health reform. I think Mr Norris is one of the first private health insurers I have heard talk at length about some of the drivers in that. I understand there is a program called AUSeMED; I do not know if that is operating throughout Victoria. Can someone talk to me a little bit about how that is evolving and how that has been a partnership between private health insurers and hospitals to get some reform?

Mr Norris—I hope my new employer, Eric Dodd, is not in the building. I was with BUPA Australia health insurance when AUSeMED was formed. I headed that up, so excuse me while I talk about this with another hat on. AUSeMED was a group of accident and emergency physicians who came to us and said, ‘We think we can play a role in minimising the need for inpatient care where it is not appropriate and necessary.’ That is very enticing to any health fund but, more importantly, what struck me was that it was very enticing to physicians. They also saw that, because of the lack of options available to them, there were people finding themselves, at the most inappropriate time, in an inpatient, acute hospital setting. What we finally came up with was a situation where an accident and emergency department in the private sector was actually triaged with a view to providing what was the most appropriate care needed at that exact point in time. In other words, when a general practitioner, who does not have the time or resources to case manage people with chronic diseases throughout the whole of Victoria or Australia—which is an absolute fact—is phoned at nine o’clock at night then that GP has no option in many cases but to say: ‘Look, we need to send you to the accident and emergency department of the hospital. It is the only place you are going to get care.’

What we did was to put a circuit-breaker in there that said, ‘Triage: this is the type of care that this person needs at this point in time,’ and, if that meant inpatient care, they got it immediately. However, if that meant more appropriate care—such as substitutional care, step-down care, 24-hour phone call access to doctors and nurses at any time that they needed it—it linked it all back to the general practitioner by saying to the GP, ‘We want you to case manage these chronic members.’ I do not believe GPs are funded appropriately through Medicare for case management. I do not believe it is anywhere near enough for them to do so but, with the right type of program that AUSeMED delivered, we were actually able to put in a circuit-breaker. I am not in a position to talk about how many people are now subscribing. I think it is something over 1,000 just with the one health fund, so it is extraordinarily significant.

Ms KING—How did that operate? Individual members of separate private insurance funds elected to pay extra to be part of AUSeMED? Or was it part of their membership?

Mr Norris—No, there is no extra charge at all. There are two ways in which a member could be referred to the AUSeMED service: either through the general practitioner or directly through the health fund contacting the member. Health funds know where a chronic member is, through their activity. They could be approached jointly, with the GP, and asked, ‘Would you like to avail yourself of this service that is available?’ There is no cost to the patient whatsoever. It is totally free for the patient.

Ms KING—There was a form of case management in that program. That sort of reform was able to happen under the current contracting arrangements?

Mr Norris—It is actually quite diverse. The answer is no. It is certainly available for health funds to do this, but the amount of money they pay is not included in the re-insurance. Those people that are most appropriate for the AUSeMED type services are chronically ill members, and they, invariable, are aged. All of that money is not included in the re-insurance pool by that health fund. That is really quite diverse.

Ms KING—How would you change the contracting arrangements? That is just an example of a good health reform that hopefully had some good outcomes for patients as well as for the costs of private health insurers. How would you change the current contracting arrangements to allow those sorts of health reforms to occur? That is a general question.

Mr Norris—I do not believe that it has anything to do with contracting. If we are going to put some honesty into this debate, we need to get the word ‘contracting’ out. This is about health funds purchasing services, it is about hospitals delivering services and it is about doctors giving best-quality health care. I stated that we really need to see ourselves as an industry and not as individuals. If we go back to the basics, this is about what is the most appropriate care that that patient requires at any given point in time. Once you have identified that, it is then, ‘What is the most affordable and is it in the appropriate setting?’ They are the only three things that need to be addressed.

Health funds’ benefits are restricted to only paying for services delivered in hospitals as an inpatient. We are actually seeing some diversity now, with people who do not need to be admitted being admitted purely so that they can get a benefit. What I am suggesting—and I think this would be embraced by most people around this table—is allowing hospitals, health funds

and the medical profession to actually sit down and say, 'Look, how do we pay for continual care?' 'Managed care' is an abhorrent term for any of us, but care needs to be managed. If care is managed, and that is through a coordinated approach, probably with the general practitioner being the key owner of it, this health sector will work.

To incentivise—to offer these outpatient programs, disease management programs and even preventative type programs—the restriction on health funds of only being able to pay for inpatient admissions need to be lifted. The only way the hospital will make revenue under the current system and the only way doctors make revenue under the current system is if they admit the patient. It is breaking those laws down. That can be quite dangerous if it is not regulated and controlled as to what an appropriate outpatient service is. We do not want to see a situation where it is purely 'cost plus' or in addition to an inpatient service. It really needs to meet the guidelines of better care, be substitutional to inpatient care or reduce the appropriate length of stay. They are the three things. This is not that difficult.

Mr Levy—I can advise the committee on a different program that also looks at avoiding the inpatient setting. As Angus mentioned, there is one that focused on the emergency department. Medibank has over the last two years looked at a different program which identifies health risks within our member base through a health risk assessment and then works through some third-party health professionals to manage the disease load for those members so that their care is coordinated. We recently released the results of that and through third party evaluation saw that in a similar cohort of members the actual need for acute hospitalisation was reduced by 40 per cent for those members. We looked at the quality of outcome for those members who went through that program—in our case it was 1,500 members across Australia. We ran a program in southern Brisbane with a GP division.

In that particular case, working with the health professionals and the member, in particular those with chronic conditions, enabled us to ensure that those members' needs were met. It avoided the high-cost hospital episode. If we are successful in that—and this is the point Angus is making—reducing the average cost of care enables us to better pay for situations when the acute care is needed. That is the point we are making. We understand the acute episode is expensive and there are many drivers that many of us cannot influence. However, if we can ensure that those who access those services are the appropriate ones at the appropriate time, which really means dealing with aged care and chronic diseases within our community, we will be more effective in dealing with the scarce health dollar.

Mr Sullivan—It is important not to misunderstand this issue. Hospitals are hugely capital intensive. People construct beds not out of whim; they have planned the health service, usually in conjunction with the funders. Hospital operators are not in the game of putting people in hospital who should not be there. They would not do that because the reality is that the beds that they are building are built for a purpose so you would not put inappropriate people in the bed because the return on the investment will not be there. It is important to make that point.

The second point is that coordinating the episode will only satisfy the community if the community trusts the coordinator. When we have a price competitive market, hospitals are not competing for patients. We do not compete for patients. We compete to acquire specialists. The specialists bring the patients. This is not about us setting up hospitals to attract all these patients. We are setting up hospitals with particular services inherent in them because we believe from our

planning they are the acute care needs of that community. Then, in conjunction with the specialists coming to use the hospitals, the patients will come. Too often this debate is dumbed down to make it sound like hospitals are trying to grab patients willy-nilly. They are not.

Dr Wainwright—We support relaxation of the rules to allow the health funds to start funding out-of-hospital services. We are aware of the Medibank Private initiatives with regard to their intervention and the positive results. It is very important, however, that when these initiatives and projects are developed the rules are not so prescriptive that the patients are prevented from going into hospital. That has not happened in the project I have seen but it is very important that, as that project is developed, it does not happen.

We also support relaxation of the rules so that out-of-hospital care can be funded by the health funds in conjunction with discussion with the medical profession. We do not want people kicked out of hospital early unless there is community support out there for them. We have already commenced discussions with the health fund industry with regard to this but there are other exciting avenues where we could start discussions—such as dialysis, oncology and psychiatry—but it is imperative that patients have the right kind of care in the right situation. So I think that is an area that we can start looking at together.

Ms HALL—There are three areas I would like to look at. Firstly, I would like to pick up on the issue that has been raised about it being an industry as a whole—including the funds, the hospitals, the nurses and the other medical and allied health professionals. What sorts of things have been put in place already in your industry for everyone to meet and discuss things? Secondly, how can you ensure that it is an even playing field, given the different power relationships that everybody within your industry has?

Dr Wainwright—We have already had a private health summit under the auspices of the minister and we have continuing discussions with the providers of health care. So hopefully we are on the same side in relation to relaxation of the rules about what the funds can provide. We are already working on it and we need to talk to individual funds and collectively.

Ms HALL—How about ensuring that the power relationship between the hospitals and the funds is fairly even?

CHAIR—Is this in the context of contracting?

Ms HALL—In the context of contracting.

Mr Norris—There is not all that much broken in this industry. Contracting has matured significantly over the last 10 years. Negotiations have matured extraordinarily. There is a degree of commercial reality that needs to be understood. Francis very rightly spoke about the costs and the cost basis within hospitals. Russell has also stated that health funds are currently paying out up to 90 per cent and probably sometimes more than 90 per cent of any revenue they get in. There is not a lot of room to play. With the drivers for costs, as the Hon. Mr Turnbull pointed out earlier, this industry is insatiable. Health is insatiable; there is no limit to what you can get or want. The private sector has to be very much on guard in regards to adverse selection. Private health is so regulated that it is not typical insurance. People who know they are going to be ill or have a problem can wait 12 months and receive absolutely anything and everything that

someone who has been a member for 30 years and has never claimed is eligible for. So adverse selection is something that we, as an industry, need to be mindful of.

Ms HALL—Would you like to see that changed?

Mr Norris—Not particularly. It is just a reality. We have something that needs to be sustainable. It needs to be sustainable and affordable to members who want to purchase health insurance. So there needs to be tension between health funds and hospital operators. Health funds need to be talking to hospital operators about efficiencies, not just the current cost base. They need to ask, 'What efficiencies do you have within your system?' At the moment there is an extraordinary bell curve with respect to what are seen to be efficient and inefficient practices within the private sector. That is a fact.

Mr TURNBULL—Could you just explain that? Go back to the sentence about the bell curve and explain what you mean there.

Mr Norris—If you look at the whole range of hospitals within any given state or within Australia, and at private hospitals, the way in which they manage their patients is extremely different. That results in extraordinary differences in lengths of stay, intervention, the types of procedures used, and discharge planning or non-discharge planning. All of those things are part of efficiencies that health funds, rightly, through their contracting, need to engage hospitals with. I stated earlier that a lot of hospitals are now engaging with us at that level, and that is a very positive thing. The real issue here to try to find something which all three parties—the hospitals, the doctors and the health funds—can find to be sustainable.

Ms HALL—Mr Roff and Mr Sullivan, do you think there is an even power relationship between the health insurance funds and the hospitals? If you do not think that is the case, how do you think it could be changed to create a more equal environment? After all, it is about delivering the best outcomes to patients.

Mr Roff—I think it is mixed. If you look, for example, at a large hospital group that operates a lot of hospitals across specialties right across the country in metro and regional areas, they are probably reasonably evenly matched.

CHAIR—Such as?

Mr Roff—Someone like Ramsay Health Care or Healthscope. They probably have a better tilt towards even than, say, a small 50-bed hospital in Sydney that has no other affiliations with any other hospital. When that sort of hospital comes up against an MBF or a Medibank, there is a big disparity in market power and also in information because the health fund has information on every one of its members that has gone to any hospital in the country in terms of costs and treatment and length of stay, whereas the hospital only has information on its particular patient load. So there is an information asymmetry there as well. So it is mixed. The same thing could be said, potentially, in relation to a large hospital group and a small health fund.

Mr Sullivan—As I said earlier, the consolidation of the catholic hospitals was driven by market realities—also the declining presence of sisters, but market realities in reality. We have found that the larger you are the more mutual the relationship. The second point is, we also have,

with ACCC approval, a catholic negotiating alliance group within our sector in which a number of the catholic hospitals participate. When some of our smaller stand-alone hospitals—some of them were in Queensland, some of them were in Victoria—entered the group so that they then became part of sharing information legally, it was obvious that in their previous existence they were being dudded in their purchasing arrangements. But when they were in a bigger group they got a better deal.

Mr TURNBULL—In terms of what?

Mr Sullivan—With health funds. It is a negotiating arrangement.

Ms KING—By how much? Are we talking 10 per cent less or—

Mr Sullivan—I cannot give you the percentage off the cuff but we might be able to give more information separately.

Ms KING—I would be interested to find out. Certainly I have heard a lot of smaller independent hospitals say similar things. It is of concern to me.

Mr Sullivan—The reason I raise the point, of course, is that that is an actual outcome of the public policy setting. You expect that, just as we are finding with our aged care sector. It is a deliberate outcome when you put in place that type of tension around price and when you put in place the transfer of commercial risk between two players. You will find this in aged care as well. There will be huge consolidation going on in the aged care industry. It is inevitable. It is actually something I think the Commonwealth wanted, and I think this is what the Commonwealth wanted in private health as well. So your question needs to be: what else can be done to assist that?

Ms HALL—Would it be a fair assumption then to say that the day of the smaller, more independent private hospital has gone so there is an even playing field for negotiations with the health insurance industry plus the private hospital sector—so it is ‘economies of scale’ everywhere?

Mr Sullivan—I think the reality would be that that is probably the working assumption. There are obviously going to be smaller, stand-alone hospitals well-located in particular markets, usually metropolitan markets, where they will be able to provide a niche product. But as I said earlier, if you are interested in providing a range of services inside an acute facility our experience is that it is better to group.

Ms HALL—Mr Schneider, you told the committee that 90 per cent of premiums go to providers. What I would like is a breakdown from providers of how that 90 per cent of funds is spent; you mentioned wages costs and I know there is workers compensation. Then could we do a comparison of how much of that money actually goes to direct patient care.

Mr Schneider—It proves my point; we hear assertions about the cost of care and the profitability of hospitals but we do not really know about the financial situation of hospitals. If we are going to move into an area where we have an informed debate we do need to have far more information. The fact is that a small private hospital may actually be very profitable—

depending on its location, on the services it provides and on its attractiveness to doctors. Another small private hospital may not be in that same position. We can all make our assertions depending on the interests we represent but until we actually see the numbers no-one really knows what is true.

Ms HALL—That is what I am trying to do, to chase some of those numbers now.

Mr Roff—You are after a breakdown of—?

Ms HALL—Your costs, yes; that 90 per cent of the premiums that go to the hospitals.

Mr Roff—I can start by saying that 90 per cent of the benefits do not go to hospitals. It is less than 50 per cent. They also go to ancillary providers, to doctors for medical payments and on things like prostheses. I do not have the exact figure but around 47 or 48 per cent of outlays go to hospitals. I can take that on notice and provide you with a breakdown with the elements of that if you like.

Ms HALL—That would be really good. I would appreciate that.

Mr Sullivan—I think it is important to clarify the transparency issue; it must be my turn to say something on it. Hospitals already contribute to their costs through the hospital case mix protocol and the national hospital cost collection; all these major collection areas are made available. They are, exclusively, information about hospitals and their costs on each procedure. The data goes to both the health funds and the Commonwealth, and it is published on the internet. At the same time health funds have the opportunity to compare the prices and costs of the different hospitals. Furthermore, what other supposedly private sector industry has to show the financial results of its companies? If you look at something like aged care or even medical practices—are we asking that medical practices also must reveal their financial results?

Mr Schneider—My point was actually that if we are going to understand the situation it is no good relying on assertions such as hospitals have a six per cent margin compared with nine per cent before. We need to look at exactly what each hospital has, and until we know that we do not really know what the true story is.

Mr Sullivan—We are talking about private companies, private enterprise.

Mr GEORGANAS—Mr Sullivan, in your opening statement you spoke about less-lucrative patients with more complex needs, at the expensive end, receiving treatment beyond the reimbursement period. What is the immediate impact on those current patients? In your personal view, is there an adverse effect on the care they receive? What do you see in the future for patients who will need long-term treatment that will go past the period of reimbursement? What is the immediate effect and what will be the future effect on people like that unless we come up with a solution?

Mr Sullivan—The immediate effect, of course, is that anybody who is a patient in a hospital falls under the duty of care and the professional ethics of nurses, doctors, specialists and the like. As far as it goes, if a person is in a hospital the quality of their care will not change because the reimbursement ran out. My point was about the impact that the contracting system will have on

the less-lucrative, complex long-stay patients if we find that they become priced out of the market. In true market theory, one could argue that a whole lot of other providers will pop up to take care of long-care patients. That is not happening, though, in the private sector to any degree. As you can see, it is not happening in the public sector either. In the public sector, the type of patient I am talking about either gets trapped in hospital inappropriately, does not even get into hospital because they are on an extended waiting list or is surviving at home with the best help of friends, family, some community based group or no-one.

Mr GEORGANAS—Is that what I was talking about earlier—the immediate adverse effect on those patients currently?

Mr Sullivan—Yes, that is an adverse effect.

Mr GEORGANAS—So they are not getting the treatment they need?

Mr Sullivan—Clearly. My other point, though—and if we want to go to data, I do not think we have proper data on this—is that we have asked a number of times, through the department, whether there has been an appropriate study to see what services are leaving the private sector as a result of the fall-out of the market. At one of our regional hospitals, for the last six years the private oncology ward has always run at a loss. The chief executive of the hospital used to work for an investor owned private hospital company. He said to us that, in that place, the oncology ward would not run. But, given the ownership of this hospital, it is imperative that they run the oncology ward at a loss, cross-subsidised through the rest of the hospital. That is what you expect from not for profits. But, in a true market sense, it is a no-brainer: you do not run non-lucrative services. If it were to run, where would the oncology patients go? Ultimately, they would go to a public service—as we have heard, usually an overstretched public service. That is my point all along. We do not know how many services have disappeared in the private sector, as much as we do know that many services have grown in the private sector. As we heard earlier, nearly 40 per cent of all surgery now occurs in private hospitals.

Mr Roff—Forty per cent of all services.

Mr Sullivan—So there is growth, but in what area and why?

Mr TURNBULL—Why did that oncology ward run at a loss?

