Submission No. 43
AUTHORISED: 30-05-05

Australian Government

Department of Health and Ageing

Mr James Catchpole
Committee Secretary
Standing Committee on Health and Ageing
House of Representatives
Parliament House
Canberra ACT 2600

Dear Mr Catchpole

Inquiry into Health Funding

The Department of Health and Ageing would like to amend it's submission to the House of Representatives Standing Committee on Health and Ageing Inquiry into health funding. The amended submission is enclosed.

The submission is amended to clarify information reported in relation to health funds. In the last paragraph on page 23 of the Department's submission we have adjusted figures for:

- health fund buying groups that negotiate with hospitals on the level of benefits paid for services provided in hospitals;
- health funds that are part of a co-operative group or an alliance of health funds; and
- health fund membership numbers of the Australian Health Services Alliance (AHSA) and the Australian Regional Health Group.

I trust this information clarifies the figures reported in our original submission.

Yours sincerely

(SIGNED)

Richard Eccles
Assistant Secretary
Policy and International Branch
Portfolio Strategies Division

11 October 2005

Portfolio Strategies Division MDP 85 GPO Box 9848 Canberra ACT 2601
Telephone: (02) 6289 8287 Fax: (02) 6202 4773 ABN 83 605 426 759

Submission to the House of Representatives Standing Committee on Health and Ageing

Inquiry into Health Funding

Australian Government
Department of Health and Ageing

May 2005

TABLE OF CONTENTS

1. THE AUSTRALIAN HEALTH SYSTEM – AN OVERVIEW

Australia's health system is world class, supporting universal and affordable access to high quality medical, pharmaceutical and hospital services, while helping people to stay healthy through health promotion and disease prevention activities.

Government sector involvement in health care is complemented by a strong private health care system. While Medicare provides universal access to public health services to all Australians, private health insurance complements Medicare by enabling people to take out cover that provides added benefits such as choice of doctor, hospital and flexibility in time of treatment.

This submission will outline the roles and responsibilities of government and the private sector within Australia's health system – exploring the mix between public and private funding and service delivery and the relationship between the different levels of government in providing health services. In looking at these roles, this submission will outline the leadership role of the Australian Government and how it works in partnership with state and territory governments and the private sector to deliver services. The submission will provide information on current funding arrangements, accountability measures and quality improvement frameworks in place to ensure the efficient and effective delivery of health services. It will also examine Australia's strong private health sector, including the relationships within the sector and between the public and private sectors, as well as consider issues around making private health insurance a more attractive option.

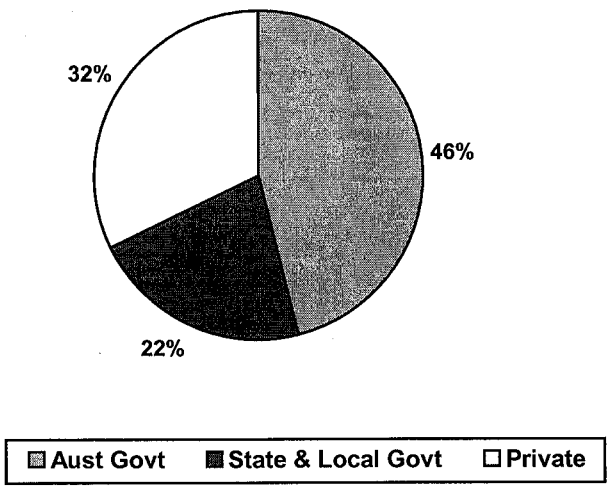
Overview of health system funding

Australia's health system is financed by a mix of public and private funding arrangements. In 2002-03 a total of $72.2 billion, or 9.5 per cent of GDP, was spent on health. Of this:

- Public or government funding accounted for $49 billion, or 67.9 per cent;
  - Australian Government - $33.4 billion (46.2 per cent); and
  - State and territory governments - $15.6 billion (21.6 per cent); and
- Private sector financing was $23.2 billion, or 32.1 per cent.

This breakdown in expenditure is illustrated in Figure 1.

Figure 1 - Health Expenditure by Sector

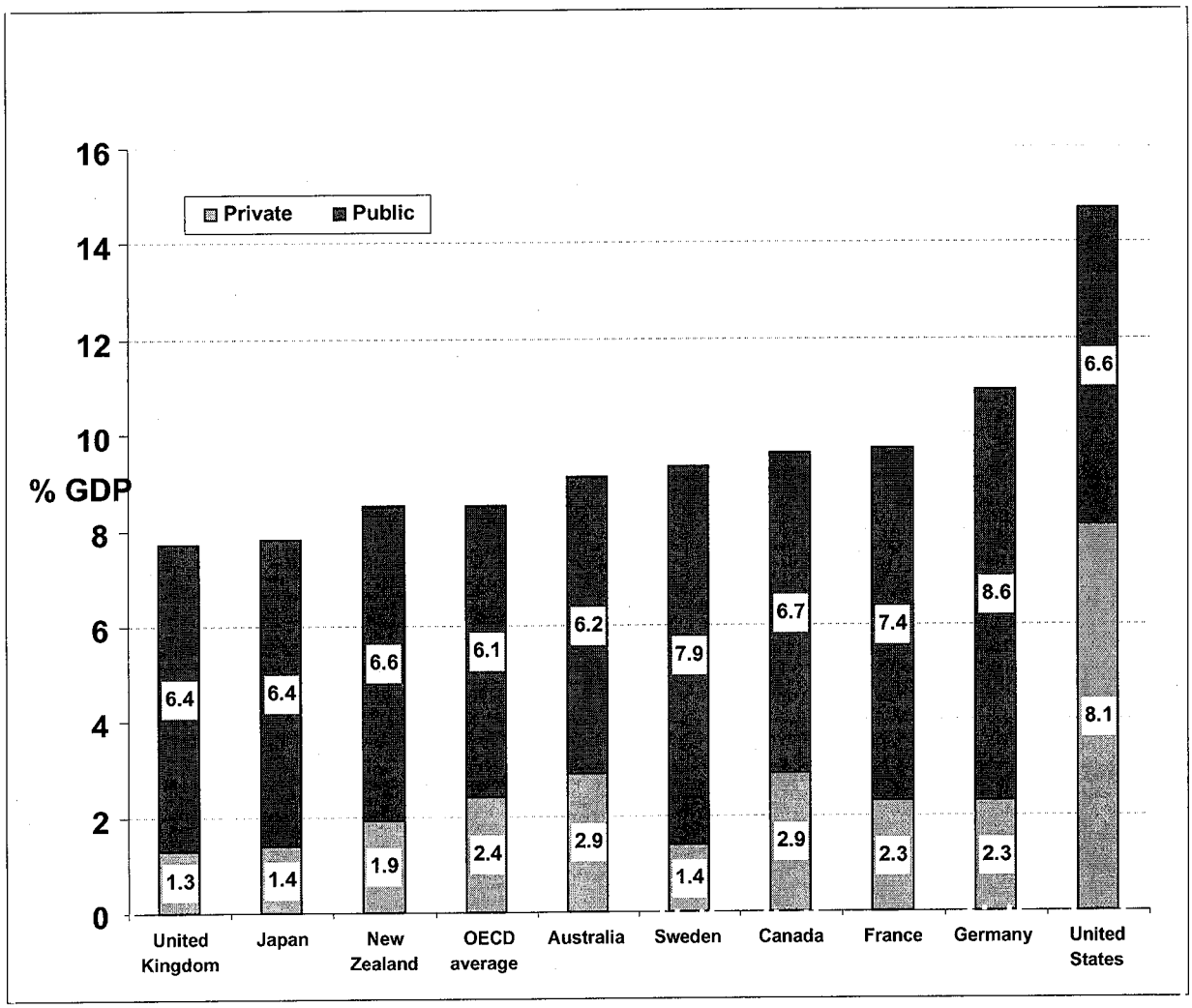


Source: Health Expenditure Australia 2002-03, AIHW.
Note: Based on preliminary AIHW and ABS estimates.

International comparisons

Figure 2 shows health expenditure, both public and private, for 2002 as a proportion of GDP, in Australia and eight other OECD countries. These nine countries all have similar socio-economic structures and standards of living. In general, most of these countries spend a similar proportion of GDP on health (the nine country average is 8.5 per cent). The exception is the United States, where health spending is 14.7 per cent of GDP. The private sector share of total health expenditure varies from less than 20 per cent in Sweden, United Kingdom and Japan to a high of 55.1 per cent in the United States. At 32.1 per cent, Australia is the second highest of the nine countries.

Figure 2 - Health expenditure by public and private sectors as percentage of GDP, Australia and selected OECD countries, 2002



Source: OECD Health Data 2004

2. ROLES AND RESPONSIBILITIES

The World Health Organisation identifies four key functions of health systems: resource generation; financing; service provision; and stewardship. These functions, in different forms and characteristics, are identifiable in widely differing health system structures. These four functions underlie the organisation of the Australian health system, where both public and private sectors fund and provide health care and all levels of government are involved, with the Australian Government providing a stewardship role. [1]

The Australian Government takes a leading role to provide universal and affordable access to high quality medical, pharmaceutical and hospital services. States and territories have primary responsibility under the constitution for the provision of health services, including most acute and psychiatric hospital services. Originally, the only Commonwealth power in relation to health was quarantine matters. However, in 1946 the Constitution was amended to enable the Commonwealth to provide health benefits and services, without altering the powers of the states in this regard. Consequently the Australian Government and state and territory governments have complementary responsibilities in health.