Mr Sullivan—It is complex. There are high-cost drugs that are not covered appropriately, and that cost is worn by the hospital. As I said earlier, medical type patients in particular are usually reimbursed for a period, but if they stay longer you start making losses. Typically, the patients in oncology wards our older and they usually have other than just cancer as an issue.

Mr TURNBULL—Do oncology wards run profitably in other private environments?

Mr Sullivan—They probably do.

Mr Schneider—I think your question is quite right. It is very complex and this is true of both the public and private sectors. The way that health care has grown up, hospitals are quite different organisations from what they were 100 years ago where if you went in, you did not

usually come out. Today it is quite different. We have a lot more specialisation of both medical techniques and hospital services. There was an incident a little while ago, which hit the media, involving the North Shore Private Hospital, where we are today, and a patient with complex problems which the hospital was not geared up to deal with. There was a private hospital not very far away from here that would have been able to deal with that patient because they were designed to deal with complex patients and cases and could have managed it. Because of medical choice, as much as anything else, the patient was not given the option of being referred to that hospital.

The same thing is true in public hospitals. We have a community psyche that seems to think a hospital is a place where you go for whatever treatment you need in one facility. All the evidence and all the science which I have read indicates to me that is no longer relevant. It is much safer to go to a hospital which specialises in the sorts of treatments that you need. It is a particular problem in regional Australia where again there is a view that every town must have its own hospital to provide services to the community. That, in fact, is no longer necessarily in the best interests of the patient. We cannot just say that, because of the way things work, we have problems with complex patients. It is the way some hospitals, quite properly, might have chosen to develop their services. The range of services they provide will be very suitable for some patients but not for others. There are, in most cases, other alternatives available where patients can go.

Mr CADMAN—I want to make sure I have got this straight. The variables are the age of the patient, the complexity of their condition and the cost of running a hospital. Is that what insurers have to look at?

Mr Levy—Utilisation, the general demand for services, is a key factor we need to contemplate as well as the cost of meeting new technologies.

Mr CADMAN—Isn’t that part of the cost of running the hospital?

Mr Levy—No.

Mr CADMAN—Did you not say utilisation of a service?

Mr Levy—The amount of times that our members seek services increases regardless of the cost of running the hospital. The amount of times that our members might wish to go to a facility would obviously increase our costs.

Mr CADMAN—Do you mean the non-medical use of services?

Mr Levy—I thought you were asking me—

Mr CADMAN—The variable factors are the age of the patient, the cost of providing a service and the condition the patient suffers from. I am trying to boil down what this argument is about. It seems to me that the insurers are looking for a process to drive the cost of managing patients to the lowest possible efficient level and that would be good business except the only variable cost in that really—provided the doctors are doing their job—is the cost of running a hospital.

There must be a big variation in the cost of running hospital. To what extent can you vary a base contract to cover the different costs of running a hospital?

Mr Levy—The point that the funds have been making is that if you take age as being a facsimile for utilisation then the engagement of a member into the health system does not necessarily have to be within the hospital walls. There may be other appropriate care settings which deliver good clinical outcomes but at a lower cost than being admitted. Currently, through the regulations, health funds are restricted to contracts with hospitals. The point that we are making is that if a member requires health care, that health care may be more appropriately provided outside of the hospital walls. Everyone would accept that the acute overnight hospital is the most expensive point within the health-care system. If we can move some of those patients out of that system then, for those who need access to that, there may be sufficient funds to meet the escalating costs.

Mr CADMAN—I would have classified that as coming out of the patient's condition but you obviously do not.

Mr Levy—No, because you are asking whether the only variable is the hospital cost. I am saying no, it is not. The place of care is the other variable.

Mr CADMAN—Okay. I will talk about that with you later. I do not understand the distinction you are making. What capacity do you have to vary a base contract depending on hospital circumstances? A small bush hospital must be more expensive to run than a large city hospital. You have been talking about the average cost of care. There are a number of factors in that average cost of care.

Mr Harrison—Contracting has evolved over a fair period of time now. Within that time frame we have seen different methods of reimbursing hospital costs. If we go right back, there was a patient classification system where all advanced surgical patients were lumped into one category, surgical patients into another category and medical patients into another category. An individual hospital would get the same benefit for all patients within each of those categories, irrespective of the actual condition.

What tends to happen now, as I think Mr Sullivan referred to, is that some of the cost weight data provided by private hospitals has enabled a cost system to be developed for each individual DRG—diagnostic related group. That looks at a condition and considers such things as age and complexity so that we are now able to come up with payment models or reimbursement systems to hospitals which consider all those factors and start to even things out. It also enables us at the same time to benchmark each of those individual hospitals on that same basis. What you will find is that there are certainly some small hospitals—and in some cases some larger hospitals—at the lower end of that scale in terms of what they are getting back on a unit cost basis but there is also a large number of hospitals right at the top of that. Within any negotiation process, you are going to find a range of hospitals at the top end and some at the lower end. If you bring everybody at the lower end right up to those at the top end—and that is included in some of the things that are being talked about—then all you do is increase your costs, blow everything out of the water, contribution rates go through the roof and so forth. What we have got is a spread of where hospitals sit in terms of their reimbursement levels, which is a historical factor of negotiations happening over the last 10 years or so.

Mr CADMAN—So there is a considerable variation between each contract with each hospital and maybe, as Mr Sullivan was pointing out, with each group?

Mr Harrison—Certainly there are variations. Not all hospitals are paid the same. I negotiate contracts with a number of hospitals, and I certainly do it with some of the smaller community based hospitals. Those hospitals have a very important role in the whole scheme of things. The funds that I represent are certainly most anxious for those smaller community based hospitals to continue the important role that they play today.

Mr CADMAN—Mr Roff, how does the discussion sit with you? What is the variation and how difficult is it?

Mr Roff—There is a degree of variation. Perhaps something we have not heard is that it actually adds another layer of administrative costs for hospitals, because health funds have different payment methodologies. Some will pay on an episodic basis—so, for example, they will say: 'I'll give you $10,000 for a hip replacement.' Some will pay on a per diem basis and say: 'I'll give you $450 a day and perhaps a bit more for theatre and a bit more for intensive care.' Some use a mixture of those. On average, because of the groupings of health funds, each hospital probably has to deal with about eight or nine purchasers—being the major funds—and then the groupings of the smaller funds. So the hospitals' administration systems and billing and payment systems have to be able to deal with all of those different payment models and the different business rules that the health funds apply, whereas each health fund only has to deal with one system, and that is its own.

That lack of standardisation in the billing and payment systems does add another layer of complexity. In fact, we did a joint study with AHIA a number of years back. I cannot remember the exact figures, but there was an order of magnitude difference between what it cost for a health fund to process a claim and what the hospital cost was. That is because of the systems and administrative support they had to have to deal with all of the different methodologies.

CHAIR—Can I put on the table the example of Medibank negotiating with the hospitals in Sydney, Melbourne and Brisbane. There was a press release back in February which said that you expected to reduce the number of hospital beds your contracts covered by 10 per cent. Is this an example of market power? How is that 10 per cent determined?

Mr Levy—It is a long story, obviously. A lot has been written about it and is being written about it even as we speak. The process that Medibank has gone through is what we would call a competitive tendering process. The code of conduct signed between the funds and the hospitals enables both hospitals and funds—in this particular case, Medibank—to go through a tendering process to identify those hospitals with which the funds wish to contract. In our particular case we set out a number of criteria that we were seeking to have hospitals respond to and there were 99 hospitals in that process. Consciously we recognised that, by doing so, we flagged the possibility that there would be fewer hospitals under contract than we have today. Today we would have about 98 per cent of all hospital beds under contract. We flagged that that may drop down to 90 per cent if we were faced with a situation where the criteria that we set, which were not only price—and I can talk a bit more about that—but also quality, safety standards and the services being provided to our members, did not result in a commercial agreement between ourselves and the particular hospital.

I think this might address the point being raised before about pricing. We placed the 99 hospitals in peer groupings and then released to those hospitals what we were paying to all hospitals in that particular peer group in that particular market. So, arguably for the first time, picking up the point made before about information, we actually showed the hospitals the variation in price that we were paying for a whole lot of reasons—not the least of which was our own past contracting arrangements—between particular hospitals. So, if you took, for example, a particular peer group—let us say one of the large peer groups, which are often determined by size and range of services; in Sydney there were 10 hospitals in a particular peer group—we showed to each hospital in that group, de-identified, obviously, except for their own data, how they compared to other hospitals that we were purchasing services from. The purpose of this was unashamedly to bring in some competitive tension. Our view is that we have a finite amount of money, as I said before, that we can use to purchase services. If, through some peer pressure across those hospitals participating, we were successful in either reducing the rate of increase or reducing our base cost which enabled us then to invest further in the services we were purchasing, that was a good thing.

On the other hand, we consciously flagged that, as there may be some hospitals that were not prepared to participate in that, as a result they may not have a contract with us. As Michael Roff said before, we actually identified that, in those particular cases, we would commit to paying the second tier rate for those particular hospitals. We identified that it may be 10 per cent. In the groups that we are talking about, that may be one or two hospitals in each metropolitan city. So it was not a slash and burn mentality. I am pleased to say that we are about halfway through that process. Unfortunately, we have got tied up with the Ramsay Affinity ACCC program going on, so that stopped us.

However, if you put that to one side—because that is about 35 of those 99 hospitals—we have contracts with about 35 hospitals already on a variety of arrangements, some of which include quite commercial and competitive rates as well as enshrining a range of quality and safety criteria, which we have done for the first time. Through that journey we are hopeful that if by chance we can recontract with all those hospitals we will do so, but if not we will maintain that there may be one or two hospitals that fall out of each of the metropolitan markets. It has, from our perspective, enabled us to be more effective with the money that our members give us to purchase services on their behalf. We believe that in doing so we have not in any way undermined the quality of outcome that they receive when they go to hospital.

CHAIR—Do Michael or Francis want to make a comment on that issue?

Mr Sullivan—How much time do we have?

Mr Roff—We do have some significant concerns about the process. I mentioned one before—the attempt to cap volume in the hospitals that are successful in gaining a contract with Medibank. Bruce referred to this as a competitive tender. I do not think it was a tender at all, because I do not know any hospital that actually submitted a tender to Medibank and had that accepted. I note the careful use of language that he engaged in when he was talking about ‘hospitals not willing to participate’. He means hospitals that are not willing to accept whatever meagre offerings they may be thrown by Medibank in this process.

Mr Sullivan—I simply add that, ultimately, the negotiations come up with an arrangement and consumers pay more if it is not satisfactory. We need to understand that, if a patient comes to the hospital, they come because the doctor refers them to the hospital. If that patient happens to be a health fund member and the arrangement is that their benefit is x and the cost is x plus y, then y is paid out-of-pocket. That will have to be the way it goes. I think we are living in gaga land if we think we are going to be able to cover every cost 100 per cent of the way. This is medical and hospital. So we can have competitive tendering. It has its place, and it may deliver some commercial outcomes for the purchaser at that time, but the reality is that we need to have enough sense in the community to know that ultimately people will also have to pay out-of-pocket if the health fund benefit does not meet the cost.

Proceedings suspended from 11.37 am to 11.58 am

CHAIR—We will now move on to topic No. 2: portability and informed financial consent. I will go around the table and ask you to please restrict your opening statements, if you wish to make one, to three minutes. Then we will go to general discussion. This time I will open with Dr Wainwright.

Dr Wainwright—Thank you. First of all, the AMA believes that strong portability provisions are essential to the future of private health insurance. There is too much capacity to characterise minor differences in products as an upgrade and to impose waiting periods. It is just an anticompetitive stunt. The government needs to remove the legal uncertainties around the meaning of ‘generally comparable products’, and I am delighted to see that the government is moving towards that at this stage. Doctors should be free to advise patients about their health insurance products. There should be no limits on doctors doing this. With regard to the selective contracting, it is absolutely essential that we have portability. If patients do not have choice of hospital because they are not contracted, it is important that they can seamlessly transfer to another health fund which will cover that particular hospital.

We have policies supporting informed financial consent, and we have made tremendous progress on the matter over the last 10 years. We are aware that there is a residual issue for anaesthesia, pathology, radiology and surgical assistants, and we are going to embark on a targeted education strategy for these groups and possibly for the introduction of some new MBS items to assist with further progress. However, 80 per cent of inpatient medical services are provided at no gap to the patient, and that is up from 10 per cent 10 years ago. It is enormous progress. We realise that we have not got there yet, but we are working strenuously to do that. Part of the problem is that the rebates for those particular groups are inadequate, particularly for anaesthesia, and Dr Mulcahy will undoubtedly talk about that soon.

It is very difficult in some instances in emergency procedures for doctors to give informed financial consent. But we think it is imperative and we will be working with our groups to do it. We do have an informed financial consent form, and we are very happy to promote that further. The lead practitioner, usually the surgeon, gives informed financial consent and we believe they should advise how the patient can contact the downstream providers—that is, the anaesthetists and surgical assistants—to be advised of the costs. So we are in favour of informed financial consent, and we will keep working on it.

Mr Roff—In relation to portability, our position was fairly well outlined in the Access Economics report we attached to our submission to the committee, and I do not have anything specific to add to that. I do want to pick up on one point that is in the submission of the Health Insurance Association. On page 23, the second last paragraph says:

Unfortunately, the hospitals have been less willing to agree to any arrangement which would prevent them encouraging transfers of members to maximise the benefits paid to them

That statement is incorrect. One thing we did reach agreement on with the health funds was the communication protocol that would apply to both health funds and hospitals to cover exactly this sort of situation.

Turning to informed financial consent, we support informed financial consent and will continue to promote it. Particularly with the roll-out of the new prostheses arrangements, we are undertaking some education sessions for hospitals around the country. I want to draw the attention of the committee to the recent survey on informed financial consent released by the government which found that, in relation to hospital charges, informed financial consent was close to a nonproblem, with only two per cent of respondents identifying it as a concern. But that is still of concern to us, and we will be working to make sure that it becomes an actual nonproblem.

Mr Norris—Portability sounds like a really easy thing to fix. I agree with the principle, as Dana quite rightly said, of a patient's right to be able to choose and move between health funds. I have no problem with that all. The key to this is to try to find a mechanism that does not give either party—that is, either a health fund or a hospital—the ability to leverage, through the contracting arrangements, by misusing the rules on portability. In other words, if a health fund were to go out of contract with a hospital, the people who would be most impacted are those who knowingly are going to that hospital in a very short period of time. They are the ones who will be most at risk with regard to certainty. There is a current code of conduct that states that all health funds and hospitals must continue to look after patients who have been pre-booked—in other words, they are protected under the code of conduct. But I do not believe that that goes far enough.

It is very dangerous to say that people can just have, willy-nilly, free access to change from one fund to another, because it is the receiving fund that will be put at financial risk if this is used in a perverse way by either party. A health fund could in fact find themselves in significant financial viability difficulties overnight. If they were to receive overnight a five per cent increase in members going through hospitals, that would be a significant problem. I believe the answer could be provided through tighter wording within the code of conduct, even to the point of saying not just those who are pre-booked but any health fund member for a period of 90 days, for example, who chooses to go to that hospital will continue to be given the same contracted rates they would have had prior to going out of contract. That basically gives everyone a bit of breathing space to communicate and to advise members appropriately, not with one-off scare tactics and not with one-off: 'But I'm going to hospital next month, what do I do?' It is a breathing tactic. In 90 days, who knows what could happen. It may even be that the hospitals and the health funds find an agreement that does away with the whole issue. But to simply say, 'Wipe off all the rules on portability and just allow free and open access with no controls,' I think would be absolutely disastrous for this industry.

I think informed financial consent has come a long way at the hospital level. Both Michael and I sit on the second tier committee and we see that that is actually working quite well. There is room for improvement but it is getting there. With regard to informed financial consent from your medical practitioner or provider, I know that the AMA is now, I think quite rightly, pushing for this to happen. The real difficulty is in the downstream, away from the principal surgeon. It is the assistant surgeon, the pathologist, the radiologist, the anaesthetist—all those who are also going to be used in that episode of care. Any focus on informed financial consent should be on the total episode of care and not just on the principal surgeon. That is where the members have no understanding: when they go to hospital they think the doctor looking after them is the only one who is going to charge them. It is about all of the hidden costs. So we need to find a process for informed financial consent through the entire episode of care.

Health funds should be able to advise their members of which doctors they have who utilise the no gap or known gap schemes in order that their members can make an informed choice. I think that should be mandatory. The key issue here is to empower the members—to empower the public, the consumers—not the health fund or the doctor. That information should be very squarely out there in the public arena.

CHAIR—Thank you.

Mr Harrison—Firstly, I would like to address the issue of portability. Portability has certainly been designed to protect the consumer, and that is quite proper, but it is also important, I think, to consider the needs of both the private hospitals and the private health funds. I can give two examples.

There was a dispute a couple of years ago between a hospital group and a health fund, and a large group of patients with chronic conditions transferred their memberships to other funds as a result of that particular dispute. The patients were certainly covered, but in that situation, irrespective of any behaviour by either the funds or the hospitals concerned, patients—existing or intending—get concerned and will automatically look to transfer. As I said, the patients were covered, but I have no doubt that the hospitals that went out of contract suffered and the receiving health funds certainly suffered. The losing health fund’s risk profile would have improved, for sure. One of the receiving funds had benefit limitations in their rules, to limit their exposure, and I think it is worth noting that if that health fund had not had such protection, I guess, then I have no doubt that it or other funds would also have gone out of contract with those same hospitals. In the event that that had occurred, the consumers would have been even worse off.

My second example is one where doctors in a medium-sized country area began encouraging patients due for hospitalisation to change funds. This is an actual case and it happened not so long ago. Many of those patients went to a fairly small regional health fund which was not protected by benefit limitations or anything else, and that particular fund was subsequently forced to increase its rates by 30 per cent. It was either increase its rates by 30 per cent or go out of business.

So portability is important to protect the consumer, but there should also be rights for the health funds and hospitals. We certainly do not believe that it should be open slather, where patients can just transfer without any sort of limitations at all. When portability was first

introduced, there were restrictions in that patients were only entitled to receive benefits they would have received from the losing fund. Maybe it is time to go back and have a look at that.

Our perspective on informed financial consent is that, although not all doctors provide informed financial consent, a lot of the issues come about because of doctors providing booking fees or administration charges which never actually appear on the accounts that are received by the health funds. So the health funds are not necessarily always aware that a gap has been charged, for example, or whether or not informed financial consent has occurred in those particular circumstances.

The current provisions are such that the health funds are almost required to reject claims where informed financial consent has not occurred. The only person that penalises is the member or the patient and, from our perspective, it accomplishes nothing. Our preferred approach would be the continued education of providers. We believe informed financial consent is occurring more and more. We are cognisant of the efforts of the AMA, ASA and others in trying to educate the providers about the importance of informed financial consent and we certainly support them.

I think one of the real issues that is going to come up out of informed financial consent will be about gaps on prostheses. I think it will be a fascinating process to see how that comes out. I agree with Mr Roff about private hospitals, that it is not an issue within the private hospital sector. I am totally supportive of the efforts of private hospitals in providing informed financial consent.

Mr Schneider—Other people have already said most of what I would say about both informed financial consent and portability. I would just like to make this point about portability—and I say this as the person who I think was responsible for getting portability put back into the National Health Act. Portability is a very important component of an individual member’s rights within the health insurance system but, equally, a member should not be able to use the fact of transferring from one health fund to another to effectively upgrade their level of cover.

We have got two interests that have to be borne in mind here. The first interest is that of the prospective patient or the person who wishes to move from one fund to another for whatever reason, and that has to be protected. But we equally have an obligation to protect the members of the fund to which the person moves. Health fund management is nothing more than an agent for those people. Health funds, in fact, are clubs where people have agreed together to share in the cost of their health care whenever one of them may need it. The moment you have new members come into the club you start to distort the position of existing members. All too often, when portability is discussed, the interests of the receiving members are not taken into account. I think there is an obligation to do that because—as Bruce has already pointed out—the financial impact on those members can be extremely significant, to the point where it will lead either to an increase in the prices they have to pay or to their fund going out of business.

We have got a proposal on page 24 of our submission which effectively says that what we need to do is go back to the old days when the entitlement a member had was the dollars paid by their fund for the service. That can be put into the existing contractual arrangements and would apply on the day the person transfers from one fund to another. Certainly, if a fund is going out of contract, people should be entitled to be advised in advance that that is going to take place so

that they can exercise their options, but their right to transfer with that former benefit should not exist in perpetuity. Sooner or later there has to be some sort of statute of limitations which would apply to the former benefit, and we would say it should be the benefit applying on the date of transfer.

I think everyone says that they would like to see informed financial consent. The question is: how you make it happen? Our proposal to make it happen is a fairly simple one, once again, and that is to say that if a bill for a medical service in hospital has not been agreed in advance it should not be legally enforceable.

Dr Mulcahy—I will start quickly with the issue of portability. We certainly support the maintenance of portability. In the environment of selective contracting, where there will possibly be a reduction in the choice of hospitals for the consumers, it is important that that facet of their health insurance is maintained.

Anaesthesia is often raised in relation to the issue of informed financial consent. We are in the category of doctors who have limited patient contact in the period before they enter hospital—and I am talking here about inpatient services. To give you an idea of the scope of the issue or the problem, there are about 18 million inpatient private hospital services per annum. On the June quarter figures just released, I think about 83 per cent are at no cost to the patient at all. There is approximately a further five per cent where there is a legislative requirement for written informed financial consent. So that eliminates 88 per cent of those 18 million services from the problem. We are talking about the 12 per cent where IFC is of relevance.

With anaesthesia, the figures are not quite so good. The number of services at no gap, at least in 2003, was 70.1 per cent. That is lower than for most other groups. The simple reason for that is that for anaesthesia the rebates, both from health funds and from Medicare, are lower than for any other group of doctors, certainly any other specialty group. Further, when the health funds introduced their schedules for higher than scheduled fees, it was acknowledged that Medicare had fallen behind the level of the Medicare rebate due to poor indexation over a period of 20 to 25 years. I also have to state that every single health fund in the country, at least for anaesthesia, since introducing their higher schedules has downgraded their indexation at one point or another. If you look at the long term, gaps must re-emerge in that environment. We will have to wait and see.

IFC is difficult in anaesthesia because, as I said, we have limited patient contact prior to their procedure. Increasingly, patients come into hospital on the day of surgery. In fact, about 80 per cent of all patients come into hospital on the day of surgery, which is a great thing from a health outcome point of view and for health economics, but it can be a problem in this one particular area.

Another important point is the nature of the health fund policies that consumers have. They are very poorly understood by consumers and they are also quite complex. Some funds have what is called a known gap product and other funds have a no gap only product. With a no gap only product, if the doctor's fee is one dollar over the health fund's particular schedule, the benefit to the patient drops back to the Medicare schedule level. For anaesthesia, that might be a 50 or 40 per cent reduction. As I said, that is if the fee is one dollar more than the health fund's schedule. With a known gap, that is not the case. If it were one dollar more, there would be a one

dollar out-of-pocket expense. I have yet to meet a patient in the last 5,000 patients who has any understanding of that at all. Obviously, if you are the health fund you would not promote that as one of the aspects of your health fund.

That is a real issue. We strongly believe that all funds should provide a known gap product. They provide a level of benefits, which is set according to their own processes, but all members who are eligible should have access to that full level of benefits. Further, many funds will only provide the higher benefits if doctors sign certain registration forms or documents and if doctors use certain batch headers and certain billing arrangements, none of which the consumer, the patient, will have any understanding of. Frequently, it will be a mechanism where there will be a lower level of benefit paid to the patient. That must have an impact on gaps and therefore on the issue of informed financial consent. It is a complex area. We believe strongly that consumers should have access to the full level of benefits if they are eligible members of the fund.

From an anaesthesia point of view, we strongly support appropriate informed financial consent. As Dana has said, there has been a huge improvement in that area from the profession's point of view. We accept responsibility in this area. We are using education of our members to increase it. We think the rate of IFC provided by anaesthetists and other members of the profession has gone through the roof for the last five years. I really do not think Russell's approach of using heavy-handed tactics to force doctors into doing something which they are already doing is really going to be the path to follow. I do not think it will provide any extra benefits at all.

My last point is that we also believe that consumer should be educated to be good medical consumers. The AMA's approach is to have the primary provider, the surgeon in the case of anaesthesia, use a form which indicates to the patient there will be other accounts from other providers, with appropriate information so that, if there is time before surgery and it is not an emergency procedure, they can contact other providers and obtain the relevant information. That should be encouraged. We need to educate consumers as well as our own providers.

Mr Levy—On the issue of portability in the contracting environment, I think the point that has been made relates to what could be termed the transitional arrangements. There is a lot of confusion amongst consumers as to their entitlements should a local hospital appear to go out of contract with a health fund and, as a result, consumers are likely to move across to another fund and to seek cover. In our selective contracting program, as it is called, Medibank increased the transitional arrangements period to avoid that concern. For example, for consumers undergoing a course of treatment, whether it be dialysis or chemotherapy, we increased the period in which we met the hospital's charges, even though we may have been out of contract. Our attempt there was to deal directly with the confusion amongst consumers.

Medibank was on the receiving end of in excess of 4,000 members who came across to us as a result of a dispute between a fund and a group of hospitals, all of whom were claiming members. In many cases these members were with us for only a short period. On the services they were undergoing we may have spent up to $15,000 in some cases on their behalf—after which, because the fund and the hospital went back into contract, they returned to their original fund. So for six months there was a large outlay that we had to meet on behalf of these members as a result of Medibank agreeing to accept the current regime of portability.

Medibank could afford that, but the point being made by Bruce is that, had that been a small fund, the financial imposition on the fund would have been huge and could have jeopardised the investment the other members had made in the fund. Bear in mind that only about nine per cent of members use their hospital cover. If there is a significant spike the only way a fund can cover it is by increasing their premium for all members.

The other issue under portability is about contracting disputes or a change in contracting arrangements. This is what people loosely call ‘gap cover shopping’—that clinicians will consciously and very overtly direct their patients to particular funds which have a better gap cover schedule than other funds and they will only stay with that particular fund during the procedure and then return to the original fund. I am pleased to say that those practices are not overt and excessive in the system, but they are certainly active. Many of our members could produce letters they have received from their doctors who suggest that they change funds for their particular procedure and then revert back to their original fund. Again, that imposes a significant financial burden on health funds.

On informed financial consent, the only thing to add is that we have a fee-for-service system and we also have an opt in, opt out system of gap cover arrangements. So a doctor can determine, on a patient by patient basis, whether they wish to charge a patient for the gap. In those circumstances it is incredibly difficult for a fund to advise what a doctor is going to do. We accept that but, as Dana has said, there is increasing acceptance across the industry that those who create the gaps need to take responsibility for them. We are certainly willing to work on that to ensure that happens.

Mr Sullivan—The issue about portability that is most striking is that we do not really have much of a consumer voice on it. The reality is that, in the case that highlighted the problem, the health fund targeted psychiatric and rehabilitation members—in other words, vulnerable people, not any group. A waiting period was put on for people who would want at some point to draw on benefits for psychiatric care. I think that is a very telling example of what can happen for consumers. Earlier we talked about the balance between hospitals and health funds with power. The reality for consumers is that they have very little. I find it odd that some years ago—not many, though—during a political debate about the increase in premiums, the Treasurer, Peter Costello, made it very clear that health fund members, if they were not happy with one premium from one fund, could shift to another. This was meant to be their commercial power. Now we are talking about a situation where we will inhibit that power.

With regard to informed financial consent, our only point here is that it clearly is an issue between the medical profession and insurers. It does appear to be a cultural issue with some elements of the medical profession—around the billing, around giving consent and around the relationship between the specialist that a patient sees and the other specialties that they never see. Again, if we can run a line through this and talk about the real power that the consumer has, you begin to wonder.

Mr CADMAN—To what extent is portability now complete portability? Where is it limited? Do you know, Russell?

Mr Schneider—I am not aware of any limits on portability. I have heard providers complain about portability problems; I have not heard of any consumers complaining about them. I would

like to know any specific cases that the providers have. But people can transfer from one fund to another, although, as I said, with the limitation that you cannot selectively upgrade your cover by moving from one fund to another fund, because that would be unfair to the existing members of the fund to which you move. If a person wishes to upgrade their level of cover within a fund, they have to serve a 12-month waiting period to get the higher benefits. They get their old benefits, but they do not get the higher ones. I do not think anyone would regard as fair a situation in which people could move from one fund to another to effectively jump that waiting period that their own fund would apply.

The other thing that is a real problem is this question of arbitrage and the extent to which the providers know which fund is paying the best benefits. The consumer does not necessarily know that because of contracts. Providers are in a position where, if they wish to encourage someone to move from one fund to another, they can actually increase their income selectively—and I do not think that is fair either. So these are the sorts of things that any measures to deal with portability have to take into account.

Mr CADMAN—Mr Roff, are the so-called transitional arrangements for Medibank Private satisfactory?

Mr Roff—Not having seen the detail of them, I cannot comment. If they are broadly in line with some arrangements that were also agreed between hospitals and health funds last year, I do not think we would have a problem with them, but I cannot comment on the specifics.

Mr CADMAN—Does that mean that, if I were in Medibank Private and my only option was a hospital that did not have a contract, I would be covered?

Mr Roff—I cannot comment on what Medibank Private is proposing.

Mr Levy—There are transitional arrangements that come into place if there is a hospital that goes out of contract with Medibank. These are industry-accepted standards. If a member is pre-booked to go into that hospital after the expiry date—so, when the contract is at an end—or, in our case, if they are having a course of treatment which transgresses the expiry date so it continues into a period where there is no contract, then we would continue to meet the hospital charges.

Mr CADMAN—What if there is no choice for a patient but to go to a non-contract hospital, whether or not the expiry date had been reached?

Mr Levy—Portability comes into effect. That member could change funds and go to another fund who would presumably—

Ms HALL—Who may.

Mr Levy—or may have a contract with that hospital.

Mr CADMAN—Do you see that as being a problem, Mr Schneider?

Mr Schneider—If the number of members is relatively small, it does not matter. The administrative inconvenience of trying to track a patient from one fund to another, and find out precisely what the contractual arrangements of the other fund were, makes it not worth going into. If the hospital effectively attempts to dump patients from one fund onto another then there is a problem. I would make this point too: under the National Health Act, any health fund manager who attempts to encourage a person to move from his fund to another fund faces a penalty, from memory, of $50,000 per offence. There is no such penalty on providers for doing the same thing.

Mr Roff—I would emphasise that I take offence at the language about hospitals 'dumping' patients. It is August now, so it was 12 months ago that we actually agreed to communication protocols for both hospitals and funds that would prevent that happening. For the health insurance companies to continue to push that as a line of argument is, I think, totally specious.

Mr Schneider—Provided the protocols are adhered to—and we have agreed to those and the ombudsman in fact has virtually codified them, and we support that—there is no problem. The problem can arise, though, if—

Mr CADMAN—Let me interrupt, because we have heard of a fund dumping patients and the problem that created for Medibank Private. What instances are there of hospitals dumping patients?

Mr Schneider—May I go into that? It was not the fund dumping patients. In fact the fund concerned provided virtually the same protocols that Medibank Private has now picked up, which was to ensure that all prebooked patients were guaranteed a cover. All people in the course of treatment were guaranteed cover and in the case of emergencies they were also covered, although the hospital reserved the right to impose a co-payment if it wished in those circumstances. So there was no dumping of patients by the fund. There was a very unpleasant media coverage of the incident, and the hospital, I understand, was asking people to present their credit card when they went to the hospital gate for admission, even though the fund was willing and had undertaken to fully cover them. So that was a problem there. In respect of Victoria, Francis referred to rehabilitation and psychiatric patients being targeted—

Mr CADMAN—Yes.

Mr Schneider—In Victoria, the original fund—we might as well have the names: it was BUPA and Healthscope. BUPA went out of contract with Healthscope for a period of time then they came back into contract. In Victoria, however, there were some hospitals that BUPA had not covered—I think Gus can correct me if I am wrong here—in the psychiatric and rehabilitation area. So they did not have contracts with them, but what they did do was arrange with those hospitals with which they had contracts not only for the patients to be able to go there but also for their treating doctors to have visiting rights, to fast-track visiting rights for those doctors to treat the patients in the hospitals with which they had contracts. So there was really no barrier to the people having full coverage other than the convenience of their doctor. To try to overcome that they fast-tracked the visiting rights. In some cases the doctors did not wish to take up that option.

Dr Mulcahy—I would like to comment on a point that Mr Schneider made, and some of the other health funds have mentioned this issue of providers advising their patients to change funds. It is not, as Mr Schneider said, a matter of providers increasing their income. It is to do with this issue of known gap versus no gap. To make it quite clear, say a surgeon has a procedure and the fee is $1,000 and the Medicare fee may be $500. These are realistic proportions. The health fund fee for Medibank Private might be $800, and from MBF, similarly, it will be $800. However, for the patient with the surgeon's fee of $1,000, with MBF they will be $500 out of pocket. With Medibank Private, they will be $200 out of pocket. It may be misdirected, but the surgeon will say, 'If you change to Medibank Private you will save $300.' It is not a matter of them putting their $1,000 fee up; it is a matter of them looking after their patients' interests. Perhaps they should not do it, but that is what it is about.

Mr CADMAN—I need to follow that, if I may, Mr Chairman, because complaints I hear from my constituents about anaesthetists are that they have not got a clue what they are going to charge, they have not got a clue what their bill is going to be, and many of them are shocked with the size of it and what they have to fork out. I can understand why you want to put your bid in today, because it is the only element that I have experienced of the whole treatment process where one part of the profession has been so criticised.

Dr Mulcahy—I have explained earlier about—

Mr CADMAN—I know you have, but it is not a very satisfactory explanation, I would have to say.

Dr Mulcahy—There are difficulties with providing the information to the patients. Many of the patients unfortunately get misinformation that they will be fully covered, when that is not the case. We know that 71 per cent of them will pay nothing. So 29 per cent of them will be out of pocket. With limited patient contact it is difficult for that information to be passed on to the prospective patients. With emergency patients it is obviously very difficult. With patients in obstetrics it is very difficult. But there will be patients who are booked in advance and it is still difficult because they will not have seen their anaesthetist. We as a society are encouraging patients to see and consult their anaesthetists prior to entering hospital. That will provide a range of health benefits and improvements in health outcomes. At the same time, it will allow this problem to be overcome. As well as other appropriate assessment of the patients, which provides economic savings as well as less time in hospital, the issue of fees can be discussed in a timely manner before they enter hospital. That is what we are promoting and it is improving, but it is a work in progress.

Mr Norris—I have had members write to us—as Medibank has—showing us copies of letters about being encouraged to change their health fund by doctors and so on. I have not seen one where the doctor has not benefited financially out of that change. To say that it is purely to minimise the gap is in fact another way of saying, 'Because I'm getting paid more, your gap will be less.' I think I need to put that on the table very squarely. I believe that informed financial consent for anaesthetists is difficult because of the type of role they play. However, there are ways around it. Emergency is already covered. There is already legislation and a code of conduct that says: 'If it's an emergency situation, informed financial consent is given as soon as practicable thereafter.' So that is a furphy: that is very easily handled. With obstetrics, people get nine months to be informed about how much the bill is going to be—unless I am mistaken!

Ms HALL—That can vary.

Mr Norris—The other reality is that you have a principal surgeon who you have been referred to in the first—

Ms KING—Yes, you can move from initially not wanting drugs, and suddenly you really want drugs!