Australian Government
Through Medicare, the Australian Government subsidises access to primary care providers, including medical practitioners, and to a range of specialist and diagnostic services. The Pharmaceutical Benefits Scheme provides subsidised access to pharmaceuticals. The Australian Government also contributes funding to public hospitals through the Australian Health Care Agreements (AHCAs). The government's main role in the provision of care for older people includes financing and regulating residential aged care and community care. In addition to these roles, the Australian Government provides leadership in broader social policy issues concerning an ageing population as well as the general population, including promoting the health, independence and wellbeing of all Australians.

The Australian Government takes a leadership role in areas of national policy significance, including protecting the overall health and safety of the population, improving access to health services by the Aboriginal and Torres Strait Islander population, guiding national research and evaluation, trialling innovative service delivery approaches and coordinating information management. In addition, the Australian Government has various regulatory responsibilities carried out by bodies such as the Therapeutic Goods Administration and Food Standards Australia New Zealand. Through the development of national strategies, the Australian Government provides leadership on approaches to significant health issues such as HIV/AIDS, mental health and ageing. These strategies build on the partnerships between and with affected communities, governments at all levels and healthcare professionals.

State and territory and local governments
State and territory governments are the main providers of publicly provided health goods and services in Australia. Those goods and services are financed by a combination of specific purpose payments (SPPs) from the Australian Government, funding by the states and territories out of their own fiscal resources, and funding provided by non-government sources (usually in the form of user fees).

The state and territory governments provide public hospital infrastructure and services, including in emergency department and outpatient settings, and are the major providers of community based health programs. Public dental services and allied health services have traditionally been a state

[1] The World Health Report 2000, Health Systems: Improving Performance

government responsibility and continue to be so, either through the public hospital system, or through state funded community health services. State and territory governments have primary responsibility for the provision of population health programs.

The local government sector also delivers health programs, often contributing a portion of funds through cash or 'in-kind' contributions.

Private Sector

Within the Australian health system, the private sector delivers a significant proportion of primary, specialist and allied health care through general practitioners (GPs), specialists, pharmacists, physiotherapists, dentists and the like. Access by individuals to private providers is often subsidised through Medicare or through private health insurance. The Australian Government's contribution to health funding provides universal access to affordable, quality services under Medicare, while allowing choice for individuals through a substantial private sector engagement in the delivery and financing of health services.

The Australian Government has also committed to giving all Australians greater choice in health care by supporting a private health sector that complements the public health system. To do this, it seeks to:

- improve the affordability of private health care;
- increase consumer confidence, awareness and choice;
- improve health industry efficiency;
- enhance competition between health insurance funds; and
- encourage the development of innovative new health insurance products.

As well as increasing choice for consumers, the private sector plays an important role in providing the infrastructure and health providers required to meet the increasing demand for health services.

The private sector operates private hospitals and, through health funds offers private health insurance. As at March 2005, approximately 42.9 per cent of the population was covered by private health insurance. During 2003-04 private hospitals treated 2.6 million patients.

Private hospitals are operated either on a profit or non-profit basis. The non-profit hospitals are predominantly religious or charitable. Both non-profit and for-profit private hospitals are subject to state regulation. Individual hospitals range in size from very small facilities of fewer than 25 beds to major facilities with several hundred beds. The latest available data from the Australian Bureau of Statistics show that there were 536 private hospitals in operation during 2002-03. This total comprises 271 acute hospitals, 25 psychiatric hospitals and 240 free-standing day hospitals.

The private hospital sector has grown considerably since the 1990s and offers an increasingly diverse range of services:

- Private hospital admissions have been growing by 8 per cent a year, compared to 2 per cent in public hospitals since 1999-00. There are 11 per cent more private hospital beds now than in 1996 compared to 9 per cent fewer public hospital beds over the same period; and
- 55 per cent of all surgery was performed in private hospitals in 2002-03 up from 46.7 per cent in 1998- 99.

There has also been an increase in the number of day only and free standing day hospital facilities. This growth in day-only stays is particularly evident over 2000-01 and 2002-02 with

an increase in both years of 21 per cent. This was followed by an increase in 2002-03 of 4.8 per cent and 5.8 per cent in 2003-04.

Public hospitals also provide services to insured patients that choose to be admitted as a private patient. In the March 2005 quarter, there were 73,110 privately insured episodes in public hospitals, an increase of 1.8 per cent on the March 2004 quarter.

The Commonwealth is required under legislation to declare private hospitals and day hospital facilities for the purpose of payment of health insurance benefits. Hospitals must also meet specific criteria relating to quality and safety to qualify for the payment of the Second Tier Default Benefits (more information on the Second Tier Default Benefit is provided in Chapter 6 of this submission).

Most non-government funding for health goods and services in Australia comes from out-of-pocket payments by individuals. This includes situations where individuals meet the full cost of a service or good as well as where they share the funding of goods and services with third-party payers—for example, private health insurance funds or the Australian Government.

In 2002–03, of the estimated $14.5 billion out-of-pocket expenditure by individuals on healthcare goods and services:

- 32.7 per cent was spent on pharmaceuticals;
- 20.5 per cent on dental services;
- 14.7 per cent on aids and appliances; and
- 9.9 per cent on medical services.

As a result of greater take-up of private health insurance, there has been a commensurate expansion in the extent and diversity of services performed in the private sector. This is explored in more detail in Chapters 5-7. All Australians that are eligible for Medicare have access to public hospitals regardless of whether or not they have private health insurance.

Joint responsibilities and partnership arrangements

The different roles and responsibilities of the various levels of government have made it essential that there be ongoing cooperation in the interests of the health and wellbeing of all Australians. Cooperation can also help to address periodic problems of cost and blame-shifting which have at time led to duplication, waste or service delivery problems across the system as a whole. While there is some scope for flexibility funding arrangements are usually handled through clearly defined agreements. Some of these are discussed in the next chapter.

3. FUNDING ARRANGEMENTS

Australian Government

The Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS) directly support patient access to affordable health care by subsidising patients for the costs of services and therapies delivered predominantly by private medical practitioners and suppliers. In 2003-04, the Australian Government provided almost $14.2 billion to subsidise access by individual Australians to medical and pharmaceutical services. In addition, the Australian Government finances and regulates residential aged care. Further information on funding arrangements for the MBS, the PBS and the provision of aged care services follows.

Medicare Benefits Schedule

The Medicare benefits arrangements are designed to provide assistance to people who incur medical expenses when they receive professional services that are listed on the MBS. Although the Australian Government is responsible for setting fees for Medicare benefits purposes and for the payment of Medicare benefits, it has no direct power or authority to determine the fees charged by doctors or their billing practices. Medical practitioners are free to set their own value on their services, and the actual fee charged is a matter between the doctor and the patient. If a practitioner chooses to bulk-bill, the patient 'assigns' their right to Medicare benefits to the practitioner, as full payment for the medical service received.

The Medicare Safety Net protects all Australians against high out-of-pocket medical costs. Out-of-pocket costs are the difference between the fees charged by the doctor and the Medicare benefits paid. Once an annual threshold is reached, Medicare meets 80 per cent of the out-of-pocket costs for medical services provided outside hospital.

In 2003-04, total spending through the MBS was $8.6 billion, of which $2.9 billion (or around 33 per cent) was for "un-referred services[2]", generally accepted as a measure of GP attendances. This equates to almost 97.5 million services, or around 43 per cent of the 226.4 million total Medicare services claimed in the period. Table 1 shows services provided and benefits paid through the MBS in 2003-04.

Table 1 - MBS benefits and services by broad type of service, 2003-04

	Benefits	Services	Services per capita
	$m	'000	
GP attendances	2,854.8	97,467	4.8
Specialist attendances	1,119.5	20,313	1.0
Obstetric services	76.6	1,418	0.1
Anaesthesia	209.1	1,956	0.1
Pathology	1,407.5	73,762	3.7
Diagnostic Imaging	1,330.5	13,458	0.7
Operations	839.9	6,590	0.3
Optometry	196.5	4,786	0.2
Other	565.6	6,632	0.3
Total MBS	8,600	226,382	11.3

Source: Medicare Statistics http://www.health.gov.au

[2] While there are a small number of un-referred attendances claimed by non-GPs, it is generally accepted that the patterns for un-referred attendances can be used to represent GP services.

Pharmaceutical Benefits Scheme
In many cases, access to medicines is central to achieving optimal health outcomes. The PBS provides Australians with affordable, reliable and timely access to necessary and cost-effective medicines. The PBS is a world class scheme based on rigorous analysis of the benefits and efficacy of individual medicines. The PBS subsidises the cost of pharmaceuticals by providing all Medicare-eligible people with access to effective and necessary prescription medication at a reasonable cost to them and the nation. Special safeguards are in place for individuals covered by Commonwealth concession cards.

The PBS is a very fast-growing component of the Australian Government's health budget. Over the decade 1993-94 to 2003-04, PBS expenditure grew by an average 12.9 per cent per annum. Government and patient expenditure on items provided under the PBS exceeded $6 billion in 2003-04, compared with just over $2 billion in 1993-94. In 2003-04, around 166 million prescriptions were subsidised through the PBS at a cost to Government of $5.6 billion. It is estimated that three-quarters of all prescriptions dispensed in Australia are subsidised.

Aged care
Australia's aged care system is structured around two main forms of care delivery: residential and community care. There are also a number of associated aged care programs. All levels of government have some role in funding, administering or providing care for older people. The Australian Government's main role in the provision of care for older people includes financing and regulating residential aged care. The Australian Government also works closely with states and territories to help older people stay at home for as long as possible through its community care programs. Two examples of these types of programs are Community Aged Care Packages and the Extended Aged Care at Home program. Community Aged Care Packages provide care in a person's own home as an alternative for those whose dependency and complex care needs qualify them for entry to an aged care home for low level care. The Extended Aged Care at Home program provides care to frail older people who require high level residential care, but have expressed a preference to live at home and are able to do so.