Mr Norris—Absolutely, but there is no reason why you cannot be informed of those charges at any time during the course of that pregnancy. In regard to going to see your principal doctor, the principal doctor knows what anaesthetist group he is using.

Mr CADMAN—Yes, exactly.

Mr Norris—Why can't the informed financial consent be given at the principal doctor level?

Dr Mulcahy—I will just make a comment there. That will help alleviate the problem. It will not solve all the issues, because the principal surgeon does not always know who the anaesthetist is. He or she may know the anaesthetic group. ACCC regulations preclude a group from having a single fee, so there has to be an individual fee, and the principal surgeon may not know that anaesthetist. The lead time in private medicine, as those over here understand, is often less than a week for an elective procedure. So writing to the patients in advance or contacting them is also problematic, because the lead time, unlike in the public system, can be very short for many of the minor procedures, which by volume are the main procedures that are performed. So that will help. We are working with the IFC task force, with the AMA, to do just what Gus has said.

Mr CADMAN—How long do you as a profession think it will be before you will have a result?

Dr Mulcahy—We already have results. It is improving. We measure the rate of IFC annually through our membership, and each year for the last three years it has been increasing and improving. In the profession as a whole it is improving. Not only is the rate of patients who have to pay anything reducing but, for those who do, the rate of IFC is increasing. The results are there. We have not finished.

Mr GEORGANAS—Just following on from that answer, I find it hard to understand why one anaesthetist will charge more than another from the same group for an existing patient with the same ailment, as you said earlier. Why would it be the case, when you are treating a patient for XYZ, so XYZ remains XYZ, that one anaesthetist will charge more than another from the same group?

Dr Mulcahy—I think it is like in any private commercial enterprise: there will be a range of fees depending on the type of service you provide. For example, many anaesthetists provide 24-hours-a-day, 365-days-a-year on-call anaesthesia service. There is no direct payment for providing that service; it has to be built into the fee structure. Many anaesthetists will provide an assessment service in their rooms, for which the Medicare rebate is $30, so there has to be a payment built into the anaesthesia fee. So that is going to vary from one to the other.

Mr GEORGANAS—So therefore it is potluck, when that particular patient is referred to a particular doctor to be looked after, whether it is one who provides in-room service et cetera—all those differences that you just listed?

Dr Mulcahy—One would hope that the surgeon that the patient has chosen to go to or has been referred to by their local doctor has a good relationship—and this is how it works in the private sector. There is a relationship between the surgeon and an anaesthetist or a group of anaesthetists which takes into account all the requirements of anaesthesia service. If you are a surgeon who needs emergency anaesthesia for after-hours cases, you will be using anaesthetists who can provide such a service. So it is not potluck. Patients can prefer and select anaesthetists, but it is not the majority by any means.

Ms HALL—I would like to concentrate a little on the issue of portability. That is an issue for the people I represent in parliament. Recently, in my electorate—within the general region—a health insurance fund dramatically increased its premiums; it was 16 per cent or something like that. A large number of people were very upset by that, and they chose to move from one fund to another. I believe that proper protocols need to be put in place to protect people who may have been a member of a fund for 40 years and have not been jumping from one fund to another to obtain some esoteric benefit that has been alluded to. I believe that a protocol needs to be put in place so that people who have been long-term members of funds do not need to go back to a 12-month waiting period. I believe that it is the responsibility of the industry to come to terms with that and to put in place those protocols.

Mr Schneider—I do not believe they would have had a problem moving from their former fund to any other fund that they wished to.

Ms HALL—You would guarantee portability in those circumstances?

Mr Schneider—Yes. The National Health Act requires it.

Ms HALL—So it is selectively that you are not guaranteeing portability?

Mr Schneider—No, portability exists in all circumstances. The question arises as to how it should apply in respect of a circumstance where a health fund has ceased to have a contract with the hospital and, in those circumstances, what prospective patients may wish to do. As an industry we have committed to the sorts of arrangements that Medibank Private has already alluded to of providing advanced information to people about the fact that at some time the contract will cease. We must remember that it is not always easy for a health fund to determine what that is going to be, because contracts can be broken by either party with 30 days notice, in most cases, and hospitals may well be the initiators of a contract being broken. The health fund knows nothing about it until the hospital says, 'We're breaking the contract.' The reason the hospital usually breaks the contract is to try to leverage a higher payment from the fund. The fund will try to tell its members—

Ms HALL—I see Mr Roff getting quite excited as you use that language.

Mr Schneider—It has a perfect right to do so; that is part of the commercial world, whether we like it or not. However, the question that is in dispute between hospitals and health funds is

whether, after the contract has ceased, the members should be able to transfer to other funds that have contracts with the hospital.

Ms HALL—I would like to push what I was saying a bit further—that is, why should a person who has had health insurance for 40 years all of a sudden find that they are in a situation where they cannot change and access the services they require through a given hospital? They have done the right thing and made a commitment to the health insurance industry, and there needs to be something built in to your protocols to cover those people.

Mr Schneider—They have that right today. The question is not whether they can transfer from one fund to another while there is a contract. In any case they can transfer from one fund to another, but if the contract has ceased, and if they have been given notice of the contract ceasing so that they have an opportunity to make up their minds as to whether or not to transfer, they should not have the right, after that has happened, to transfer to another fund and secure the contract benefits that that fund has negotiated. That fund, on behalf of its long-term members who have been there for 40 to 50 years, has negotiated a contract with the hospital predicated on its expected use of that hospital. If the use changes and more people come in and more people go that hospital, the numbers it has worked out when setting its premiums are distorted. They can be distorted to the point where, if it is operating on a very narrow margin, it can get into severe financial problems. What I am saying is that people are entitled to be told, and should be told, well in advance of the fact that a contract is ceasing. They should also be told, and they are told, that if they are pre-booked into that hospital they will be covered.

Ms HALL—I understand all that. I will give you an example. In the region I live in, there is one private hospital that specialises in cardiac surgery. There is one health insurance company, a very large health insurance company, within the area that was going to refuse to renew its contract with that private hospital. This effectively meant that a large number of people within the region would be in a situation where they did not have an option. I would argue, and they would argue to me because I am their voice at this table, that that should not be the case and that the industry needs to arrange something to cover that. Luckily, a last-minute solution was reached, but it was very dicey.

Mr Schneider—But those people had the right to transfer to other funds that had contracts with the hospital.

Ms HALL—But then their portability—

Mr Schneider—They had the right to transfer to during that period when the contract was still in force. They would have had the right to transfer afterwards, but the question is: if they wait, how long should the members of the other funds leave their doors open for someone else to come in, join and take advantage of the benefits that they are paying for? That is the issue, and it is not an easy one to resolve. What we are saying is that if we want to have real portability in place in a situation where a contract has ceased and members then wish to transfer to other funds they should be able to do so but the funds should not be required to pay more than the benefits that are being paid by the fund from which they have transferred for a period of 12 months. The hospital should be required to accept those benefits for a 12-month period.

One of the things that I do not think we have touched on here is the extent to which the Commonwealth could influence hospital behaviour as well as health fund behaviour. The Commonwealth has absolute power to impose conditions of registration on health funds and frequently does and will continue to do so. It tends not to use its power in relation to provider numbers to influence hospital behaviour. It should seriously consider doing that, because hospitals are free to charge whatever they like, or do whatever they may wish, in relation to charges, other than that which is covered by a contract. If we really wish to protect patients, we need to be imposing the same conditions on hospitals that the government imposes on health funds.

CHAIR—How do I, as contributor to a health fund, find out that my health fund no longer has a contract with my local hospital? How do I get that knowledge?

Mr Schneider—I would expect that your health fund would write to you and advise you that that had taken place.

Ms HALL—Is that only an expectation?

CHAIR—Has that ever happened before?

Mr Norris—That is an absolute given. The code of conduct, and the ACCC, states that we will absolutely write to advise any member of any significant change to their product. So that would happen.

Mr Roff—Once it has taken place; but there is no requirement to give the notice period that they are talking about.

Mr Norris—That is actually not correct. It is prior to; it is beforehand.

Mr GEORGANAS—What is the notice period?

Mr Norris—This is really confusing. This discussion is even confusing me. The reality is that portability exists today. The real issue that I think everybody is trying to come to grips with is: how are people informed and educated during the point of crisis—in other words, at the time that a health fund or a hospital goes out of contract? It is that small window where all the confusion happens. The BUPA and Healthscope dispute is the reason for this discussion. Let me explain to you what happened during that dispute. Members were advised by the hospital that they no longer had a contract with that health fund and, because they no longer had a contract with that health fund—

CHAIR—Members were advised by the hospital?

Mr Norris—Yes.

CHAIR—That means they were on the hospital's books.

Mr Norris—Yes.

CHAIR—What about all the other people who were members of that fund?

Mr Norris—The health fund wrote to all members explaining exactly what the transition period would mean to them. We said prebookings would be covered, people with chronic illness would be covered for the course of treatment, and emergencies would be covered—although we could not guarantee out-of-pocket expenses. The reality at that time was that if you were going in for open heart surgery, costing maybe $26,000 or $27,000, the hospital was asking to be paid cash up front. It would not accept any payment from the health fund. Even though there was not a contract, the health fund was still going to pay money towards the hospitalisation, but the hospital refused to take it. It said, 'No, the member will pay the full amount up front.' The option then available to that member was to change to another health fund. That is not appropriate; that is unethical. What is being discussed here is how we make sure consumers' rights are protected through this period. Portability is covered for almost any other situation, but we do not want a situation where it can be replicated and one health fund can be severely financially penalised or the member can be financially penalised. It is about protecting the interests of the member during that period. They currently have it through the code of conduct. You could expand the code of conduct to look after the concerns you may have, but it is only a small period of time.

CHAIR—Can you explain to me what would have happened if that patient had paid the $26,000 up front? What would he be entitled to from his existing fund?

Mr Norris—Part of the point is that the existing fund would not have known what the hospital charges were going to be. They could quite easily have told the member what their benefits were going to be, but it was impossible to tell them what the out-of-pocket expenses would have been, because they were not advised of the hospital costs. The member would have had the opportunity to be advised prior to going to hospital. In fact, I know that the health funds had set up hotlines for the members to be able to pick up the phone and ask what they would be covered for.

Ms KING—Mr Schneider, you were saying earlier that where portability is particularly problematic and where you think it should be limited is where a contract has run out. Obviously, those members need to be covered in some way during that period but, once the new contract is renegotiated, they should not be able to jump funds and benefit from a contract with a new fund. Is that what you were saying?

Mr Schneider—No. I am saying that the right of a member to transfer from one fund to another fund should be unimpeded, but the right of providers to secure better benefits by virtue of that transfer should not be permitted. When I say that the patient should not upgrade their cover, that applies in terms of actual upgrading. But, in a contract dispute situation, I mean that the hospital should not be able to effectively upgrade its benefit entitlement by encouraging a transfer. I concede that this is complex. I will go back to our submission. I do not want to take a lot of time with this, but it is quite important. When portability was originally enshrined in the legislation, for which I was the architect, it was predicated on the fact that, at that time, health funds pay a visible dollar amount for services—$300 per day, $500 per day. If I moved from a fund paying $300 per day to a fund paying $500 per day, if I went to hospital I was only entitled to $300 per day for the first 12 months. At the end of a 12-month period with my new fund, if I went to hospital I would get $500 per day. Contracting has taken those dollar amounts out of the equation, and the funds do not know what each other fund is paying. The hospitals have

contracts with all the different funds, so they know which fund is paying the best and which is paying the least. But the funds do not know.

At the moment, if you move from one fund to another which has contracts with the same hospital as the other fund, it is a seamless transfer. There is no problem and there are no barriers put in your way; indeed, funds will actively encourage you to move from one fund to another. The only time a problem occurs—and this is the source of this current discussion—is when a health fund and hospital go out of contract. What is the situation in relation to the transfer entitlement? If the member transfers prior to the cessation of the contract, under the current arrangements that is a seamless transfer. The question that arises is: how do we treat persons who move after the contract has expired? If the new fund has a contract with the hospital, should they automatically be entitled to full coverage, if they go to that hospital, if they were not prebooked with their other fund, which will look after them?

The number of people involved in this is actually very small, but the hospitals would say that, once they transfer, they are entitled to full cover. They do not say when this limits. So theoretically it would be possible, 20 years after a health fund ceases to have a contract with a hospital, for a member to move from that fund to another fund that had a contract with the hospital and be fully covered. If that took place, we would have within the market a circumstance where members would stay with a very low cost health fund and no contracts. That is how I can have a very cheap product, and I will have all my good risks in that. But when they need to go into hospital, they will move to a fund that has contracted with the hospital which costs far more than the fund that they were with and be fully covered. And then they will go back to the cheap fund.

Ms KING—You are a private industry. Isn't that a risk that you should bear?

Mr Schneider—We are not a private industry. We are agents for our contributors. Most of the health funds are not-for-profit organisations. They are mutuals. They are agents who hold their members' money in trust and try to manage those finances as best they can in the interests of the members.

Ms KING—If you extend it to another sector, basically you are saying that in an enterprise if a union negotiates an enterprise bargaining agreement, and I am on an individual contract in that agency and I decide I am going to opt into the EBA, I should not benefit from that unless I am a union member.

Mr Schneider—I do not wish to get into a debate about union membership or EBAs. I am talking about the health insurance system. The way the system works is that, if you allow total indefinite periods of time for a person to move from one organisation which does not pay anything in terms of benefits to another one which is paying very good benefits, and you allow the person to get the benefit of that, you are going to drive up the cost for all the other members of that fund. I do not believe that is fair.

Ms HALL—Doesn't this put a lot more power in the hands of the health insurance fund when they are arranging their contracts? If a private hospital does not have a contract with that fund, then they are not in the game. The member of certain funds basically cannot access services with

the private hospitals. I saw Mr Roff busting to have an input into this conversation. He wanted to say something.

Mr Schneider—The solution is to have a realistic period during which the member may exercise their right to move from one fund to another without it being open-ended and, in effect, perpetual.

Mr Roff—To distil this for the committee, I think when most people think about portability of health insurance they think about portability of coverage, portability of cover, whereas what the funds are talking about is portability of a particular benefit, a particular level of benefit. That is what their proposal is all about. Mr Schneider often takes things to ludicrous extremes, but what this would do is penalise private hospitals. They are talking about if a member moves from a fund that does not have a contract to a fund that does, outside the context of a dispute. Say the first one has put up its premium, so they move to another fund that does have a contract with a hospital that they subsequently go to. Six months down the track the gaining fund only pays the default rate, the off contract rate. That penalises the hospital. The hospital had nothing to do with that transfer. It may not have even known it happened. It would not know it happens until they get the default payment from the health fund.

In fact, if you want to take it to ludicrous extremes, this could lead to gaming by health funds. We know that they are out in the marketplace; they offer MP3 players and movie tickets—'come and join our fund'. This could actually accelerate that, because, if they know that there is a fund in a marketplace that goes off contract with the major hospital, they go out there and plump for all of those members, because they know for the next 12 months they will only have to pay default benefits for them.

I will take it back to a number of statements that were made at the beginning of this discussion. There was a lot of talk from the health insurance people about the detrimental impact on the gaining fund of all these people coming in making claims. If the gaining fund is taking a financial hit, the losing fund is receiving a financial benefit. Once again, take a helicopter view of this; look down at the health insurance industry. You have the same amount of members across all of the funds. You have the same amount of premium income going in. You have the same amount of benefit payments going out. There are not new claims being made because people switch from one fund to another; they are being paid by a different fund, who may or may not have had the benefit of the premium income.

But the global situation is the same. If one fund is taking a hit and another fund is taking a benefit, then there are ways you can smooth that out. You could try and do it through the reinsurance pool. My understanding is that you could not do it through the current reinsurance arrangements, but certainly that is one option. There could be some other actuarial arrangement to smooth this risk between funds, or you could use a very simple and very crude method like the losing fund having to pay the gaining fund full benefit for the first 12 months. There is not just the solution that the health funds are proposing.

Ms HALL—That is the sort of answer I was looking for: solutions.

Mr Roff—If I can go back to Mr Cadman's original question about what threats or obstacles to portability there are, the very real one is the benefit limitation period that we saw Australian

Unity apply in response to people coming into the fund. I think somebody mentioned before that it was lucky they had a benefit limitation period in place; they did not. They introduced it on psych and rehab patients in response to the influx of members. There is nothing to stop any other fund or every other fund introducing a benefit limitation on a particular service or all services. Once you do that, portability is gone overnight. That could happen overnight. There is nothing to stop that at the moment.

Mr Sullivan—I think that has summed it up.

Dr Wainwright—I am interested that the whole discussion has been on portability and very little on informed financial consent. I support everything Dr Mulcahy has said. Perhaps one plank of our approach should be consumer education with regard to the fact that there may be gaps. Consumers are not upset about gaps; they are upset about unexpected gaps. Perhaps we could educate them—maybe that is the obligation of the health fund—that there may be medical gaps. When you go to hospital, ask your doctor. One fund around this table is already going to include that in their brochure. Unfortunately, some of the funds have what they call no-gap schemes and many of the doctors do not participate in these no-gap schemes. We would be very comfortable if they advised their members as well that there may be gaps—in which case they would be disadvantaged, because a patient would get less rebate if the doctors charged a gap from the funds. I think consumer education—be aware; ask your doctor and ask your fund: 'Will there be medical gaps?'—is part of the plank of solving the problem.

CHAIR—Are there any concluding remarks before we break for lunch?

Ms KING—In terms of what Mr Roff was saying about the large groups of patients, particularly mental health and psychiatric patients, is there any evidence of that occurring in any other groups? I am specifically referring to your comments in relation to people with chronic conditions, and not just through the issue of portability. Is it occurring through contracts as well? Are there any large groups of patients that you think are missing out or are being targeted by health insurers?

Mr Schneider—I do not think there is any evidence of that at all.

Ms KING—Mr Roff is nodding and saying there is.

Mr Schneider—I would like to see the evidence.

Ms KING—Which sorts of patients are you talking about?

Mr Roff—Particularly psychiatric. We have provided some information to the Senate inquiry into mental health in relation to that.

Mr Sullivan—The only thing we would add to that, using the example I used around oncology, is the high-cost drugs. The way the contracts are structured is such that the commercial risk is borne by the hospital. What I keep coming back to is that there comes a point at which that, for some hospital groups, it is untenable and they begin to reduce the amount of work they do in that area. I am sure that, if you talk to specialist physicians, they will say that for

a lot of medical cases, particularly for elderly people, it is just as difficult to get them access into the private hospital system as it is the public. Is that correct?

Dr Wainwright—That is correct. It certainly was so last winter. I have not seen any figures but it is better for the funds to take the high throughput fractures and other orthopaedic and surgical things than the chronic complex elderly cases. There is often a barrier there, though it is hard to measure that.

Mr Norris—You mean hospitals, not—

Dr Wainwright—I mean hospitals. Yes, I am giving a bouquet to the funds.

Mr Schneider—But that could be an effect of the structure of the particular hospitals too. If I may intrude, Michael talked about benefit limitation periods becoming widespread throughout the industry. I think you have to be a little bit realistic about some of these things. There would not be a large incentive for members to join funds if they were confronted by a range of benefit limitation periods. I do not think that is a real major issue.

Mr Roff—Are you talking about benefit limitations on transfer?

Mr Norris—He did not say that.

Mr Roff—Sorry.

Mr Schneider—Again, the same things applies. Many funds are not going to do that because they do not want to deter people from transferring to them. Members who transfer are not all bad risks. The other point that is also very relevant, if we come back to the Healthscope dispute, is that the liabilities did not just get moved from one to another; there was also a net loss of members who just dropped out of the system because they did not like the media coverage that was going there. So it was not a case of one fund saving money and another fund having to pay it out; the whole system suffered as a result of that. Finally, one of the reasons I am particularly concerned about the impact of portability or about the abuse of portability arrangements is that shortly after the dispute I was at a gathering of financial analysts at which the managing director of Healthscope spoke and he said that their portability was fundamental to their strategy of levering higher benefits from the health funds.

Ms HALL—Ms Schneider, what I look for when I am asking questions of you and all the participants today is some solutions, not excuses or passing the buck. I think this is an excellent opportunity for everybody involved in the industry to look at things in a new way and to make some suggestions to people who are really keen to make the system work. I do not think we get anywhere unless we move ahead and you come up with some ideas that will benefit the people that we represent and who count on us to make sure that their private health insurance works for them. Could you throw in a few examples of how you think portability can be made to work for those people? That is what I meant when I said Mr Roff gave us some tangible suggestions of how it could be improved, but we have not had any indications from the health insurance industry as to how that could be done.

Mr Schneider—With the greatest of respect, I think we have tried to do that. I would also point out that everyone here representing health funds also represents consumers. I certainly consider myself as representative of the interests of the consumer as well as the funds that they are members of. We have a number of solutions here. Firstly, member should be able to transfer seamlessly between funds without any new waiting periods for the same cover that they had before. This happens. This is in the National Health Act today. So we do not need to solve that problem.

Ms HALL—We need to make it work.

Mr Schneider—We need to deal with one very small facet where it can become a problem under the existing law, which is if there is a dispute over a contract. The simple way to do that is to provide a window during which members are able to be properly informed and exercise their option to take advantage of portability or remain with the fund that they have been with. That is the simple solution.

CHAIR—On that note we will break for lunch.

Proceedings suspended from 1.10 pm to 2.00 pm

CHAIR—The next topic is the scope of private health insurance cover. I understand Dr Mulcahy had to leave and Dr O'Dea from the AMA is going to represent the anaesthetists.

Mr Sullivan—From our perspective this issue is conceptually attractive with regard to insurance cover being wider than acute care. The only proviso that we have is that it will be important for the coverage to be adequate, and that is in the sense that, from a hospital perspective, we have already seen a decline in benefits since about 1988 from a figure of around 56 per cent of all benefits down to about 47 per cent now. Certainly, the hospitals we represent continually register that as an issue. They would be further concerned if cover beyond the hospital takes further benefits away from the in-hospital stay. So, at the end of the day, it is obviously important for people to have some type of private cover for their health costs beyond hospital. There is no question about that. It is exceptionally important that the same people receive appropriate benefits back in hospital. It is a balancing act. We can only at this point say there will need to be an identified separate funding source through which you expand private health insurance benefits rather than trying to stretch the existing pool further.

Mr Levy—We have heard the comment before that much of clinical treatment nowadays is about the right treatment at the right time at the right place at the right price. The issue with health insurance cover is that clinical practice has changed. Within that paradigm, the ability of funds to cover the right treatment at the right place has been restricted and, as a result, members are being disadvantaged and the system is, more than likely, incurring excessive costs where it does not need to do so. The opportunity of looking at what we loosely call prevention, which is to avoid the high-cost environment where it is appropriate, or substitution, which is to avoid the inpatient setting when it is appropriate, I think are key tenets of this. Certainly, Medibank would be supportive of any actions which are taken to pursue that opportunity.

A comment was made before as to how the current contracting environment could assist that. We have heard around the table that the contracting environment has matured over a number of

years. One of the ways that it has matured is that it has moved predominantly out of the per diem environment, where you just pay for a day of stay for as long as that may occur, to a more episodic environment whereby you pay for a course of treatment or care. As a result of that, hospitals have taken those opportunities and looked at alternative care settings rather than just the inpatient setting to manage the hospital episode or the episode of care. That has delivered some advantages to the system. I think many of the health funds have moved in that direction, as has the public health system, in the pursuit of trying to manage the acute care setting being the highest cost area. Again that is something that Medibank will support.

CHAIR—Mr O'Dea, on behalf of the anaesthetists.

Mr O'Dea—I am not sure what Andrew would say, except that he would probably say it a lot better than I would. I think anaesthesia has been behind a lot of the reductions in length of stay, actually. It is changes to anaesthetic techniques that have enabled day surgery to grow, for example, so it is now 50 per cent of admissions or more, and it has brought about huge efficiencies for the private sector. If it was not for that, I guess premiums might be double what they are now. Again, I think all these changes are continuing to push the work out of the hospital into the community. It is sensible for private health to follow the work in that way. I guess he would probably also want to make a comment about the fact that if there is legislation or change in this area there should be no restriction on what doctors can charge in the community setting or no capacity for some other third party to set their fees on their behalf.

Mr Schneider—I will add to the points that Bruce made and that we made at the front of our submission. There have been very significant changes in clinical practice but they are not reflected in the funding arrangements. We hear a lot of discussion about cost shifting between the federal and state governments, but the same thing happens between the public and private health-care sectors, where a patient can move between a number of different treatment settings and, as they move through that pathway, the funding arrangements change. That must be very confusing for the patient. The only person who has a direct responsibility to pay all through the system is the patient themselves, but at any given time it might be Medicare paying, it may be a state government paying, it might be the Commonwealth government paying through Medicare arrangements or it might be private health insurance.

The concept of a continuum of care is undermined by the fact that there are different people paying for different stages of the process. Why does that matter? I think it matters for one reason and one reason only, and that is that with a mixture of different payers no-one has really got a concern about what the outcome is for the patient. Their principal concern is about trying to make sure that somebody else pays rather than them. What we really need to do is to provide a system whereby the health insurance product is able—not forced, but allowed—to move outside the hospital campus so that a patient can receive the most appropriate care, which may or may not involve a hospital episode. You could say that that is only because we are interested in saving money, but that is not true. In some cases the care outside hospital may be as expensive as a hospital stay, but it might be more appropriate care—it might be better for the patient and it might mean that the patient does not have to risk infection by going into a hospital if they can be treated outside it.

Ms HALL—For the record, could you say what you mean by 'more appropriate care'?

Mr Schneider—The right care in the right setting. It is not always necessary to have someone go into hospital.

Ms HALL—Could you give an example?

Mr Schneider—You do not need to have someone go into an acute care hospital to have dialysis, chemotherapy, radiology or a number of other treatments—a whole range of office-based minor surgery. But the way we pay for it today is encouraging admission of the patient into the acute care hospital or, if they opt to have it outside hospital, there is no benefit from their health insurance. So you lay the responsibility for paying for that care on either a state or federal government which could be providing that care for uninsured patients rather than insured patients, so we are not as a society getting the best bang for our health dollar in either the public or private sector.

We are certainly not arguing that the health insurance system should move in to take over from Medicare and GP visits or all sorts of things like that. I do not think that would be sensible or appropriate. What we are saying is: if one of our members needs treatment but that treatment can be provided somewhere other than hospital or if services can be provided to allow that patient to get back into their home environment more quickly than would otherwise be the case, funds should be able to pay for it if they wish to do so. At the moment it is possible for them to pay it, but it can cost more to provide services for a person outside hospital than having them inside hospital, because of the reinsurance arrangements. The reinsurance arrangements simply allow you to share the cost for an in-hospital episode but impose in some cases a very real financial penalty on a fund that provides for services outside.

The AUSeMED experience we talked about before was an extremely bold and brave risk taken by the fund that commenced it, BUPA, because theoretically it was to save them money but the reinsurance arrangements actually could have cost them a lot of money. Very few directors of health funds would be prepared to authorise that sort of experiment with the financial risk involved. So we would hope that, if an environment were allowed in which health funds could pay for services outside hospital that are substitutable for hospitalisation, we will get better health care and a more attractive health insurance product.

Mr Harrison—I support what Russell is saying, so I am not going to go into any depth after listening to that. We certainly support the movement towards allowing funds to pay benefits for services outside hospital walls. The other extension of that is not just services in the home but that it may be more appropriate to have a step-down facility, which is not necessarily an acute hospital but a facility which assists in the transition, particularly of some of the elderly people, from the hospital to the home. We also support allowing health funds to include health management type programs and benefits for that under their hospital tables as well, whether they are preventative type programs or programs for the management of high-risk type patients or identified high-risk type patients. As our population ages, we are going to have to do more and more in terms of keeping people out of hospital if our hospital system and our health system generally is going to cope. The more of these sorts of programs that are out there, the more they should be encouraged.

The only thing I would like to add is that, whilst I think the lifetime health cover and everything else is working really well, if we are losing any members or potential members, it is

ex-dependants coming off their family memberships. That could be anywhere from, say, age 21 to 25, generally. If we could build within the system some way to provide incentives for these people as they come off their family memberships, perhaps we could encourage some better-risk members to come into private health insurance—certainly, before they are 30. That is something that I think should be part of the scope of this inquiry, something we should have a look at. Thank you.

Mr Burningham—There has been a lot of discussion, certainly this morning, about the Australian health system and the role of the public and the private mixed system. When we think about issues to do with the scope of private health insurance, I think it needs to be in the context of what role we want private health insurance to play in that mixed system and whether it is a complement to, a supplement to or a replacement of some of the other services.

Francis expressed the view that he would be uncomfortable with seeing any diminution in the proportion of health fund payments that flows to hospitals. We would see that as a hospital-centric view rather than a patient-centric view of the system. We would be very interested in ideas that actually moved private health insurance away from just the acute setting and more towards the continuum-of-care setting, and being quite patient-centric and allowing health funds to pay for things that can prevent hospital admissions, as long as they are truly replacements and substitutions and are things or services that have quality outcomes. All of that is quite difficult, but I think that is the style of health system that Russell's point allows, where health funds can provide a valid proposition to their contributors and their members that meets their needs and does so at an affordable price.

Mr Roff—I did not want to add too much to what Francis said at the beginning. I am willing to be corrected, but my understanding was that if the services provided currently are under an approved outreach program, such as a Hospital in the Home program, it is eligible for inclusion in the reinsurance pool. So I do not see that that is a particular impediment to the establishment of things like Hospital in the Home.

A lot of private hospitals are very keen on developing those sorts of programs but one of the issues is that they cannot get support from enough health funds in a particular area—and it may be one or two of the major funds that are not agreeable to it—and that makes the whole concept nonviable, so it does not go ahead. That is just a word of caution in relation to the discretionary element that the health funds were talking about in terms of these programs. If reinsurance is an obstacle then that is something that should be looked at in terms of expansion of funding along the continuum of care.

Another issue could require some federal government involvement. I do not know of any state government at the moment that considers the role or contribution of the private sector as it is currently configured when they undertake any service delivery planning. I do not think the Commonwealth does any service delivery planning because they do not provide the services. But if we are talking about an expansion of out-of-hospital services I think there is a consensus that that is a good thing. Let us look at providing appropriate care settings for appropriate patients at an appropriate time. For example, somebody raised the issue of step-down facilities. That could be a future role for some of those independent smaller private hospitals that are finding it difficult to operate as private hospitals. Perhaps they could reconfigure and become a step-down facility and operate with lower overheads and provide another stage in that continuum of care. I

think that really needs to be looked at in the context of overall service delivery planning—what future needs might be—and that may involve some sort of structural adjustment program for the industry. As far as I know no government has looked at that issue so perhaps that is something that could be taken up at the Commonwealth level.

Dr Wainwright—We cautiously support the proposal to extend private health insurance cover into the non-hospital environment, provided there is adequate access to acute care, with no barriers with all these methods of intervention, so that the barriers are not such that the patient cannot go into hospital when they want and that there is no interference in the clinical decision making about discharge and about admission. That is an absolute must with respect to our support for any of this.

With regard to pre-admission, there is an opportunity for intervention to prevent acute health care needs—for example, what MBP are doing at the moment—but that is a very small opportunity. Perhaps there are some opportunities for preventing admission—such as with acute care, some Hospital in the Home, IV services for infection et cetera—but this should only happen as long as the patients have care, because that is what it is all about, and it does not place an undue burden on their spouses or partners. We cannot just keep them out of hospital with these measures, with a visit twice or three times a day from a nurse.

So we would be supportive of that as long as it was appropriate and one size did not fit all. We are supportive of early discharge and we need some transitional care beds. We need step-down facilities and rehabilitation—which would be cheaper—as long as that is the most appropriate care for the patient. We cannot have a situation where we have drive-through deliveries with only two days allowed for a delivery, irrespective of whether the clinician thinks a patient should stay longer, and they are discharged home when it is not in their best interests.

There is certainly a lot of scope for alternative care, as has been discussed, with regard to oncology, chemotherapy and radiotherapy, where the only way patients can access private health benefits is by occupying a bed. It is a similar situation with psychiatry, some dialysis and some Hospital in the Home. It is absolutely essential that if we adopt these models the patients' care is the first thing we take note of and are guided by. The conditions around any of these services should not be too prescriptive. So we need to see the detail and we need to be in there involved in it, but I think there is some scope for it if there is an extension of the insurance to out-of-hospital services.

CHAIR—With the extension of these services, are the services substituting for what is happening in private hospitals or would they be in addition to some services in private hospitals? Russell, how would this affect premiums?

Mr Schneider—Firstly, if I could just make this point, because it is a vital point about the whole concept: we are talking about providing clinicians and their patients with more choices than they have today. The choice today is either to admit a person to hospital or not to admit them to hospital. If you admit them to hospital, they will receive care and that care will be paid for by an insurer. We are not talking about taking over from the right of the clinician; we are really talking about giving clinicians an opportunity to select different treatment settings for their patients at times when they think that that is necessary—whether it is to move them out of

hospital faster or to put them into a step-down facility if they cannot go home because one partner is frail and cannot look after the other, or things like that.

One would hope that it would have a restraining influence on premiums, because I believe the health insurance industry is collectively talking about those things that would substitute for a hospital stay and should be lower cost than an acute hospital stay. That is not always easy to predict in advance, but I would have thought it would be more likely to have a beneficial impact on premiums rather than an increasing effect on them, provided, as I said—and we have all been saying, I think—the reinsurance arrangements make it possible for funds to embark on those sorts of risky experiments. I would not see premiums increasing as a result. It would be a brave person who ever predicted that premiums would go down.

Ms HALL—This might be the time for me to ask some questions of all parties involved about managed care. I would like to hear the perspective from the insurance industry, from the private hospital industry and from the doctors in particular, because I think it is very important that we look at this with regard to the quality of care that patients receive. Who wants to go first?

Mr Burningham—I will ask a question back, if I can.

Ms HALL—Certainly.

Mr Burningham—Do different people mean different things when they say managed care? In order to answer your question, I would need to understand what you meant by managed care, otherwise I might answer the wrong question.

Ms HALL—Managed care is where you are managing the care of the patient whilst they are within the hospital system—the standard understanding and definition of ‘managed care’.

Mr Burningham—I do not think it is necessarily standard.

Ms HALL—I think that most people understood what I meant.

Mr Roff—You are talking about funder intervention in clinical decisions.

Ms HALL—Yes.

Mr Burningham—Certainly, from the perspective of MBF Australia, we have no interest in being inside the hospital walls dictating what care does or does not take place. We do have an interest in making sure that any care that we are purchasing on behalf of our clients, customers or contributors is quality care and is appropriate, and that they get the best value for their money that they can.

Mr Schneider—I would support that.

Mr Roff—I would too.

Dr Wainwright—Our definition of managed care is American-style managed care whereby—

Ms HALL—Yes, that is exactly what I am talking about.

Dr Wainwright—the health funds dictate what care you have—how much, for how long et cetera—and interfere in clinical decision making: drive-through deliveries, three lots of pain before you can have your gallbladder out et cetera. That is what I was alluding to before. If we extend the scope of private insurance, it is absolutely imperative that we do not get into the trap of managed care whereby you can only go into a hospital if your pneumonia is at such and such a severity et cetera. The clinicians have to decide and make clinical decisions based on the care of that patient, and the funding should follow, rather than the funds dictating the parameters around which that care can be delivered. I can see that, if funds were able to provide this out-of-hospital care, we may well have the potential for the funds to interfere with the clinical decision making, and we would be very concerned about that. If every old lady had to stay out of hospital with her pneumonia et cetera, we could not possibly accept that.