When frail, older people can no longer be assisted to stay in their homes, care is available in residential care services. As at 30 June 2004, there were 2,931 residential services in Australia providing high level and low level care. At that time there were 174,657 allocated places with 156,056 operational. Residential care is divided into high and low level care depending on the level of nursing, accommodation, support, personal care and allied health services required.

Areas of shared responsibility between different levels of government

While the Australian government generally does not have responsibility for direct service delivery, it provides leadership and influences policy and service delivery through its financial arrangements with state and territory governments, through the provision of benefits and grants to organisations and individuals, the regulation of health insurance, and the development of national strategies in key areas of health and aged care. The Australian Government works in partnership with state and territory governments to deliver health care in a system with many types of services and many providers, and a range of funding and regulatory mechanisms. Both levels of government work together to ensure that a coordinated system of health care is available to all Australians.

This cooperation is formalised through a range of funding agreements with associated performance reporting requirements and in joint ventures such as the Australian Council for Safety and Quality in Health Care and through the work program of all Health Ministers including the National Health Reform Agenda.

There are many examples in the health sector of the Australian Government and state and territory governments cooperating effectively in areas of shared interest through both long term initiatives and time limited trials. This submission does not attempt to explore them all, rather it focuses on higher level examples of joint initiatives including through the AHCAs, Public Health Outcome Funding Agreements, Australian Immunisation Agreements and the Home and Community Care Program, Multipurpose Services and Indigenous programs.

Funding for activities in these areas is provided mainly through specific purpose payments (SPPs) from the Australian Government to state and territory governments. In 2004-05 the Australian Government will provide an estimated $23.4 billion in health-related SPPs, comprising almost 13 per cent of total Australian Government expenditure.

Australian Health Care Agreements

The AHCAs provide universal access to free public hospital care, delivered through the state and territory government sector. The AHCAs are five-year bilateral agreements between the Australian Government and each state and territory.

Through these agreements, the Australian Government provides financial assistance to the states as a contribution to the cost of providing public hospital services in accordance with specified principles. These principles include that public hospital services must be provided free of charge to public patients on the basis of clinical need and within a clinically appropriate period, regardless of geographic location.

The AHCAs ensure access to free public hospital services via funding from the Australian Government to state and territory governments. Over the life of the 2003-08 AHCAs, the Australian Government will provide up to $42 billion in funding to state and territory governments. Actual expenditure in 2003-04 through the AHCAs was approximately $7.5 billion.

In 2002-03, preliminary estimates of total recurrent funding of public (non-psychiatric) hospitals was $17.5 billion of which approximately 49 per cent was contributed by the Australian Government, 43 per cent by the states and territories and 8 per cent by the private sector.[3] This funding supported 748 public hospitals and 52,200 public hospital beds across Australia. In 2002-03, the public hospital sector accounted for 4,155,956 patient separations and around 42.5 million occasions of non-admitted patient services.[4]

Population health

Population health includes health promotion, disease and injury prevention and health protection, including immunisation. The Australian Government provides significant funding to states and territories for population health through a range of funding agreements, the most notable of which are the Public Health Outcome Funding Agreements (PHOFAs) and the Australian Immunisation Agreements (AIAs).

The PHOFAs are bilateral funding agreements between the Australian Government and each state and territory government. The agreements provide states and territories with broadbanded (or pooled) funding linked to the achievement of outcomes in a range of public health programs including HIV/AIDS and related sexually transmissible and blood borne diseases, cancer screening (breast and cervical cancer), and health risk factors (prevention of alcohol and tobacco misuse, sexual and reproductive health, women's health and some programs under the National Drug Strategy).

---

[3] AIHW (Australian Institute of Health and Welfare) 2004. Health Expenditure Australia 2002-03. Canberra:AHIW

[4] Department of Health and Ageing. Australian Health Care Agreements: Performance Report 1998-99 to 2002-03.

The current PHOFAs cover the period 2004-05 to 2008-09 and provide states and territories with $812 million over five years. Although jurisdictions are not required to match the Australian Government funding under the PHOFAs, states and territories make a major contribution towards total expenditure on PHOFA activities.

The AIAs are bilateral agreements between the Australian Government and each state and territory. The agreements provide funding of $832 million over 2004-05 to 2008-09 to cover the funding of approved vaccines to designated population groups under the National Immunisation Program (NIP). The Australian Government provides full funding for the purchase of NIP vaccines, and states and territories take responsibility for delivery of vaccines through immunisation providers, such as GPs, nurses or Aboriginal Health Workers (the Australian Government also subsidises GP delivery of vaccines through Medicare). The AIAs also provide some Australian Government funding for the delivery of specific school-based vaccination programs.

Aged Care

Recognising the links between the hospital sector and aged care in community and residential settings, the Australian Government is taking a leading role in establishing a cost-shared Transition Care Program with the states and territories. In addition, under the AHCAs, the Australian Government has funded the Pathways Home Program to assist states and territories to expand their provision of step down and rehabilitation care.

The Home and Community Care (HACC) Program is a joint Australian Government, state and territory initiative that provides services for frail aged and younger people with disabilities and their carers. HACC services include community nursing, personal care, meals, domestic assistance, home modification and maintenance, transport and community based respite care. The Australian Government contributes around 60 per cent of funds and maintains a broad strategic role. States and territories provide the remaining 40 per cent of the funds and are responsible for the day-to-day management of the program.

Multipurpose services

Multipurpose Services (MPS) are a joint Australian Government and state and territory initiative to deliver residential and/or community aged care and health and community services in rural and remote communities, many of which cannot sustain separate services. By bringing together health, aged and community services, economies of scale are achieved to support the viability of services in small communities, which would not otherwise be viable if provided separately. Each MPS is financed by a flexible funding pool to which both the state or territory and the Australian Government contribute. This is reviewed every three years. The MPS can use the money to provide a mix of services, including aged care, best suited to the community's needs.

Indigenous health services

Funding for these initiatives is in addition to funding from mainstream health programs such as the MBS and PBS. The Australian Government has worked to improve the accessibility and responsiveness of the mainstream Australian health system to meet the needs of Aboriginal and Torres Strait Islander people. For example, MBS and PBS expenditure on Aboriginal and Torres Strait Islander people has increased by around 50 per cent since 1996. Under the provisions of the *National Health Act 1953* the Australian Government has implemented special PBS supply arrangements to eligible remote area Aboriginal health services ($17.85 million in 2003-04), while an estimated 425,000 Medicare-funded services were provided by Aboriginal and Torres Strait Islander community controlled health services at a cost of ($13.5 million).

The Australian Government provided $281 million in 2004-05 for Indigenous-specific primary health care services and, in partnership with state and territory governments and the community sector, improved Indigenous people's access to high quality primary health care services across Australia. Examples of these collaborative initiatives include:

- the expansion of primary health care services;
- the upgrade and expansion of health clinics;
- capacity building activities such as training and support, information provision and the development of community representative steering committees;
- the construction of health care staff housing in remote areas to encourage health care staff recruitment in these regions; and
- regional planning activities.

Joint government policy forums

The Australian Health Ministers Conference (AHMC) and the Australian Health Ministers Advisory Council (AHMAC) are the key coordinating bodies comprising ministers from the Australian Government and state and territory governments with responsibility for health matters. AHMC provides a forum for governments to discuss matters of mutual interest concerning health policy, health services and programs and aims to promote a consistent and coordinated national approach to health policy development and implementation. The AHMAC advises the AHMC on strategic issues relating to the coordination of health services across the nation and operates as a national forum for planning, information sharing and innovation.

AHMAC has established two groups to look at planning and reform issues in the areas of workforce and health reform.

Medical workforce

The Australian Government undertakes to ensure that there is an adequate number of health professionals to meet population need now and into the future; that the health workforce is appropriately distributed to meet that need; and that suitable education and training arrangements are put in place for the health workforce. The health care workforce is a shared issue between the Australian Government and the states and territories.

The Australian Medical Workforce Advisory Committee (AMWAC) is an independent body set up at a national level in 1996 to promote strategic workforce planning and provide advice on national medical workforce matters. In 2000, the Australian Health Workforce Advisory Committee (AHWAC) was founded to oversee wider workforce planning needs such as the nursing, midwifery and allied health workforces. Australian Government and state and territory health workforce policies are coordinated through these mechanisms.

Health Reform Agenda Working Group

The health system needs to be responsive to the changing needs of the population and changes in the way that health services can be delivered. For a number of years, Health Ministers have recognised the need for substantial reform in the health system and have sought to progress reform through more effective use of available resources. In the 12 months before the end of the 1998-2003 AHCAs, Health Ministers agreed to pursue a substantive and cooperative reform agenda and appointed the Health Reform Agenda Working Group to manage this work.

The reform effort has focussed around the themes of:

- improving health outcomes for Australians rather than a focus on funding and program arrangements and jurisdictional responsibilities;

- improving coordination and integration of services; and
- developing the national infrastructure to support reform.

Collaboration between the Australian Government and states and territories has been occurring in the following areas:

- access to specialists in rural and remote areas;
- Improving Indigenous health: Remote Area Renal Services Project;
- a National Chronic Disease Strategy;
- broader pharmaceutical reform across jurisdictions;
- national workforce planning for the emergency care workforce;
- establishment of the National E-Health Transition Authority (NEHTA), a new national entity to drive forward critical e-health priorities on behalf of all jurisdictions; and
- increasing the national organ donation rate.