Mr Sullivan—We support the coordination of care across the continuum for an individual so that they find it easier to get the care they need. This often is the problem post the hospital. Again, I keep coming back to elderly people or people with chronic conditions. When they are discharged from a hospital, they are often discharged to themselves.

Ms HALL—So you are talking about different things here?

Mr Sullivan—Yes, I am.

Ms HALL—You are ensuring that, when a person goes home from hospital, they have the carer in the home or they can go from the hospital to a low-care or high-care facility and they have the proper backups that they need—Meals on Wheels and all that type of thing?

Mr Sullivan—Yes, but I think that implies, of course, that there is some agent doing it for them or helping them, and that is also a model of managed care. The research we have done even on individuals and the ethical issues around managed care goes to what has been discussed already: individuals lose an essential right if somebody else determines their access because of an issue like finance. But what is crucial—and it goes to what we will be discussing, I think—is that we do not confuse the concepts so that we do not embark on a better model of care.

Ms HALL—I think you have made a good point.

Mr O'Dea—With respect to what Dana said, it would be the same interests for the Australian Society of Anaesthetists. The decision about where the care is provided, in what environment and at what total cost and so on should be made with the interests of the patient in mind, not dollar interests, I suppose. We would argue that the clinician always puts the patient first, and the clinician should be making that decision.

Ms HALL—I agree. So, Mr Schneider, Mr Harrison, Mr Burningham and Mr Levy, you would have no desire to introduce an American-style managed care system here in Australia whereby you put in place certain procedures for determining the funding of patients within the health system.

Mr Schneider—No, we would not. I think Dana has the right answer.

Ms HALL—Categorically? This is on the *Hansard* record; this will go through. Anyone can pick this up and say, 'The health insurance industry in Australia is not interested in adopting that.'

Mr Schneider—No-one I know in the health insurance industry is at all interested in adopting US-style systems here.

Ms HALL—You are on the record as saying that now—

Mr Schneider—Yes, I am very relaxed about it.

Ms HALL—and I am sure that many of us will repeat that many times.

Mr Schneider—It is absolutely true. I have been and seen US-style managed care, and some of it is pretty scary. But I think the important thing is that these must always be clinicians' decisions, in conjunction with the patient. The patient also has a right to make some decisions about their own care too.

Ms HALL—Of course.

Mr Schneider—But the point is to provide clinicians with options and alternatives to what is currently available.

Ms HALL—Could you expand on 'options and alternatives', please?

Mr Schneider—If a patient is well enough to be discharged from hospital, for example, a clinician today may say, 'You don't have anyone at home to look after you, so you'll have to stay in hospital for another day or another two or three days,' during which time that patient may well suffer bedsores, ulcers or other problems that are related to a prolonged stay in hospital. It would be better for the patient if the doctor could say, 'I would like to discharge you home and—aren't you lucky?—your health fund will be able to arrange for a nurse to come three times a day to change your dressings, or there will be home support to make sure that you can get out of bed, have a shower and get dressed.'

Ms HALL—This is getting into the area that we were talking about: managing the patient's care once they leave hospital. So you would never be interested in any sort of managed care—for example, where you are looking at the woman with the gallbladder problem, giving her three different alternatives and suggesting that she goes down this path a couple of times before she looks at—

Mr Schneider—I would not have thought so. I thought there might be a case in her interests for her to be able to obtain several alternative treatment paths, in discussion with a doctor.

CHAIR—Russell, you are saying that, in your model, the funds would not have a say; it would all be determined by the clinician.

Mr Schneider—Yes, but you would be putting in place those options in discussion with the clinicians. I do not think anyone around this table would suggest that a health fund would be able

to just suddenly come up with a great form of treatment for someone. What happened with AUSeMED was that it was initiated by doctors. They came up with the idea. They said: 'We can actually manage these patients better. Our problem is that no-one will pay for it if it is done.' The insurer then looked at the proposal from the clinicians and said: 'This makes sense to us. It is better for our patients and it may be better for the financial situation too.' So it would be totally determined by what was put forward by the people who actually deliver the care. The people who manage the care are the doctors. Our problem with managed care is that someone should be managing a patient's care and it should ideally be their doctor.

Mr Burningham—I would just expand on some of what Russell is saying. We do not see a future where a health fund imposes onto either the patient or the doctor any of that kind of stuff. But we do think there is a lot of value in health funds working with hospitals and doctors, as in the AUSeMED example, to run pilots or trials to find out what is actually cost-effective and still delivering quality outcomes. That is just an extension on the point that Russell was making.

CHAIR—What implications would there be for patients with entitlements under Medicare? While they are in hospital, any medical services they receive they get Medicare benefits for. How would that relate to services in the home if they went home?

Mr Harrison—Michael referred earlier to the outreach legislation. Whilst under the outreach legislation, if somebody is receiving hospital care in the home, it is as if they are actually still in hospital. Medicare entitlements would still be the same as if they were an inpatient in a hospital. I suspect that, if we can include this within the reinsurance arrangements, any treatment in the home under the sorts of provisions that we are talking about would be regarded the same way—that is, as a direct substitution for in-hospital care. Provided there is that direct substitution, I do not think there is an issue.

CHAIR—It would not be cost-shifting from Medicare to the health funds?

Mr Harrison—No, definitely not—not at all.

Ms KING—You are talking about direct substitution of hospital care. What if it is something that avoids hospital admission in the first place, which is where I think Russell was going? I will use the example of a case that I know of. An elderly patient was at home, woke up in the morning and could not move one leg. It was due to a back injury. The patient went to an emergency department—and I want to talk a bit about emergency departments and private hospitals in a minute—had a series of tests, was sent home, still could not move and was eventually admitted to a private hospital. But, before that decision, there was probably something else that could have been done before it actually got to admission. That patient ended up being in hospital for I think 10 or 15 days and then eventually having surgery. It was a very long episode of care. It seemed to me that, right at that initial intervention at the emergency department, there was probably a series of steps that could have been taken that would have avoided an admission. How would you work that into the system?

Mr Schneider—I am not a doctor, so I would not know what the alternatives are. But it would seem to me that, if there are clinically defined alternatives there, probably the ideal situation and what you would think would happen would be that the patient would ring their GP. The GP would be aware of the fact that there were alternatives and would be asking the patient: 'Are you

privately insured? If you are then you could do this or you could do that.' That is what I imagine would happen. We as payers would be quite foolish if we did not support those services. If it is going to be something that will stop a 15-day admission then, financially and for the patient's welfare, it is obviously better to do it. But I cannot answer in terms of what specific alternatives there are.

Ms KING—Sure. I was just using it as an example. What are the disincentives for that happening now? What are the blockers to that?

Mr O'Dea—I am not sure that there are any disincentives to some alternatives happening now. We would have to know a bit more about the clinical options available. It is possible that there is a perfectly adequate arrangement now.

Mr Schneider—Let us put it this way: firstly, if there is any payment involved in relation to a doctor the fund probably would not be able to pay it. That is the No. 1 barrier and may be a very real problem. With the others, it will probably be whether you can put it into reinsurance or not. You would probably say, if it is not reinsurable, why waste the time and effort trying to research it because it will cost us more. We are better off if they go to hospital and stay there for 15 days and we can put them into reinsurance.

Mr Harrison—Funds support preventative programs to, say, assist in keeping diabetics out at hospital. If high risk cardiac patients were identified amongst a fund's membership base, a fund could support programs which followed up those patients by asking, 'Are you doing this and doing that?' and so forth. At the moment there is no provision for funds to include the cost of those types of programs within the hospital tables. It is those preventative type issues that we are going to have to come to grips with in the not too distant future.

Mr CADMAN—I want to shift the emphasis to the second tier because that is an area I do not quite understand. I would like to know, perhaps from Mr Roff, what hospitals see of the second tier and then hear from insurers what they think of it. It covers some of the issues we dealt with earlier, such as interim arrangements where there is no cover or contract provided to a hospital. As I read it, the second tier is like a premium, gold card service concept. I do not know whether I have that right or wrong.

Mr Roff—A little bit of history. Second tier was first introduced by Dr Wooldridge, when he was the health minister, at a time when a number of health funds were embarking for the first time on the selective contracting path. They were making decisions about which hospitals would and would not have contracts. Normally, where there is no contract between a hospital and a health fund, all the fund is required to pay is what is called the basic default benefit, which is set by the government. I cannot remember the exact dollar amount, but it is on average about 40 per cent of the cost of providing a day of care in a private hospital. The view back in 1998 was that the decisions being taken by health funds about who was in and out of contracts were somewhat arbitrary and there should be some protection for hospitals that could meet additional standards to make sure that they were not driven to the wall. I think the minister's words at the time were, 'This is to ensure that hospitals that miss a contract are not driven to the wall financially.'

There are a number of requirements that hospitals have to fulfil apart from the normal regulation and licensing. They have to have quality accreditation from an independent

accreditation agency. There was originally an additional level of quality accreditation that they had to obtain, but those additional requirements have now been brought into the accreditation programs of those various agencies. They have to provide simplified billing for the hospital services. They have to have the capacity to provide simplified medical billing. They have to provide informed financial consent. In the early days that was a big hurdle for hospitals and a lot of them had to change their informed financial consent processes to get the eligibility. Now there is an additional requirement in relation to data provision. They make an application against those criteria and it is considered by a committee comprising both hospital and health fund representatives. They are either granted eligibility, asked for more information or told they do not comply and can try again next time. The committee meets every three or four months.

Once a hospital has obtained second-tier eligibility, if they are out of contract the fund will then have to pay them a minimum of 85 per cent of their average contracted rate in that state for that type of hospital. If the hospital wishes, it can charge an additional copayment over and above the 85 per cent, but it was designed to protect hospitals that do not receive a contract and to protect consumers who chose to go to a non-contracted hospital to ensure that any out-of-pocket expenses were minimised far as possible.

Mr CADMAN—The funds have recommended an immediate re-examination of those requirements to upgrade them. What do you think of that concept?

Mr Roff—I do not agree with it.

Mr CADMAN—Why?

Mr Roff—I think that second tier should be maintained. I think it does still provide that vital protection. As we have seen with Medibank’s process, funds are still choosing to selectively contract. If it were not for the existence of second tier, patients’ choices—

Mr CADMAN—He did not say they ought to get rid of it; he said that it ought to be revisited and upgraded.

Ms KING—What do you think he means by that?

Mr Roff—I thought there was a recommendation that it be abolished; there certainly is in some of the health funds’ submissions. Which page are you referring to?

Mr CADMAN—It is at the bottom of page 70.

Mr Roff—Of which submission?

Mr CADMAN—The Health Insurance Association’s submission.

CHAIR—That is our numbering, Alan.

Mr CADMAN—Try page 15. There is a chart on the right-hand page. It is on the page prior to that, in bold type.

Mr Roff—That is in relation to the quality criteria.

Mr CADMAN—Yes.

Mr Roff—Sorry, I misunderstood you. In effect, that is in place by default, because the health funds insist that any hospital they contract with has quality accreditation. These second-tier quality requirements have now been brought into the standards used by the accreditation agencies. So any hospital that is accredited by, for example, the Council on Healthcare Standards will be complying with these quality criteria.

Mr CADMAN—It says:

… non-contract benefits are of demonstrably higher quality than those eligible for the basic default.

I would have thought that it is looking at circumstances where you would have a boutique hospital out of contract or somebody in a remote area or somebody who does not want to give into Medibank Private. They are required to provide a quality service—and maybe a high-quality service, in some instances. Is that the way you read it?

Mr Roff—Yes. Certainly in the early days of the second tier, these off-contract hospitals were required to comply with a higher standard of quality accreditation than non-contracted hospitals.

Mr CADMAN—It sounds like a brilliant system. Why do we not do that instead of what we have now?

Mr Roff—All of these additional standards have now been rolled into the accreditation programs.

Mr Schneider—If I may elaborate, in our submission we detail the second-tier default requirements—the basic standards that a hospital has to meet to qualify for second tier. I invite you to look at them and consider whether you think they are adequate baseline standards for hospitals. Our view is that the second tier was put in place with a view to encouraging improvement in hospital quality and safety. I think everyone would agree that the most important thing in both the public and private sectors is to do whatever we can to make hospitals safer places.

I do not feel confident that the existing criteria for second tier are that much more than one would expect of a good hospital. Our view is that, given that so many hospitals are now qualified for second tier, it would be timely for the Commonwealth to make the second tier quality criteria the baseline for the issue of a hospital provider number—that is, if a hospital cannot comply with the standards required here, which are not terribly onerous, it should not get a provider number; it should not be licensed to operate as a hospital.

Mr CADMAN—Am I to understand you are saying that a non-contract hospital should provide a higher quality service than a contract hospital?

Mr Schneider—No, I am saying that all hospitals should be required to meet the quality criteria.

Mr CADMAN—So you are getting rid of second tier all together?

Mr Schneider—Different people have different views about second tier. I would like to get rid of it but I am pragmatic enough to accept that that is not going to happen.

Mr CADMAN—I do not want to put words in your mouth but I need to understand this.

Mr Schneider—I believe that these quality criteria should become the baseline for all private hospitals and that there should be a working committee of hospitals, health funds and clinicians to review them and to up the standard even more, so that every few years we would go through a process of improving the standards of quality and safety that are required before a private hospital can enter into the system. So we would be continually improving them.

Ms HALL—Mr Roff, do you agree with that?

Mr Roff—I certainly agree that the committee that Russell is talking about, that was in existence, that developed these standards in the beginning and that was subsequently disbanded by the Department of Health and Ageing should be re-established. I am happy to look again at these criteria to see if they need revising. I am also happy to look at the issue of linking, which I think Russell is talking about, the provision of a hospital provider number to accreditation, provided that the health funds agree that they should undergo mandatory quality accreditation as a condition of registration.

Ms HALL—Would you agree to that too, Russell?

Mr Schneider—I guess we do that already. It could not be much more onerous than—

Mr Roff—I do not know of any health fund that has independent quality accreditation.

Mr CADMAN—It is an interesting discussion that you are having, but left out of this process is a capacity for the insurers to say that whatever supreme quality is offered they will cover it in some way. It seems to me that you are worrying about the bottom end and not too much about the top end. You try to beat that end down.

Mr Levy—That is an interesting point. Perhaps a different question to that of the funds' view on managed care—which got the answer that I think we would expect to hear—is: 'What is the role of a health fund, if anything, in ensuring that the services that a member receives are of the highest clinical standard and quality?' I do not think you will find such ringing endorsement—certainly from around the table—as to whether a fund has any role in that at all, or whether it should abdicate it to a third party who is—

Mr CADMAN—I think you misunderstand me. I can go to a bookie and get odds on how much I am going to get out of a hospital system based on the quality of the service and how good the doctors are. Will you offer the same sort of service?

Mr Schneider—With contracting, most funds will require standards of service quality and so on that are above the basic default levels. It would vary from fund to fund as to what they would put into their proposed quality criteria. But we would see it as being that, if you have a provider

number, you are entitled to minimal fund benefits and you are not entitled to more than that, though you can negotiate more if you wish. While the second tier is there, the hospital should be entitled to a higher level of benefit in return for a higher quality than the basic. For contracting, which is a third tier above those basic government mandated minimums, you have a negotiated payment which is based on what the hospital is prepared to deliver to the funds in terms of a range of services for members.

Mr Tobin—On the quality issue, one of our concerns is that over the last couple of years each health fund has tended to come out with its own scheme to measure quality in hospitals. The problem for a hospital is when it is confronted with a dozen or more very weighty questionnaires about what they do with quality. Some of the questionnaires are extremely invasive and extremely detailed. They even talk about the standards of the various doctors that practice in that hospital. I think we need to appreciate that there are costs. We heard this morning about the cost of administration. There is nobody around this table who does not agree that quality of the highest standard should be expected without arguments in the hospitable sector. Hospitals would certainly be keen to sit down with the health funds and the departments. I think we should be able to agree on a consistent framework for measuring policy that produces the high standards that people expect. We would be very concerned if an already fragmented industry introduced even more administration whereby, at the end of the day, the poor old patient had no idea whether Medibank’s quality program was better than MBF’s or BUPA’s.

CHAIR—So you are saying that a hospital with contracts with several health funds may be required to comply with several health funds on that issue.

Mr Burningham—Yes.

Ms HALL—Would you advocate that there be a uniform questionnaire for all funds to tick off on and conform to rather than requiring them to use many?

Mr Burningham—We would certainly be very supportive of that provided we could reach an agreement that provides reasonableness to everybody.

Ms HALL—Maybe that is something that everyone needs to work towards.

CHAIR—Should it be done voluntarily or by regulation?

Mr Burningham—Obviously we would like to try to do that voluntarily but if that does not work then you would look at other more coercive measures. As an industry I think that is something we need to be serious about.

Mr CADMAN—I want to hear from the doctors about this second-tier process. I am a little concerned about hospitals being out of contract and what the requirements are on them. This second tier seems a coverage point for that. But from what has been said, it is proposed that the second tier becomes the norm. Is that right? How do you feel about that?

Dr Wainwright—First of all, I entirely support Mr Roff with regard to the retention of the second-tier default benefit to provide support for those hospitals that do not get a full contract. It is absolutely vital. It is true that the quality requirements for the second-tier default were higher

than those requirements for ordinary contracting initially. We sat on that committee setting these quality requirements. However, those quality requirements have now been taken up in general for contracting with all the hospitals in a usual contract. So they are the same for all intents and purposes. You can be guaranteed that if you go into—

Mr CADMAN—They will become the norm?

Dr Wainwright—Yes. But it is essential that second-tier default benefits are retained for all hospitals. I support all the comments of Mr Roff in this instance.