4. ACCOUNTABILITY AND QUALITY

While the Australian Government is generally not directly responsible for service delivery, over the past few years it has introduced reforms to increase state and territory accountability for funding and expenditure. These reforms have led to the development of agreements between the various levels of government on key objectives, respective responsibilities, reporting of financial information and detailed performance indicators.

Many specific purpose payments (SPPs) from the Australian Government to the state and territory governments are contingent on the provision of these accountability measures. Through these reporting requirements, the Australian Government is able to hold states and territories accountable for hospital and public health services.

AHCAs

Current reporting requirements

The 2003-08 AHCAs performance reporting requirements fall into two broad categories:

- reporting on current performance; and
- the development of an improved performance reporting framework.

For the first time, the Agreements allow the Australian Government Minister for Health and Ageing to impose penalties on the states and territories if they do not meet the reporting requirements set out in the Agreements. If a state or territory is assessed as being non-compliant in a particular financial year, the Agreements give the Australian Government the authority to withhold four per cent of that state or territory's funding for the next financial year.

Performance reporting under the AHCAs

The states and territories are required to provide information to the Australian Government on a quarterly and annual basis:

- the quarterly information relates to emergency department and elective surgery waiting times and non-admitted patient activity; and
- the annual information is more varied and includes a range of agreed national minimum data sets, performance against a set of performance indicators and expenditure information.

The Agreements also require the Australian Government to produce *The State of our Public Hospitals Report*, within six months of receiving the annual data from the states and territories. The aim of the report is to inform the Australian public on the performance of the states and territories in delivering public hospital services. This report provides a picture of what our public hospitals do and who uses them, how our hospitals are changing and how they are performing.

Development of an Improved Performance Framework

The Agreements also require the Australian Government and the states and territories to work together to develop:

- new national minimum data sets for emergency departments and outpatients;
- a range of new performance indicators; and
- a new system for reporting recurrent health expenditure under the Agreements.

PHOFAs AND AIAs

Performance reporting under the PHOFAs and AIAs

Under the PHOFAs and AIAs, the states and territories are required to report to the Australian Government against an agreed national set of performance indicators. These performance indicators have been developed in consultation with the states and territories.

The PHOFAs include output and outcome indicators for three broad areas of public health activity:

- communicable diseases (HIV/AIDS and related sexually transmissible and blood borne diseases);
- cancer screening (breast cancer and cervical screening recruitment, support, counselling and follow up, and the Victorian Cytology Service); and
- health risk factors (prevention of alcohol misuse and tobacco smoking, sexual and reproductive health promotion and women's health).

The new AIAs cover a range of requirements to support the National Immunisation Program such as the reporting of immunisation coverage levels.

Safety and quality

There are a number of different approaches across the health system where the Australian Government works with state and territory governments and NGOs to ensure the ongoing provision of high quality health services. These include:

- The establishment of the *Australian Council for Safety and Quality in Health Care,* to provide national leadership to improve the safety and quality of care in hospitals and other health settings. The current term of the Council ends in June 2006. A Review of the Future Governance Arrangements for Safety and Quality in Health Care is currently being undertaken to advise Ministers on the future arrangements for leadership and national coordination of safety and quality in health care.
- The development of National Service Improvement Frameworks (NSIF) for the national health priority chronic conditions of cancer, diabetes, asthma, cardiovascular disease and stroke, and arthritis and musculoskeletal conditions. The NSIFs will identify key intervention points across the care continuum (from prevention to palliation) where improvements can be made.
- Funding organisations such as the Divisions of General Practice to improve health outcomes by supporting general practitioners and encouraging quality improvement.

There are also a range of strategies in place to ensure quality outcomes in the provision of primary care. The strategies include a number of different funding arrangements and incentives such as:

- Enhanced Primary Care – MBS items to encourage health assessments and multidisciplinary care.
- A range of service incentive payments, which reward completion of best practice cycles of care for mental health, asthma and diabetes.
- A range of incentive payments through the Practice Incentive Program aimed at population health outcomes such as cervical screening and immunisation.
- Practice payments are linked to practice accreditation, which covers quality standards such as practice arrangements and infrastructure drawn up by the Royal College of General Practitioners.
- *Australian Primary Care Collaboratives Program (APCCP)* to improve clinical outcomes, reduce lifestyle risk factors, help maintain good health for those with chronic and complex

conditions, and improve access to Australian general practice by promoting a culture of quality improvement in primary health care.

To ensure that older Australians receive quality care, the Australian Government has instituted a quality framework based on the accreditation and certification programs for residential care and Home and Community Care National Service Standards.

5. THE PRIVATE HEALTH INSURANCE INDUSTRY

Within the Australian health system, the private sector delivers a significant proportion of primary, specialist and allied care through a medical workforce that includes general practitioners, specialists, pharmacists, physiotherapists, aged care workers, nurses and dentists. The sector includes private hospitals, contributions from patients and health funds that offer private health insurance. Private hospitals and patient contributions were outlined in Chapter 2. This chapter focuses on private health insurance.

The private health care sector complements the public health sector by allowing the health system to meet the health needs of the Australian population and by giving individuals a choice in whether they are treated as a public or private patient.

When a patient chooses to be treated as a private patient in either a public or private hospital, they are charged for the hospital accommodation and the medical and other services they receive. Medicare will refund 75 per cent of the MBS fee for medical practitioners' services provided as part of the hospital treatment. The responsibility for meeting the remaining 25 per cent of the MBS fee and other costs such as hospital accommodation, theatre fees, diagnostic tests, drugs, dressings and other consumables rests with the patient. People may choose to purchase private health insurance which will cover some or all of these costs.

There are two types of private insurance cover available - hospital cover and ancillary cover:

- Hospital cover will pay the remaining twenty-five per cent of the MBS fee for medical practitioners' services and some or all of the other costs associated with the treatment such as hospital accommodation; and
- Ancillary cover will pay for some of the costs of services that occur out of hospital such as dental, optical and physiotherapy health services.

Private health insurance may cover all hospital and medical bills or the patient may have to pay a gap (or an out-of-pocket cost). The amount the patient will have to pay will depend upon the type of cover they have purchased and whether the doctor and/or hospital and health fund have a gap agreement or gap cover scheme in place.

Private health insurance hospital cover can only cover the costs of services provided when patients are admitted to hospital. Where medical services are provided on a non-admitted basis such as outpatient services, patients are responsible for paying the gap between whatever the doctor charges and the MBS rate.

More than forty per cent of the population now have private health insurance and the policy setting and regulatory regime that governs the provision of private health insurance supports the industry in the provision of ready access to appropriate services.

Government expenditure on private health insurance

The Private Health Insurance Rebate

The majority of Australian Government expenditure in the private health sector funds the Private Health Insurance Rebate. The 30% Rebate was introduced on 1 January 1999 to increase the affordability of private health insurance by reducing the cost of premiums by 30 per cent. Higher rebates for older Australians were introduced from 1 April 2005.

All Australians are eligible to claim the Rebates if they have an appropriate health insurance policy that provides hospital, ancillary or combined cover, and where each person covered by the policy is eligible to claim Medicare benefits.

In 2003-04 the total cost of the 30% Rebate was $2.5 billion and is estimated to be $2.7 billion in 2004-05. The cost of the higher rebates for older Australians is estimated to be $29.9 million in 2004-05 and $125.1 million in 2005-06.

Composition of health fund benefits outlays
The Rebates are calculated on the amount of premium paid, so increases in health insurance premiums have a direct impact on government expenditure on the Rebates.

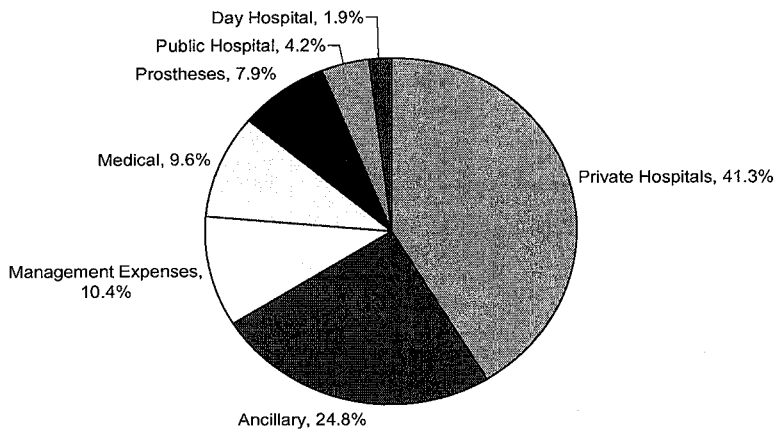
As health costs rise, fund benefits increase and more premium income is needed. Between June 2000 and June 2004, benefit outlays per health fund member rose on average 8.0 per cent a year while contribution income per member rose on average 6.6 per cent a year.

- In 2003-04, total health fund benefit outlays increased by 8.2 per cent which comprise:
  - hospital benefits increases contributing 7.2 per cent of the 8.2 per cent; and
  - growth in ancillary utilisation contributing 1.0 per cent.
- In 2003-04, benefits paid for ancillary products made up approximately 25 per cent of health funds' expenditure. However, the funds have some ability to control ancillary costs because they can place caps on entitlements for an individual each year.

Figure 3 breaks health fund outlays into categories.