Mr Roff—I want to draw out points that I think Russell and Patrick were alluding to. Russell spoke about the concept of linking requirements for hospitals to the provider number. What happens at the moment is that each state health authority licenses a private hospital. For example, this facility would have a licence from the New South Wales health department. Once it has received its state licence, the Commonwealth automatically grants it a provider number which then makes it eligible to receive health fund benefits. I think Russell was talking about a step for making additional criteria relevant to the granting of a provider number. Patrick talked about the differing quality requirements of the funds. But there are also differing licensing regimes in each state. This is particularly relevant where you have groups that operate in multiple states. Some of them are quite prescriptive. Some of them just deal with building codes and where fire hydrants should be; some of them go into quality type requirements. They are all different in each state and the different types of facilities. For example, Queensland is very prescriptive about licensing of day surgeries and the level of anaesthesia that is provided in a particular sort of facility. In South Australia you do not need a state licence to open a day surgery. Another bit of standardisation that perhaps would be of assistance is if the Commonwealth looks towards either taking over or standardising those hospital licensing requirements which could conceivably be linked to accreditation in some way.

Ms HALL—Good suggestion.

Ms KING—I want to ask you, particularly Mr Tobin—who has a fine Ballarat surname, I see—and Mr Roff, about emergency departments in private hospitals. How are emergency departments funded within private hospitals at the moment?

Mr Roff—Usually only by a private contribution from each patient.

Ms KING—And there are no circumstances in which private health insurance cover covers emergency departments in private hospitals?

Mr Schneider—Sometimes, if the patient is admitted, there is a provision within the contract for some of that cost to be—

Ms KING—But not at all hospitals with emergency departments?

Mr Schneider—No, because it is an outpatient service and therefore the medical component cannot be paid for by health funds. They do not pay for the facility.

Mr Harrison—Just on that, there are some contracts between funds and some hospitals that I am aware of where they do actually provide partial cover to the hospital for emergency treatment provided by that hospital. I know they are rare, but there are some circumstances where it does exist.

Ms HALL—Are there any cases where the doctors bill the patients they see through Medicare? Yes? That is how it is done.

Mr Schneider—There is an argument, which I am not fully apprised of, about the level of the Medicare benefit for emergency physicians.

Mr Harrison—In discussions with most of the private hospitals on this, they generally do not want the health funds to provide cover for it because they do not want to encourage people to use their emergency areas as outpatient facilities, which is what tends to happen as soon as the health fund provides that sort of cover and there is no patient contribution.

Ms KING—Why do private hospitals have emergency departments then?

Mr Levy—Prior to that, they had consulting rooms on site and they used that, because a certain percentage of patients going through the specialist consulting rooms would be admitted. More recently, although it is not as prevalent, emergency departments were seen the same way, because about 20 to 30 per cent of patients who attend an emergency department would be admitted.

Ms KING—Yes, they are your shopfront.

Mr Tobin—Obviously, from a hospital's perspective, you get a certain type of patient coming through emergency departments as well. They tend to be the more expensive patients with more complex conditions, so that is an issue for their finance and provisioning of hospitals.

Proceedings suspended from 2.58 pm to 3.12 pm

CHAIR—We resume this public hearing for our last session this afternoon on a topic that is near and dear to the committee members' hearts: regulation and relations with government of the private health sector. We will have the same format—that is, a couple of minutes each—with Dr Wainwright first this time. We will go from right to left. Then we will go to questions.

Dr Wainwright—Thanks very much. I am not sure what you mean by 'government relations'. Perhaps you can explain a little more before I go into what I am about to say, which may be totally off beam. Relations with us, with health funds or with what?

CHAIR—The whole gamut. The involvement in the private health sector and how you are affected by government regulation. Of course, the government runs the public system. It is really up to you.

Dr Wainwright—Thank you. I had my say this morning about the way governments run the public hospitals and how there is much need for improvement there. I think the government regulates the private health industry and it is very important that the balance of power between the funds and the hospitals and the providers of health care—the doctors—is kept in balance rather than one particular part of that triumvirate having extraordinary and undue power. I think it is very important that we continue with our real quality of health care delivery in Australia and we do not let that be driven down by a lowering of standards, which is what the government does control, that we make sure we keep our work force up to scratch and we make sure we keep the standards of our work force up to scratch. I feel that if the government interferes too much in the delivery of health care then the standards may well go down if they start looking at substitute roles—substitutes for doctors, for example—just to make cheaper models of health care available. As we said earlier, we have got the best standards of health care in the world.

I think we are also very supportive of the 30 per cent rebate because, after all, it saves the government money in the long run. If they had to provide a total NHS, they would be paying much more for health care in Australia as opposed to subsidising and paying one dollar in every three for the private customers. So it is very important that that is maintained as well. Apart from that, I think the government should provide a framework, make sure it is being delivered and then back off to some extent and not be too prescriptive about what they do.

Mr Roff—I would start by drawing the committee's attention to the comments we made in our submission about the fragmentation of the health system, fragmentation of funding, delivery, policy development and regulation. There are issues there about crossover between different government jurisdictions and about silos within particular health departments and authorities that I think are adding complexity, administrative costs and waste across the whole of the health system. Having a look at the way the health system is administered could generate some significant efficiencies. There were some figures thrown around this morning about the proportion of government funding for health that actually goes on providing patient care, so that is probably a key issue, as that relates to the private sector. We have talked about the licensing requirements already. It is interesting to note that the licensing requirements that the state governments impose on private hospitals do not necessarily apply to public hospitals. So there are also competitive neutrality issues in relation to regulation that need to be addressed.

Talking about relations with government, the structure of the Commonwealth Department of Health and Ageing changed a couple of years ago. They used to have a section that looked at private hospitals and a section that looked at health insurance, but they both came under the one private health industry branch. I think the way that operated was very good, and there was a good understanding of the operations of both sides of the equation. There has been a restructure since then—it was some years back—and I do not think the overall understanding of the private health sector is as good within that department.

The other comment I would like to make generally in relation to the government is that their frame of reference for the private health sector always seems to be private health insurance. That is partially understandable when you look at the government outlays on the private health insurance rebate and the fact that the Commonwealth does not want to get involved in service delivery, but I think for their frame of reference they need to look beyond just the funding system. There were a couple of examples that we gave earlier in relation to the Private Health Industry Quality and Safety Committee. It used to be under the auspices of the department and was subsequently disbanded, but we think it should be re-established and perhaps provided with some funding, given that the industry participants in that committee provided something over $1 million in kind in their contributions over two years or so. We would also like to see funding restored for the National Hospital Cost Data Collection in relation to the private sector.

Mr Burningham—Michael outlined some of the licensing requirements and some of the processes around private hospitals, so I will provide a parallel for health funds. Health funds are federally licensed, so the licensing arrangements are through the federal government. Prices are regulated; by and large our products are regulated; the activities that health funds are allowed to undertake are mostly regulated; and the investments and the operations that we can engage in are also mostly regulated, either directly through the NHA or through mandate or dictate from the Department of Health and Ageing.

So private health insurance funds are in this interesting position. I will let some of the other large funds speak for themselves, but my view is that the larger health funds in Australia view themselves as insurance operations—we provide an insurance product to our members and consumers. We have always thought that the department of health probably views what we do more as a policy program or a social community issue rather than as insurance and financial services, and the way you then operate within those frameworks is quite different.

Supporting what Michael was saying, we have had experience recently with the department of health where the people you deal with one-on-one are individually quite good, but inside the department, when we tried to cross over silos or issues and talk to them as a health fund about something that does not relate to a hospital—we were talking about disease management programs or preventative care—they had to refer us to someone else in the department of health and they were not sure who we should talk to.

Those kinds of structural interactions are sometimes problematic, particularly when health funds, at the urging of consumers as well as the department of health in some ways, are asked to be more innovative, to produce new products and to do things in new ways. As we start to explore those paths there are some obstacles, both regulatory and structural, that inhibit—they do not stop us completely—our ability to pursue some of those ideas and innovative product offerings with enthusiasm.

Mr Harrison—We are not a lobbying body and we are not a fund, so our relations with government are in some ways fairly peripheral. I support what Ian was saying about the regulations and the impact they have on funds. I think the funds are probably subject to more scrutiny and regulation than just about any other form of business in this country, and that is really quite onerous. The only other thing that I would really want to add is to support what Michael was saying in relation to funding being restored to the private hospitals cost data collection databases. That is crucial from an industry perspective, and I totally support it.

Mr Schneider—I guess that sometimes one feels the extent of government regulation is a bit one-sided in that, as has been pointed out, the prices of health funds are regulated, their benefits are regulated, their investments are regulated and so on. Whereas the people who are the recipients of health fund benefits, the doctors, hospitals and allied health professionals, are not subject to anything like the same degree of Commonwealth regulation.

I have already said that I think the Commonwealth could make more imaginative use of its power to issue provider numbers, to influence behaviour and, indeed, to improve quality and safety. That is one area I think should be explored. I join with Michael in strongly supporting the re-establishment of the private health insurance quality working committee—which I think it finally became known as—with a view to bringing all of the sector together to try to continually upgrade standards, because I think it is a very positive achievement we have had.

It is interesting that government and the parliament—although probably the government to a greater extent than the parliament—and insurers have a common interest with the private sector in trying to ensure that consumers get the best possible care available but at prices that the nation can afford to pay. I think that is true of government and both the public and the private sectors. The unfortunate challenge today is that most of the regulation of insurers comes about at the instigation of provider groups, with a view to trying to ensure that their income is maintained or maximised. That puts government in a very difficult position because it has an interest in reducing costs, or avoiding cost growth, at the same time as having to make regulations which must inevitably drive prices up. Unfortunately, that is not always recognised. It would be more comforting for us if we felt that government was aware of the financial consequences of the regulations that it imposes on insurers. You cannot make a health fund pay more benefits without that coming out at the other end in higher prices. Yet, somehow, people seem to try to separate those two things as though there really is a magic pudding, but unfortunately there is not.

There are some things that we have outlined in our submission that could be very usefully done. One of the most important is to try to expand, or maintain, the marketplace, and to make sure that we have a pool of good risks who are able to cross-subsidise the cost of the less good risks. We can elaborate on that if you wish.

Mr O'Dea—You have asked an interesting question. This area has probably been the success story of health over the last six or eight years. Private health insurance was a basket case in 1997-98. Membership was dropping by two per cent a year and was just 30 per cent of the population. We were all wondering when it would go over the cliff. The government intervened with the Lifetime Health Cover and the 30 per cent rebate and we have seen a pretty remarkable turnaround. But there are not too many people who actually applaud it. Most people are critical of it, particularly the academic community in Australia. There is a strong public-private intellectual divide in Australia, which prevents any support for private health insurance. Private

health insurance went up to 45 per cent of the population; it was about 50 per cent growth. It is still at 43. I think that is pretty impressive after five years.

If you look out to the future, we might continue to get eight per cent premium growth, which we would all like to avoid. What Russell said is pretty right. You probably will get that. But it is still sustainable for five years out into the future, I would have thought. It is a pretty good achievement and it has been done at 30 per cent cost. The government pays 30 per cent of the premium. The alternative is that they pay the whole lot. You have had 60 something per cent growth in admissions in private hospitals over the last six years and over the same period about 14 per cent in the public system. Things are still bad in the public system, but they could be a lot worse.

We are not very good at claiming our victories. It looks reasonably stable to me into the future. There is too much regulation. We have thought about what is essential. People will disagree, but we thought you have to have regulation around lifetime community rating, prudential requirements, portability, and maybe some special measures for groups like the mentally ill and so on. So you try and define the minimum regulation you would need and gradually wind it back. People do complain that there is too much regulation. We have this annual charade where premiums are approved, but there really is not much option for anybody but to approve them. If you want to go much further than where we are, I think private health insurance is stuck. You have universal Medicare that covers everything but what is done in private hospitals, basically. We had a conversation today about breaking down the edge of the hospital community divide, but we cannot go much further without fundamental reform, and that means revising Medicare, which I suspect will come eventually. But I cannot see it happening in the next three or four years.

Mr Levy—I would like to endorse the comment John has made that we often forget the progress that is made in the private health system. I have only been in it for a short period of time after spending 10 years in the public system, and I can certainly confirm the comments that Dana was making that it is acutely and chronically sick and there is some desperate need for some reform there. But on this side, I do not think it is broken, so the desire to rapidly try and fix it should be tempered.

That said, the role of government is interesting in that it is, as we have heard, the funder, with the 30 per cent rebate; it is an owner in the case of Medibank Private and, at least at this point in time, it is certainly a regulator and has its hands in many parts of the business and, lastly, it is the price setter. Wearing all those hats on an ongoing basis must continue to cause it some conflict, especially as it tries to determine the best way to use the scarce resources that there are. So within each one of those, I would imagine, there is some room for some reform. We have talked about reform today in the regulation area with the areas that could be covered, but certainly also in the pricing opportunity there is more than likely some models out in the community today where government has moved from, in effect, privatising some of the utilities, moving the safeguarding of prices for those utilities into third party price regulators and moving it away from government, which has been a part owner in that. That opportunity still exists and could be pursued at some stage.

Mr Tobin—In the spirit of unanimity I will certainly endorse the comments about the private health insurance quality group. I think it is very important that we try to resurrect that group.

Today's proceedings have reminded me—and I had a conversation about this with someone else earlier today—just how complex the health care system is. I think the delivery of health care in an advanced Western country is going to be complex enough as it is. If you looked at what we have done in Australia to date with our states, territories, separate jurisdictions, Commonwealth involvement, private-public sector interfaces, and you sat down and tried to make it more complicated through planning, you would probably fail miserably compared to what we have evolved into. Bear in mind that the government is looking at workplace relations and, regardless of your views about where that should go, I think they are finding just how complex it is to rewrite the legislation to simplify it.

If you ever try to read the National Health Act and the Health Insurance Act, as I have had to read bits of it on occasion—and I have only done it because I have had to—you will see that it is very difficult to understand. Portability was a great example of trying to find out what the obligations were on the various parties. You have to go from one section to another section to another section, and I think people have got different bits of legal advice in any case. So I think it would be a worthwhile exercise at some stage if the industry as a whole could have a look at the current legislation and see if we could try to simplify some of it.

In terms of the fragmentation comments that have been made, as Michael, Ian and others have observed, even within a department, you can talk to one section about an issue and, with an issue which you think is a fairly contained one in your organisation, you have to talk to several different parts of the department, all of whom are well entrenched in their own silos. So one suggestion in our submission was that we create a beast called the private health industry council where we actually bring together, maybe once or twice a year, all of the relevant players. Perhaps we could pick a couple of issues and everybody could focus on an issue from their own different perspectives. Two good examples that come to mind are quality, for all the reasons that we have been discussing, and work force.

When you look at who is responsible for training, you see that you have got the state governments, postgraduate and undergraduate training—they are all different players, the Commonwealth, public hospitals, and increasingly you need to have private hospitals. Then that overlays with medical indemnity arrangements, which is another hugely complex area. I am very loath to create yet another committee because I have to turn up to enough of them, but if you get it right—you get the right group of people together and you have a decent agenda and perhaps pick one or two meaty issues—that could be a worthwhile initiative.

On private health insurance membership, I would endorse what has been said about the growth in membership and the maintenance of that membership. I think that is a significant achievement. We are a little bit concerned, just looking at the figures, that the age of the insured population is rising. We are probably not quite as optimistic as perhaps some of the other contributors about the sustainability of that over time. In our submission we have proposed a couple of specific initiatives which I could go into in a bit more detail, but they are probably not the most politically popular things that we have ever said or recommended.

CHAIR—Can I start by asking Medibank Private a hypothetical question. How would the industry be affected by the privatisation of Medibank? How would you operate differently in a privatised environment? What impact would that have on other funds and private hospitals?

Mr Levy—That is an interesting question. We are speaking hypothetically. Obviously part of the hypothetical response needs to understand in what form we are privatised. So if we assume that we still exist as an entity and operate as a national health fund under our name then the response would be—certainly in the area of pursuing change and reform as we believe is necessary and as we have undertaken through our hospital purchasing strategy that has had a lot of airplay or noise, as I call it, and we have actually undertaken other areas of reform in the ancillaries area—that there is an increased and significant degree of oversight by government as to what we do and why we do it. Even though we would be steadfast in our belief, as would our board, that the actions we are taking are in the best interests of maintaining value in our product for our members, we find that we are nevertheless required to meet the requirements of government policy or lobbying with government and politicians to meet the outcomes of particular electorates. Speaking honestly, that happens and it happens frequently.

CHAIR—I confess!

Mr Levy—It may have happened with yourself. So that is a significant overlay, and in our view some of those decisions would not be in the best interests of our members. They may be in the best interests of an electorate or voters, but they certainly would not be in the best interests of our members, and that would certainly make a difference. The other point to mention, which again is influenced by what sort of form the privatisation takes, is that if it becomes a listed company on the Stock Exchange—which is one of the things that has been discussed—that itself might generate further actions by other funds and opportunities for rationalisation and consolidation of the industry, and there would be many who would say that that is not necessarily a bad thing.

CHAIR—Do any other funds want to make a comment?

Mr Burningham—Hypothetically speaking?

CHAIR—Hypothetically speaking.

Mr Burningham—Certainly from the perspective of MBF, were anything ever to take place as Mr Levy outlined, we do not believe that we would change very much of what we do at the moment, because we view the way we operate as being sensible, commercial and grown up and we are a business suitable for the kind of environment that I think Bruce was outlining. In fact, irrespective of whatever hypothetical future we face, I think that the industry would be well served by having organisations with a consumer focus that are actually large enough to deal appropriately with national issues and to get the benefits of economies of scale, however they may arrive.

CHAIR—One issue that comes up in parliament, in our party room and in our electorates at all levels is that of mental health. It is of growing concern in the community, and I hear people say that we have solved our mental health problems by people being in jails instead of getting treatment. We have talked a bit about mental health today. Does anybody want to comment as to whether the private sector can play a lead role in the future of mental health treatment in Australia?