Figure 3 - Health fund outlays

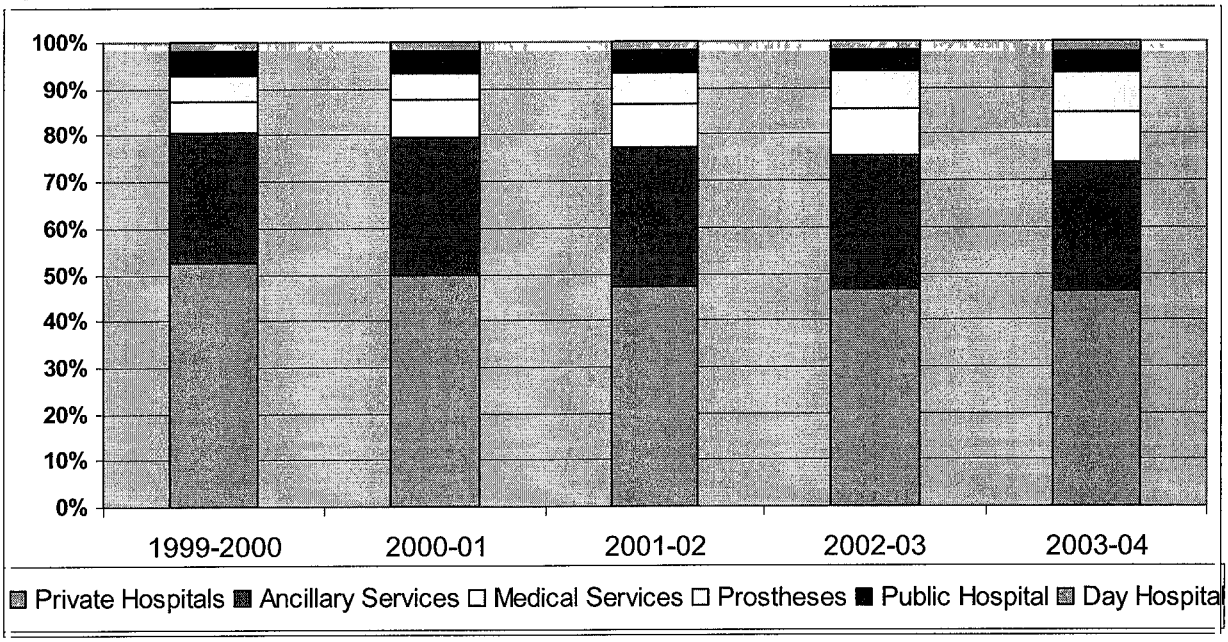
Hospital and Ancillary Benefits plus Management Expenses, 2003-04



Source: Private Health Insurance Administration Council

Figure 4 provides a breakdown of health funds' expenditure on benefits by type over the last five years. The chart shows that while expenditure on ancillary, public hospitals and day hospitals as a percentage of benefits paid is reasonably stable, medical services and prostheses have continued to increase.

Figure 4 – Health fund expenditure on benefits by type



Source: Private Health Insurance Administration Council

Cost drivers for private health insurance

Health funds provide benefits for two types of cover: hospital and ancillary. While benefits paid for ancillary services have remained relatively stable since 1999-00, benefits paid for hospital services have continued to increase steadily.

The components of hospital benefits are medical, private hospitals, day hospitals, public hospitals and prostheses. It is important to examine each of these components when looking at the reasons for increases in hospital benefits.

Table 2 compares the growth in benefits and episodes in the 2002-03 calendar year to the 2003-04 calendar year. The table indicates that there has been a shift from cost to utilisation as the main driver for the growth in benefits paid.

Table 2 - Annual rates of increase in benefits and episodes

	Benefits		Benefits per episode		Episodes per person	
	2003 cf 2002	2004 cf 2003	2003 cf 2002	2004 cf 2003	2003 cf 2002	2004 cf 2003
Private Hospitals	6.6%	6.4%	5.4%	-0.9%	1.7%	7.4%
Prostheses	28.2%	18.3%	29.6%	4.2%	-0.5%	13.5%
Public Hospital	3.3%	15.4%	4.9%	2.9%	-0.9%	12.2%
Day Hospital	7.5%	11.6%	1.8%	0.6%	6.3%	11.0%
Medical	10.6%	13.3%	8.4%	5.5%	2.6%	7.4%
Total hospital	9.2%	9.5%	7.7%	1.0%	2.0%	8.4%
Total ancillary	0.8%	3.0%	-4.4%	-0.1%	4.0%	1.8%
Total benefits growth	6.7%	7.7%				

Source: Private Health Insurance Administration Council

Total hospital benefits continue to grow by around 9 per cent per year compared with overall benefits growth of 7 per cent per year. The growth rate has remained similar between 2003 and 2004 but the main factor driving the growth is different.

- In the twelve months to December 2003 the increase in benefits was mostly due to increases in prices:
  - hospital benefits per episode increased by 8 per cent; while
  - episodes per person increased by 2 per cent.
- In the twelve months to December 2004 utilisation was the main factor driving the increase in benefits:
  - hospital benefits per episode increased by 1 per cent; while
  - episodes per person increased by 8 per cent.

This indicates that there has been some downward pressure on hospital costs in the last twelve months, while at the same time there has been an increase in the number of services provided by hospitals.

Two components of hospital benefits, medical costs and prostheses, are discussed in more detail below.

Medical Costs

Over the past two years, total medical benefits have grown by more than 10 per cent per annum. In a similar way to hospital benefits, the growth rate has remained similar but the main factor driving the growth has changed.

- In the twelve months to December 2003, price rises were the main factor driving the increase:
  - medical benefits per episode increased by 8 per cent; while
  - episodes per person increased by 3 per cent.
- In the 12 months to December 2004, utilisation was the main factor:
  - medical benefits per episode increased by 5 per cent; while
  - episodes per person increased by 7 per cent, double that of the previous year.

As with hospital benefits, this indicates that there has been some downward pressure on medical costs in the last twelve months, but there has also been an increase in the number of medical services provided.

Prostheses

One of the major cost drivers of health insurance premiums has been the costs of prostheses. Current rates of growth in prostheses costs are estimated to contribute around 2 per cent a year to total premium growth. There was an annual average 29 per cent increase in prostheses benefits paid in 2003-04 compared to 2000-01. Benefits paid in 2003-04 totalled over $647 million.

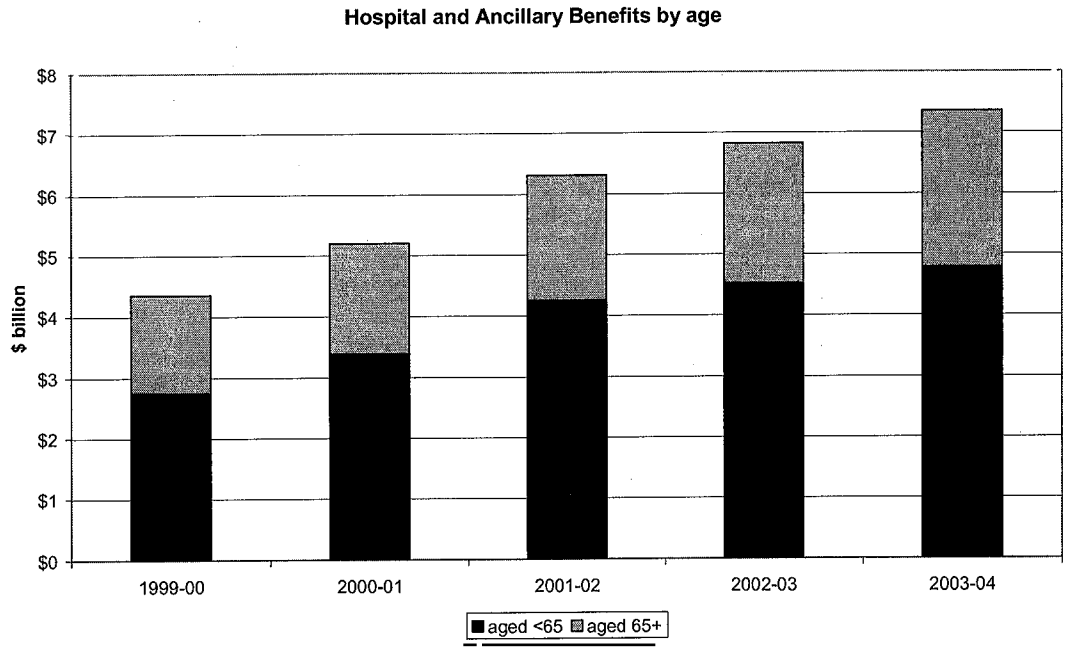
In response to the increasing costs of prostheses, the government introduced new arrangements for the funding of prostheses in March 2005 which are expected to be implemented in August 2005. The new arrangements require health funds to provide benefits for two groups of prostheses - "no gap" and "gap permitted". It is anticipated that the majority of prostheses will be listed as "no gap" and for many contributors out-of-pocket costs will not be an issue. However, there will be some cases where the consumer, in consultation with their doctor, will choose a prosthesis for which they will be required to meet some of the cost.

These new arrangements are expected to make a significant contribution to reducing pressure on health insurance premiums by limiting the rapid growth in the benefits for prostheses that has been occurring to date. A commensurate curbing of the growth of the Rebate is also anticipated.

Age of Members

The Productivity Commission report, *Economic Implications of an Ageing Australia*, and the Treasurer's Intergenerational Report both suggest that as the population ages, expenditure on health will also increase. Twelve per cent of private health insurance members are over 65 years, yet benefits paid for people over 65 years of age make up approximately 25 per cent of total benefits and are increasing over time (Figure 5).

Figure 5 – Hospital and ancillary benefits by age



Source: Private Health Insurance Administration Council

The private health insurance market

Health funds operate in an environment where products, prices, registration and financial and prudential aspects of their business are regulated.

There are currently forty registered health funds in Australia and these can be separated into two membership types; open membership funds and restricted membership funds. An open membership fund means that anybody can apply for health insurance, whilst a restricted membership fund only allows membership to people who belong to a particular organisation or community (eg, Navy Health).

Of the forty funds operating in Australia, thirty-six are not-for-profit organisations and fourteen have restricted memberships. Any surplus generated from carrying on the business of a not-for-profit fund remains in the fund to be used for the benefit of contributors. The few organisations operating health funds on a 'for-profit' basis may use any funds available that are more than the statutory minimum reserves level for other purposes such as payment of dividends and re-investment.

Of the $8.6 billion contribution income received by funds in 2003-04, $7.6 billion was paid out by funds to meet the costs of member claims. Table 3 provides a breakdown of health funds' finances since 1999-00.

Table 3 - Health Fund Finances

$ million	1999-2000	2000-01	2001-02	2002-03	2003-04
Contribution Income	5,462	7,132	7,265	7,885	8,637
Investment and other income	214	226	66	194	296
Total Income	5,676	7,358	7,331	8,079	8,933
Benefits	4,578	5,663	6,558	7,055	7,630
Management Expenses/other	717	843	805	829	852
Expenditure	5,295	6,506	7,363	7,884	8,482
Surplus/Deficit (income minus expenditure)	381	852	-32	196	447
Surplus/Deficit as a % of Contribution Income	7.0%	11.9%	-0.4%	2.5%	5.2%
Contribution Income growth	10.9%	30.6%	1.9%	8.5%	9.5%
Benefits growth	6.2%	23.7%	15.8%	7.6%	8.2%
Proportion of Contribution Income returned as Benefits	84%	79%	90%	89%	89%

Source: Private Health Insurance Administration Council (various years)

There is a significant range in the size of health funds. The industry is dominated by six large funds; Medibank Private, MBF, AXA, HCF, HBF and NIB, which together have approximately 76 per cent share of the market. There are 26 individual health funds that each have less than one per cent of market share, and when combined, comprise eight per cent of the market. A number of these funds may only operate in one or two states or in smaller regional markets.

While there are forty funds, consumers cannot choose from forty funds. This is because:

- of the six major funds, three have most of their market share in one state;
- there are fourteen closed membership funds; and
- there are seventeen smaller funds with strong niche markets in particular states and territories.

The private health insurance industry is generally considered to have had a low incidence of merger activity. However, since 1992 there has been continuous, if slow, consolidation and this trend is expected to continue. Some sixteen mergers and transfers have occurred since January 1992. Almost all involved small health funds with limited market share merging with or transferring their business to larger health funds.

Medibank Private is the largest health fund with around 30 per cent of the market. It is the only fund with national coverage and the only fund that is owned by the government. In 2003 the Minister for Finance and Administration became the sole shareholder Minister for Medibank Private.

While there are forty registered health funds there are only seven buying groups that negotiate with hospitals on the level of benefits paid for services provided in hospitals. Apart from the top five funds (by benefit outlays) there is currently a total of thirty-five funds that are part of a co-operative group or an alliance of health funds. Twenty-seven funds are members of the Australian Health Services Alliance (AHSA) and eight funds are members of the Australian

Regional Health Group (ARHG). Both the AHSA and ARHG provide a range of services to its member funds including negotiations on their behalf.

Private health insurance members

As at March 2005, there were 8.7 million people, or 42.9 per cent of the Australian population covered by private health insurance for hospital cover. There has been a significant increase in the number of privately insured people since the mid 1990s, particularly among the younger population. Table 4 compares the number of insured people over the period December 1999 to December 2004.

Table 4 - Insured people (hospital cover) by age December 1999 – December 2004

Quarter ended	Aged under 65	Aged 65 and over	Total	% aged under 65	% aged 65 and over
Dec-99	5,108,293	861,379	5,969,672	85.6%	14.4%
Dec-00	7,808,645	934,233	8,742,878	89.3%	10.7%
Dec-01	7,784,589	974,225	8,758,814	88.9%	11.1%
Dec-02	7,711,736	1,005,415	8,717,151	88.5%	11.5%
Dec-03	7,640,325	1,039,482	8,679,807	88.0%	12.0%
Dec-04	7,621,624	1,081,897	8,703,521	87.6%	12.4%

Source: Private Health Insurance Administration Council, December 2004 and earlier, "Hospital Insurance, Age cohort, quarter ended"

The proportion of persons covered by private health insurance increased significantly between March 2000 and June 2000, and has remained relatively constant since then (Table 5).

Table 5 - Persons covered and members with private health insurance for hospital cover

Quarter Ended	Number of persons covered '000	Percentage of population covered	Number of members '000
Jun-83	9,806	63.7	
Jun-84	7,784	50.0	
Jun-96	6,149	33.6	2,881
Mar-00	6,157	32.2	2,936
Jun-00	8,236	43.0	3,874
Sep-00	8,789	45.7	4,109
Dec-00	8,743	45.4	4,082
Mar-01	8,720	45.0	4,073
Jun-01	8,712	44.9	4,072
Sep-01	8,733	44.8	4,078
Dec-01	8,759	44.8	4,089
Mar-02	8,745	44.6	4,089
Jun-02	8,705	44.3	4,086
Sep-02	8,709	44.1	4,074
Dec-02	8,717	44.1	4,077
Mar-03	8,697	43.9	4,078
Jun-03	8,639	43.5	4,070
Sep-03	8,655	43.4	4,074
Dec-03	8,680	43.4	4,085
Mar-04	8,661	43.2	4,082
Jun-04	8,627	42.9	4,074
Sep-04	8,670	43.0	4,089
Dec-04	8,704	43.0	4,104
March - 05	8,706	42.9	4,114

Source: Private Health Insurance Administration Council
Note: Membership numbers not available before 1996

Regulation of the private health insurance market

Private health insurance is different from most other types of insurance because it is community rated, not risk rated. The principle of community rating is that persons should not be discriminated against in obtaining or retaining hospital coverage. In setting premiums or paying benefits, funds cannot discriminate in relation to a member on the basis of health status, age, race, sex, sexual orientation, use of hospital, medical or ancillary services or general claiming history. Community rating has underpinned the operation of Australia's private heath insurance industry since 1958.

As with all types of insurance, there are a number of risks that are present in the health insurance market that may impact adversely on consumers. These risks include adverse selection where only those consumers who believe that they need to use a health service will become members of health insurance funds, and risk selection where insurers may choose to cover those which they regard as low risk or charge higher premiums for high risk members.

The focus on regulation of the private health insurance industry therefore, is on ensuring that members are protected through equal access to health cover and that the health insurance industry remains financially stable.

The Department of Health and Ageing's responsibilities
The Department of Health and Ageing is responsible for administering private health insurance legislation including the *National Health Act 1953, the Health Insurance Act 1973* and the *Health Insurance Regulations*.

The Department manages a number of regulatory issues including the assessment of the annual premium increases requested by health funds. The premium round process requires health funds to justify their premium increases to the government. This is now done at around the same time each year and announced in March. Each health fund makes a submission to the Minister regarding their proposed premium increases. The Private Health Insurance Administration Council closely scrutinises these submissions and the Department of Health and Ageing provides advice to the Minister on the submissions. The *National Health Act 1953* (the Act) only allows the Minister to disallow an increase for the following reasons:

- might result in a breach of the Act or conditions of registration;
- imposes an unreasonable or inequitable condition affecting the rights of contributors;
- adversely affects the financial stability of the fund; or
- is contrary to the public interest.

The Private Health Insurance Administration Council
The Private Health Insurance Administration Council (PHIAC) was established in 1989 as an independent Statutory Authority that regulates the financial and prudential aspect of the private health insurance industry. It collects and disseminates financial and statistical data regarding health funds, as well as information about private health insurance to enable consumers to make informed choices.

PHIAC releases the annual report on Registered Health Benefits Organisations (RHBOs – ie – health funds) which sets out statistics and financial information on the performance of health funds in that financial year. The latest report is for 2003-04 and is available at www.phiac.gov.au. PHIAC is funded by four industry levies, which in 2003-04 amounted to $2.8 million. PHIAC's operations are overseen by a Board appointed by Cabinet and 13 staff. PHIAC reports to the Minister for Health and Ageing.

The Private Health Insurance Ombudsman
The Private Health Insurance Ombudsman (PHIO) established in 1995 as an independent body to resolve complaints about private health insurance and to be the umpire in dispute resolution at all levels within the private health insurance industry. The Ombudsman's services are available to health fund members, hospitals, medical practitioners (including some dentists) as well as health funds.

In 2004 legislative changes were made to broaden the powers of the PHIO. In particular the PHIO is now required to release a State of the Health Funds Report. The first State of the Health Funds Report was released in February 2005 and is available at www.phio.gov.au. The Report is an assessment by the PHIO of the comparative performance of health funds.

Australian Competition and Consumer Commission
The Australian Competition and Consumer Commission (ACCC) is the statutory authority responsible for ensuring that individuals and businesses comply with the Commonwealth competition, fair trading and consumer protection laws. In the private health insurance market, the ACCC particularly focuses on anti-competitive conduct (including anti-competitive mergers) and unconscionable, misleading, deceptive or otherwise false trading practices. The ACCC is required under a Senate order, to produce an annual report containing an assessment of any

anti-competitive or other practices by health funds or providers which reduce the extent of health cover for consumers and increase their out-of-pocket medical and other expenses. The ACCC has produced six reports to date, and these reports are available at www.accc.gov.au.

Australian Government policies to support private health insurance

The government ensures choice for consumers by supporting a health system that comprise a strong universal health system and a robust private system. To support the private sector in the provision of health services, the Australian Government has implemented a number of policies to make private health insurance more affordable and to encourage take-up of private health insurance. The aim of these policies is also to ensure that the health insurance industry remains financially stable and that members are protected through equal access to health cover.