Dr Wainwright—First of all, you are quite right—people do say that the mental health institutions were emptied out and those very same patients have gone into and filled the prisons. It results from the failed policy of 10 or 20 years ago, where they cleared out the mental institutions and said that they never put the money into looking after the patients with the community. The funding has never been there to support these patients, which is why they are on the streets and going into the prisons. That is failed public policy, with no money going into the community mental health care systems, and it needs to be urgently addressed. With regard to the private system, I think they already play some part in looking after the private psychiatric hospitals. It is very important that people have access to private hospitals when they are mentally ill if they are privately insured and there are no barriers to those. I am not sure what greater role they can play, but it is an extremely important issue, because mental illness occurs irrespective of social class. It can be people who can afford private insurance or people who are down and out. It is very important that the government addresses this now and puts the funding in.

CHAIR—Do the hospitals or funds have a view?

Mr Schneider—There are two things. Firstly, we are involved with the AMA, hospitals and other groups in an organisation called the Strategic Planning Group for Private Psychiatric Services, otherwise known as the SPGPPS or the 'spaghetti' group. It has had a number of significant achievements, including collecting data about psychiatric care and outcomes and trying to get some degree of measurement of outcomes. John O'Dea may be able to elaborate on that a little more than I can.

The other thing that is being done, of which not much is known outside South Australia, is a funding model which has been entered into by the insurers and the same organisation that owns the building we are sitting in, which virtually has control of all the private sector psychiatric services in South Australia. The funds and hospitals negotiated together a funding arrangement whereby the hospitals receive, from the insurers, global payments for a number of patients who pretty well routinely go there each year.

CHAIR—Payments from where?

Mr Schneider—From the insurers. It is based on the number of patients each insurer had last year who were going to the hospitals. The hospitals manage that money. This is not US style managed care, but it is a case of allowing the hospitals to determine the best treatment for each individual patient, which may be in-hospital treatment, out-of-hospital treatment, a combination of the two or a particular course of treatment. The outcome of that is that all the participants involved are happy with the result, including the consumers and the patients. It works largely because there is only one organisation operating the psychiatric hospitals in the state and because the funds have cooperated in the model and see it as being worth while. The challenge is to see whether that model could be developed and applied in other states where there are competing owners of psychiatric hospitals or more than one owner. But we believe it is a model that is well worth investigating and pursuing.

Mr O'Dea—On that group—the SPGPPS—are the hospitals, the health funds, the medical groups and the government, so it has all the right people. If you go back seven or eight years, the funds were frustrated about paying out benefits for psychiatric services and so on, because they really did not know what they were getting. This group has been able to come up with some

outcome measures that can show how much improvement in mental health you are buying with the money. It has come up with clinical guidelines and a whole lot of other things. It has been very positive and long lasting. I guess it is another success story on the private side.

Mr Tobin—Our organisation runs psychiatric services in both the private and the public sectors. In the private sector there are some worthwhile initiatives out there and we would certainly support those. There are also some constraints that people should be aware of. One is the work force—there are just not enough psychiatrists, particularly in a lot of areas more than about 20 kilometres from a CBD. It is very difficult, particularly in rural and regional areas.

We were talking before about the scope of private health insurance coverage. One of the issues I have become aware of is the hospital in the home program that at the moment covers some psychiatric services. The only problem is that it has to operate as a substitute for hospital care. That means that a patient already has to be sufficiently sick, even if they are being treated in the home as a hospital in the home patient, to warrant being classified as a hospital patient. At the moment there is no capacity for health insurance to pay for people who might be on the edge of either getting sick or staying well, and obviously we want to keep them well. That is another example.

On the public sector side, the funding for mental health services is in a fairly desperate state, and that is something we have commented on to the Senate inquiry. The last comment I will make is that, with mental health services, for people to have private health insurance they need to have a certain level of organisation and wherewithal, which a lot of mental health sufferers do not have. It is very much a public sector problem but the private sector can play an increased role.

Mr Roff—I did have some specific information on this which I cannot lay my hands on. Perhaps I could take that on notice and provide it to the committee.

CHAIR—Absolutely.

Mr Harrison—In relation to what Russ was saying about the model in South Australia, it is worth while adding that what has happened as a result of that is that the hospitals involved have actually closed beds, because more and more patients are accessing services within the community environment and outside the hospital walls. We have seen a fairly drastic reduction in hospital costs as well as terms of the treatment plans. It has been a very successful project.

Mr CADMAN—Are you covering that out-of-hospital support?

Mr Harrison—It is certainly covered. As Russell explained, it is a capitation type arrangement where the funds provide X dollars and it then up to the hospital to manage the treatment.

Mr GEORGANAS—My question moves away from the psychiatric area and goes back to a comment from Mr Michael Roff. In your statement earlier you mentioned the private health industry branch that was dismantled a few years ago. What void has that left? Has there been anything to replace it? What has the impact been of that particular branch no longer existing?

Mr Roff—Once again, it is this silo issue, because health insurance is dealt with by the health insurance branch and what are nominally hospital issues are dealt with in the acute care branch that also covers public hospitals, but then there is no real crossover on the myriad of issues that impact on private hospitals and health funds.

Mr GEORGANAS—So obviously it has left a fairly big void.

Mr Roff—What happens at an operational level is that the people who look after health insurance also look at those hospital issues but to some extent it is beyond their remit. For example, the government has been reviewing portability and that is all being done within the health insurance branch when really it is an issue that is broader than health insurance. It impacts on hospitals and it impacts on consumers as well. Because there is such an interaction between private hospitals and private health funds, there is no real mechanism for addressing that in an even-handed way in the department, as we see it.

Mr CADMAN—With regard to private patients in public hospitals—this is a government regulatory thing—I notice that the AHIA submission says:

> The Commonwealth should claw back any increase in revenue State Governments make by raising inappropriate charges on privately insured patients who do not receive bona fide private status.

That is the biggest whinge I get from some of my constituents. They are insured, they go into a public hospital, they say they are a private patient and they are treated the same as everybody else.

Mr Schneider—It depends on how they go in. The system should sort that out. In most cases people would go to their GP and be referred to a specialist if they are privately insured. The specialist would then arrange to admit them to hospital as his patient, whether it be public or private. If they are not insured, he would normally refer them to outpatients in the public hospital and then a decision would be made by the hospital doctor or a doctor who is a VMO and they would be admitted as a Medicare patient.

The issue you are talking about probably is when someone goes in through casualty, they say, ‘I’m privately insured,’ they expect to get some prioritisation and the public hospitals will not give them that prioritisation, basically because under the Medicare agreements your insurance status does not get you in faster than if you are uninsured. I can certainly understand the complaint that the individual has about the fact that, being insured, they are not able to get some sort of—

Mr CADMAN—Don’t the states make a profit out of that process though?

Mr Schneider—This is the other side of the coin. The concern we have is more in cases where a person who is privately insured goes to a public hospital and is asked whether they are insured or not, they admit that they are and are then charged for the privilege but are not given any of the benefits that they have paid insurance for, such as choosing their doctor or being able to get a private room and so on. So we say that in effect all that is happening there is that the states are using the privately insured patient as a taxation resource. We do not mind people going into public hospitals as private patients if they have the opportunity to choose their doctor or

receive a private room or be treated at the time of their choosing. But what we do say is unfair is when the privately insured patient simply gets the same treatment they would if they exercised their Medicare entitlement but are charged for it. In fact, in some cases, by declaring their privately insured status, they are also subject to medical bills, gaps and other costs that they would not have had if they had elected to be a Medicare patient.

Ms HALL—I must say that I am very lucky, because hospitals in my area are very good. They offer patients special treatment if they go in as private patients. You talked about regulation, and I gather from what you said that you feel that your industry is overregulated. Would you like it to be changed and how does it all fit with everybody that is involved in the industry? Maybe the private hospitals think that the private health insurance industry is underregulated. How do you as doctors feel about the level of regulation in relation to insurance and the providers of the services? Can you comment on that?

The second question I want to raise concerns looking at the waiting lists for public hospitals and the ability for the private sector to take that up and provide the services. In New South Wales we had the Port Macquarie hospital that was not so successful and in the last election the Labor Party's Medicare Gold looked at the private sector providing service to a certain group. Catholic Health Australia, in their submission, talk about providing that service to people aged 75-plus.

I think Mr O'Dea mentioned Medicare. What is the general feeling of people in this room? Do you want Medicare to go and private health insurance to take it over or do you believe there is a role for universal health care? I am interested in hearing from the people in the AMA and from Mr O'Dea.

Dr Wainwright—I will tackle the second question, which is the ability for private hospitals to take up the waiting list services, and that is a lose-lose situation for both the public hospitals and the private hospitals. We lose from the public hospitals the ability to provide those services and, as I said, we have to build up and strengthen our public hospitals. They are losing because those services will be irrevocably lost and never regained within the public hospitals, which is our premier place for teaching and training. I think it is a loss for the private hospitals as well. Obviously the only reason they are being used is that they deliver these services more efficiently and effectively than the public hospital sector. But, ultimately, I think it will devalue private health because patients will wonder why they have private insurance if public patients are next to them, and I think the private patients will drop their private health insurance. I think it is a lose-lose situation for both. We would rather see the public hospitals built up and strengthened so that they can provide the services that, under the health care agreements, they are obliged to provide, rather than remove those services indefinitely.

Ms HALL—And with respect to regulation and Medicare?

Dr Wainwright—I cannot comment specifically on regulation, except to say that there should not be too much. At the moment in the public hospitals there is too much. In the private sector it is verging on too much. I think there should be a framework but it should not be too prescriptive. With regard to Medicare reform, we would like to be in the discussions on Medicare reform because, currently, public expectations are greater than what can possibly be delivered by what we do, and we have to look at the medical savings account and all kinds of other aspects.

Ms HALL—Do you believe that there should be universal health care?

Dr Wainwright—Through Medicare?

Ms HALL—Yes.

Dr Wainwright—Yes, as a safety net, but whether there should be user pays on top, means tested, medical savings account, is open to debate. But I think it is a discussion we have to start looking at.

Mr Tobin—In terms of private patients in public hospitals and public patients in private hospitals, firstly, we are concerned that some state jurisdictions are actively encouraging private patients to come into public hospitals and, at a time when there are large waiting lists in those state jurisdictions, we think that is not very helpful in terms of the overall health system. If the local public hospital, particularly in small country towns, is actively and aggressively encouraging private patients then that makes life very difficult for a private hospital to continue to exist, and they are already under a lot of pressure.

We really think that public hospitals should concentrate on getting the public waiting lists down. Having said that, we do still see a role for private hospitals, where they do have spare capacity, to assist in treating patients, particularly those who have been waiting for a very long time and elderly patients. We are not quite sure whether that could be everybody, but certainly I think it is a bit silly to have resources that are available in the country, to the extent that they are available and that differs across the country. But there is a role, I think, for the private sector to assist in that regard and that is already happening in some jurisdictions. Obviously, the treatment of veteran patients does show an example of how that can work.

On the issue of regulation, one comment I would make is that often, where health funds are regulated, they are regulated to ensure that there is a comprehensive coverage of benefit payments. Where holes start to develop in the payment of benefits, there has been regulation brought in to try to stop that. Obviously, it is very difficult in Australia for health insurers because you have a free alternative. For most of the people who are members of private health insurance, their premiums are probably higher than they would be because a small number of elderly members actually draw a lot more in terms of benefits than most of the other members. I think having any younger privately insured people remaining as members of health funds is quite an achievement for health funds. It is difficult, but the regulation is necessary. Whether it needs to be so complex, difficult and voluminous is, I think, another question.

On Medicare, Catholic Health certainly does see a continuing role for a universal health system. We do not want to see a two-tiered system develop, but at the same time I think that having a private system which offers choice—a viable private system—is also an important part of what this country does well. I think you can look at other systems that are strongly totally public. You can see what is happening with the NHS in Britain. There is a lot of dissatisfaction there and a huge amount of additional resources now going into that system. That has its problems. The US obviously has its problems. There are 40 million people who have no health insurance at all, which is socially tragic from our perspective.

Mr Roff—First, on regulation, as private sector organisations obviously the overriding philosophy is that less is better than more. But then it goes back to the issue that Patrick was picking up—that a lot of the regulation there is designed to provide some sort of protection in relation to cover. Then it is a question, if you are winding it back, of where you draw the line and how long you want the piece of string to be.

Every now and then I go over to New Zealand to talk to our sister organisation there and explain how the system here is set up. They are obviously a much more laissez-faire society. They cannot believe the amount and scope of regulation that we have to endure in the Australian health system. But then, if you compare the two systems in terms of cost, access and outcomes, you would rather stay here than be in New Zealand or probably anywhere else in the world. So I think the issue in regulation reform is not throwing the baby out with the bathwater.

In relation to public patients in private hospitals, our position on that is that it is effectively a decision for each individual hospital, depending on their capacity and circumstances and whether or not they can provide a separate ward or wing for public patients in order to make some sort of differentiation. There are collaborative arrangements between individual private hospitals and public hospitals in particular states and regions. The private facility will be able to provide some services that the public facility cannot and public patients are treated under agreement.

More recently, in New South Wales, we have seen the state government contracting out waiting list work, particularly day surgery. I think they started with cataracts and some lens procedures. I know there are a number of day surgeries that put tenders in. The results have not been announced, but my understanding is that a lot of those tenders were actually won by public hospitals. I am not sure how that works. I think Medicare does provide a strong underpinning. We had the discussion about managed care before, and that is one thing that distinguishes the Australian system from the US system: having the GP there as the gatekeeper, which I think is a very important part of our Medicare system. Hopefully, that is what the health funds are talking about with the expansion of scope of their services.

Just one other thing that may be worthy of consideration, not just in relation to public patients being treated in private hospitals but perhaps in terms of looking at some administrative efficiencies, is looking at private management of public facilities—and there are a number of successful models around the country that potentially could be expanded. We have all heard about the bureaucracy and administrative waste in health. Contracting out the management of public hospital facilities is one option to try to alleviate some of that.

Mr Schneider—We agree that there is too much regulation. We have got to temper that by saying that there are some areas where regulation is necessary to ensure this very unusual market operates effectively. By that, I mean that community rating is not a common insurance principle, so there needs to be some degree of regulation there. I do not think price needs to be regulated the way it is, but our main concern is that price should ensure the viability of insurers. I will not waste your time by going through all the things about regulation, but we will put that in the submission.

Ms HALL—Did you say you would provide that in writing?

Mr Schneider—Yes, if I may.

Ms HALL—That is great.

Mr Schneider—I have no problem with Medicare as a universal health care system, but I think the discussion we have never had is: what are the relevant roles of the public and private sectors? The thing is that the public sector, by its very nature, has to provide services for the public. That ranges from protecting us from bird flu through to providing accident and emergency services, trauma services, primary care and the whole range of health care that we need. By definition, if you do that, you must prioritise—triage, if you like—and determine whose need for care is greater than somebody else's. What is good for the total population is not good for the individual, and individuals may well feel that if they are prepared to pay for it then they should be able to go into a system side by side for the services that they believe are vital for them.

Ms HALL—Can I clarify that: say somebody comes into accident and emergency with a severe trauma and goes in first, but somebody with private insurance feels that they should go in prior to that—is that the situation?

Mr Schneider—No, they should go somewhere else. They should not jump the queue; they should go into another queue or into a different system, where perhaps there is not the same queue. This is the debate we have never had as to how these two interlink for the maximum 'satisfaction', I suppose, of the society. Individuals will make their own decisions about what prioritisation they want. That should not be at the expense of other individuals who wish to be part of a Medicare system. The two should be integrated and we should be discussing how we can integrate them more effectively so that that combination of need and choice is provided. That leads me to the question of Medicare Gold, which you asked for a comment on.

Ms HALL—It was waiting lists. I just threw that in as part of an example.

Mr Schneider—With waiting lists in private hospitals, I do not think we have got to the bottom of why they are, where they are and what causes them. There is a range of different reasons.

Ms HALL—The private sector helping out with them was—

Mr Schneider—The private sector has reduced the waiting lists for elective surgery enormously. When you take out health fund membership you only have to wait 12 months to be treated. The figures demonstrate that the sorts of surgery and treatments that are being done by the private sector today are not trivial; they are not things that people do not need to have done. If there was not a private system, the waiting lists in the public sector would be much larger than they are.

Ms HALL—I have no argument with what you are saying but that was not the question I asked. What are your thoughts on the private sector coming in and taking up the public system waiting lists?

Mr Schneider—There are some experiments with that already. The difficulty is that if everyone could get into a private hospital by virtue of being on a waiting list why would they take out health insurance? All it would do is create a very big waiting list problem. If private hospitals are to be used to admit people who cannot get into a public hospital without being insured, then we have to be very careful that we do not throw the baby out with the bath water. We could make the problem worse than it is today.

CHAIR—I would like to wind up this roundtable now. In my opening remarks I said that I was very impressed with the standard of submission this inquiry has received from you all. They are certainly the highest quality submissions I have seen before a parliamentary inquiry in the last 15 years. Today’s interaction at this roundtable has been useful. One thing that is evident to all of us is that the main concern of the participants has been the patient. Every remark has been made on the basis of what is good for the patient. We have received some very good evidence today to our inquiry. You will all get the opportunity to read the transcript. A copy will be sent to each organisation. I invite you to get back to Hansard with any amendments you may wish to make. If any other ideas come to mind or if there are recommendations you want to put this committee please do so, particularly after you have read the evidence and have reminded yourself what your colleagues have said. I thank you all for participating in this roundtable.

Resolved (on motion by **Mr Cadman**):

That this committee authorises publication, including publication on the parliamentary database, of the transcript of the evidence given before it at public hearing this day.

Committee adjourned at 4.09 pm