- the ***30% Rebate*** on private health insurance premiums was introduced in January 1999. The Rebate is intended to increase the affordability of private health insurance by reducing the cost of premiums by 30 per cent;

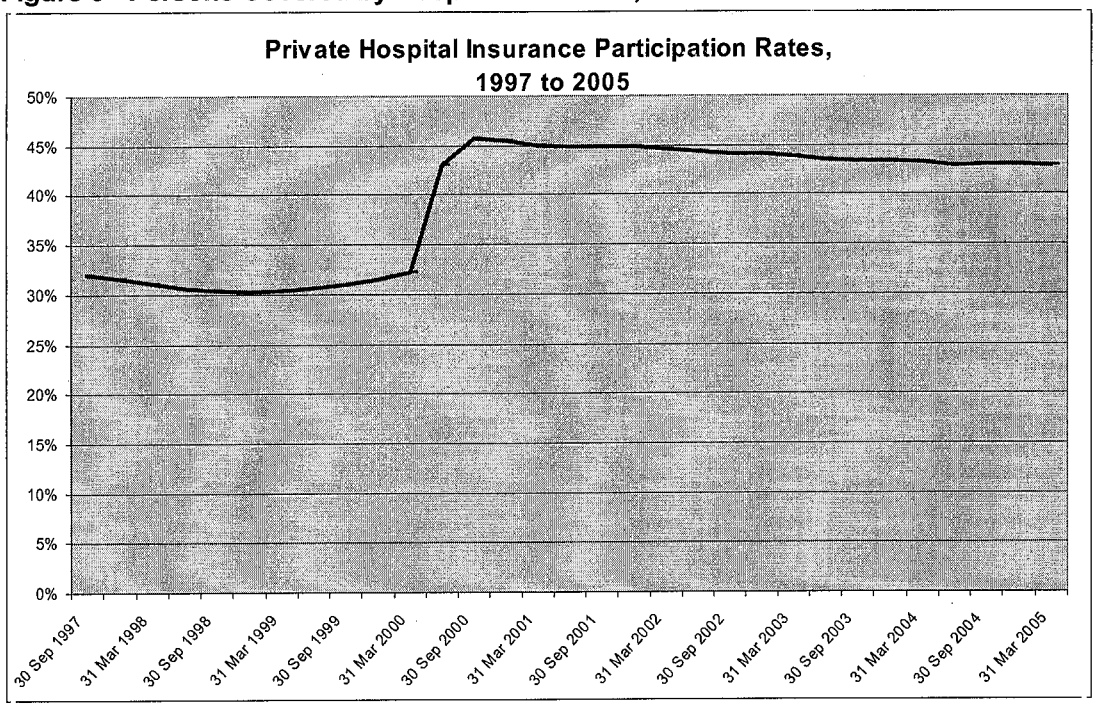
- the ***Medicare levy surcharge*** was introduced in 1998 to encourage individuals earning $50,000 or more and families earning $100,000 or more that do not have private health insurance hospital cover, to buy private health insurance. Individuals on these income levels are required to pay an extra 1 per cent of their taxable income for the Medicare levy surcharge if they do not have private health insurance; and

- ***Lifetime Health Cover*** is an Australian Government initiative that was introduced on 1 July 2000 to encourage people to take out private health insurance earlier in life, and to maintain their cover. Under Lifetime Health Cover, health funds are able to charge different premiums based on the age of each particular member when hospital cover with a registered health fund is first taken out. The Lifetime Health Cover provisions set a deadline of the 1 July following their 31st birthday for people to take out hospital cover without a loading. If they did not have hospital cover by that date, but later joined an insurance fund, they would pay an extra 2 per cent for each year they remained uninsured since the 1 July following their 31st birthday; and

- ***Higher Rebates for Older Australians*** were introduced from 1 April 2005. The government increased the private health insurance rebate from 30 per cent to 35 per cent for people aged 65-69 years and from 30 per cent to 40 per cent for people aged 70 years and over. The higher rebates are intended to help to keep premiums affordable for older Australians with private health insurance.

These measures have been very effective in boosting private health membership. The proportion of the population that has private health insurance has increased from 31.4 per cent in December 1999, to around 42.9 per cent in March 2005 (see Figure 6).

Figure 6 - Persons Covered by Hospital Insurance, December 1999 to March 2005



Source: Private Health Insurance Administration Council

In implementing these policies the government has also looked at the overall regulatory environment in which health funds operate. Reforms that have been implemented to encourage industry efficiency, competition and product innovation include:

- from 1 July 2004 a reduction in regulation around the introduction of new products balanced by an improved reporting regime for the industry;
- from 1 July 2004, increased powers for the PHIO to deal with complaints;
- the new requirement for publication by the PHIO of an annual State of the Health Funds report to provide consumers with comparative information on the performance and services of the health funds (the first report was published on 22 February 2005);
- changes to administrative arrangements relating to premium increases with effect from the 2003 premium round; and
- new arrangements to contain the spiralling costs of surgically implanted prostheses which are expected to be implemented later in 2005.

6. RECENT CHANGES AIMED AT ENSURING THE SUSTAINABILITY OF A STRONG PRIVATE SECTOR

The Australian Government has implemented a number of measures to ensure that the viability of the private sector is sustained into the future. These changes have also had an impact on the environment with in which private health funds, private and public hospitals, medical practitioners, other health professionals and government agencies operate.

Medical costs
Since 1995, a number of reforms have been introduced that allow health funds to negotiate and pay benefits above the MBS fee in certain circumstances.

Until 1995 private health insurance funds were not permitted to pay doctors in excess of the Medicare Benefits Schedule fee for in-hospital services. Medicare covered 75 per cent of the MBS fee and funds were only permitted to cover the remaining 25 per cent. Because many doctors charged fees higher than the MBS fee the difference (the gap) had to be paid by the consumer.

In 1995, legislation was introduced (*Health Legislation (Private Health Insurance) Amendment Act 1995),* that allowed for contracting between health funds, doctors and hospitals. Under contractual agreements funds were able to cover doctors' charges above the MBS fee where either:

- the doctor has an agreement with the health fund (a Medical Purchaser-Provider Agreement, or MPPA); or
- the doctor has an agreement with the treating hospital (a Practitioner Agreement), and that hospital has an agreement with the consumer's health fund (a Hospital Purchaser-Provider Agreement, or HPPA).

Between 1995 and 1999 these contractual provisions made virtually no impact on the percentage of medical services covered by no gap or known gap arrangements. In the June 1998 quarter only around 2 per cent of medical services were covered by no or known gap arrangements.

As part of changes made to introduce an incentive for private health insurance membership, changes to legislation were introduced from 1 January 1999 that required funds to provide no gap or known gap schemes in order to be eligible to offer the 30% Rebate as a premium reduction.

This initiative signalled a significant increase in the market penetration of no or known gap arrangements. By June 2000 almost 23 per cent of medical services were provided under no or known gap arrangements. However, these no or known gap arrangements were still under the existing contractual arrangements with medical practitioners.

In 2000 the *Health Legislation Amendment (Gap Cover Schemes) Act 2000* provided for gap cover schemes, whereby health funds could pay above-MBS fees to doctors without the need for agreements. Under a gap cover scheme, a fund agrees to pay above-MBS rates where a doctor agrees to:

- charge up to a specified above-MBS amount determined by the fund ("no gap"), or;
- obtain informed financial consent, in writing and in advance of treatment where possible, if the consumer will still have a gap to pay (ie, if the doctor's charges are still not covered by the fund's determined amount; "known gap").

As a result of the introduction of gap cover schemes there has been a significant improvement in the number of in-hospital medical services provided where there is no out-of-pocket expense for the patient.

The proportion of services with no out-of-pocket expenses for the patient has increased from 60 per cent in the September 2000 quarter, when data was first collected, to 80.6 per cent in the March 2005 quarter.

Contracting between private hospitals and health funds

Contracting between health funds and private hospitals determines, among other things, the amount a fund will pay for hospital accommodation and nursing care when a fund member is treated. Health funds are free to choose with which facilities they will seek a contract, having regard to the needs of their members. These decisions may take into account, for example, the types of services offered at a particular facility, the number of similar facilities within a locality and the residential profile of their membership.

In more recent times the funds have been inclined to target services they see as member priorities. This has meant that some hospitals are contracted for all their services, some for only part of their services and others are not offered a contract at all. The increasing number of day hospital facilities has also meant that some funds are being selective about whether they offer a contract to new day hospital facilities.

Private hospitals and private day hospital facilities receive hospital benefits from health funds through either a hospital purchaser provider agreement (contract) that they have negotiated with the fund or, where a contract does not exist, the Australian Government determined default benefit. Health funds are required to cover all eligible members that receive hospital treatment even where the fund does not have a contract with the hospital.

Impact of hospital default arrangements on contracting

Basic Default Benefit

The aim of Basic Default Benefit is to ensure that health fund contributors are guaranteed some level of reimbursement for shared ward overnight and day only accommodation and nursing care in public and private hospitals that do not have a contract with their health fund. It is not intended to reflect the true cost of delivering services, and therefore does not discourage hospitals from seeking contracts with health funds.

The Basic Default Benefit is primarily paid for private patients in public hospitals. It should be noted that while there is nothing at the Australian Government level stopping a public hospital from negotiating a contract with a health fund, to date no public hospital has done so.

In setting the Basic Default Benefits the Australian Government increases the benefits each financial year by March on March CPI (2% for 2003-04). The average Basic Default Benefit for overnight shared ward accommodation for 2004-05 is $255.

Second Tier Default Benefit

The Second Tier Default Benefit was introduced in March 1998 to provide greater financial security (through a higher benefit than the Basic Default Benefit) for private hospitals and day hospital facilities which met certain administrative and quality criteria, but were unable to obtain a contract from a health fund/s. Its introduction was primarily driven by concerns about health funds commencing selective tendering processes.

The benefit is no less than 85 per cent of the average of rates referred to in the relevant fund's contracts that were in force on 1 August of each year, for comparable hospitals in each state or territory for an equivalent episode of hospital care.

Prior to 1 July 2004 health funds were required to provide their Second Tier Default Benefit rates to any private hospital or day hospital facility that requested them. As such, there was an argument that the Second Tier Default Benefit set an artificial floor price for contract negotiations and thus placed upward pressure on health fund premiums.

In 2004, the government decided to retain the Second Tier Default Benefit. However, to help reduce any potential pressure on premiums, from 1 July 2004 health funds have not been required to provide copies of their second tier rates to hospitals. The impact of the Second Tier Default Benefit on premiums will be reviewed in two years time.

Impact of contracting arrangements on consumers

Contracting arrangements are a commercial matter for the parties, and the Government does not intervene in the negotiation process. There is always potential for negotiations to break down as in any commercial relation, and sometimes they do. If either a health fund or a hospital feels that the other party is exercising inappropriate market pressure, they can pursue this through the Australian Competition and Consumer Commission (ACCC). Hospitals and health funds can also make a complaint to the PHIO.

The Australian Government's main interest in contracting arrangements between health funds and hospitals, is to make sure that negotiating parties act in the best interests of consumers. Commercial disagreements should not put people at risk, or stop them from getting the services they need. In this context, the government has asked the industry to resolve how to better manage the impact of contract disputes. A group comprising representatives of health funds and private hospitals (including Australian Private Hospitals Association), and the PHIO, has been working since early 2004 on how to make the arrangements better for consumers, funds and hospitals.

Consumers are also able to raise any issues relating to private health issues including those arising from contract disputes with the PHIO. The PHIO has powers under the *National Health Act 1953* to investigate complaints and recommend a course of action to the health fund, hospital or medical practitioner concerned.

Patient election

The right of patient choice is one of the foundations of the Australian health system. The Australian Government is keen to ensure that patients can exercise that choice based on timely and accurate financial information to allow them to make a fully informed decision.

The 2003-08 AHCAs require that all eligible persons be given the option to elect to receive admitted public hospital services as either public or private patients. This means that public hospitals must ensure that the patient is given the opportunity to make a choice at the time of, or as soon as possible after, admission. The AHCAs prescribe that the election is to be made in writing on a patient election form, which is developed in accordance with the National Standards for Public Hospital Admitted Patient Election Processes (the National Guidelines) – Schedule E of the 2003-08 AHCAs.

The National Guidelines set the minimum requirements for patient election in order to achieve a desired level of uniformity across the public hospital sector while allowing flexibility to states

and territories and individual hospitals to accommodate their particular preferences in creating a patient election form. As a result, a variety of patient election forms have been developed and implemented in each state and territory, sometimes in consultation with private health funds.

Industry innovation

The private health industry recognises the need to enhance the value of private health insurance to existing and prospective members. A number of industry committees are looking at improving efficiency and value including the Theatre Banding Committee and the Critical Care Committee.

One example of a recent initiative of the Strategic Planning Group for Private Psychiatric Services is the development of an additional funding model that is unique to the private psychiatric hospital sector in Australia. This is known as the prospective payment model which is an all inclusive contracting arrangement that some health funds and hospitals have entered into for psychiatric hospital treatment. It allows funds to make a prospective payment (based on historical funding amounts) to a particular hospital, rather than paying individual benefits on a retrospective basis, for patients who are seriously ill and require ongoing treatment and support.

The model has shown to be particularly suitable to psychiatric care as it gives hospitals and funds a greater certainty over their budgets and allows the hospitals to develop more innovative and cost-effective methods of treatment for private psychiatric patients. The hospital continually reviews outcomes to ensure that the prospective payment arrangement does not adversely affect the quality of health care provided to patients.

The prospective payment covers both:

- admitted hospital treatment (including approved outreach services); and
- private non-admitted support services purchased by the hospital to provide follow up treatment for the patient, for example psychologist consultations (these types of services would otherwise be paid for under a health funds ancillary table).

Under the prospective payment model, health funds are required to remove the benefits that do not qualify for reinsurance from the prospective payment amount provided to hospitals. The prospective payment model has been operating successfully for a number of years between particular health funds and private psychiatric hospitals in South Australia.

7. MAKING PRIVATE HEALTH INSURANCE A MORE ATTRACTIVE OPTION

While there has been a significant increase in the proportion of the population having private health insurance over the past few years, the challenge now is to ensure the recruitment and retention of members.

One of the functions of the PHIO is to receive and report to the Minister for Health and Ageing, on the number and type of complaints received relating to private health insurance issues. The PHIO publishes quarterly reports on the PHIO website, as well as information in the PHIO Annual report and the State of the Health Funds Report. The reports provide a breakdown of the types of issues that private health insurance members have about their private health insurance.

The Minister and the Department are also aware of these issues from correspondence from health fund members about their private health experience.

These sources provide a good indication of the issues that are of concern to consumers about purchasing and using their private health insurance products and may indicate areas where improvements might be considered in order to encourage an increase in membership.

Gaps and informed financial consent

People are concerned about their out-of-pocket costs, particularly when these are unexpected. There are three ways in which privately insured people can incur out-of-pocket expenses when they go to hospital and it is possible for a patient to have out-of-pocket expenses arising in any or all of these ways:

- on doctors' fees for medical services;
- because they have a health insurance product which involves some risk-sharing; and/or
- on hospital accommodation charges, if their health fund does not have a contract with the private hospital to which they are admitted.

Doctors' fees

The Australian Government does not set or control doctors' fees. Data show that for most medical services provided in hospital, doctors either charge the MBS fee or their fee is fully covered under health fund gap cover arrangements. There is no gap to be paid by the patient in these cases.

Some gap cover arrangements permit doctors to charge patients an out-of-pocket cost over and above what the health fund will cover. However, the level of cost to be borne by the patient will be controlled by the terms of the gap cover arrangements in place between the doctor and the health fund. Where doctors are not participating in gap cover arrangements at all, there is no control over what they can charge and therefore no limit on what the patient might have to pay out of their own pocket.

Risk-sharing products

Health fund members can choose to pay a lower premium on their insurance product in return for receiving reduced benefits or having to pay towards some of the cost of the treatment at the time it is received – for example, some products require a one-off 'excess' payment or a daily co-payment towards the cost of hospital treatment, or may exclude or restrict the level of benefits payable by the health fund for certain services.

Consumers can misinterpret as a 'gap' payment the out-of-pocket expenses they are required to bear through taking out one of these policies.

Hospital costs

The benefits to be paid by health funds towards hospital accommodation charges are agreed under contract between individual health funds and individual hospitals. Generally, a patient's hospital accommodation charges will be fully covered if they are treated in a hospital that has a contract with their health fund. However, if a patient is treated in a hospital that does not have a contract with their health fund, the patient will encounter a significant out-of-pocket cost.

Health fund members considering hospital treatment need to discuss fees and benefits in detail with their doctors and health funds to determine whether there will be any out-of-pocket cost. Doctors using health fund gap cover arrangements are required to advise patients in advance of the likely cost of medical treatment and the patient is then able to agree whether to go ahead with treatment (Informed Financial Consent). However, there is no requirement for doctors who are not participating in gap cover to inform their patients of likely costs.

Complexity and number of products leading to confusion for consumers

Health fund brochures are marketing tools designed to attract consumers to certain products. They do not necessarily contain all the information about a product, nor do they provide general information on health insurance.

Health funds make available a wide range of products designed for different age groups, family situations, income levels and health needs to attempt to gain market advantage. Patients are often confused by the number of products on offer, and the range of benefits attached to these products. While people generally have an understanding of 'excesses' or 'co-payments', they are less likely to be familiar with the consequences of taking out a policy with benefit limitations or exclusions, or of the fact that they can still encounter 'gap' payments even when they have taken out a 'top cover' product. Consumers are not necessarily aware that the level of benefit paid for hospital accommodation depends on whether their health fund has a contract with their hospital.

This lack of understanding of what different products and health funds offer can lead to dissatisfaction with private health insurance if, for example, members discover that they need treatment for a condition which is excluded under their policy or in a hospital that is not contracted to their private health fund.

Independent information on general health insurance issues is produced by the Department of Health and Ageing, PHIO and PHIAC, but its availability is not widely known among consumers. Market research recently undertaken by the Department has highlighted areas for improvement in both the production and dissemination of this information.

Since 2001, health funds have been encouraged to produce key features guides which set out, in a uniform style, the key features of their products. The intent is to allow consumers to examine key features guides from various health funds to assist them in identifying a suitable product. The key features guides have not been very successful – the complexity and range of products make it difficult to compare like with like. Further work is being undertaken to refine these documents to make them more user friendly. However, comparison of products and informed consumer choice will remain difficult while there is such a range available.

One issue of particular concern is the misunderstanding of consumers about exclusionary products. Under these products, the health fund will not pay any benefits at all towards hospital

and medical costs where the patient is treated for the excluded condition. Consumers tend to take out exclusionary products when they are young and anecdotal evidence suggests that they neglect to upgrade their cover when they are more likely to need treatment for the excluded conditions.

The Australian Government requested that the private health insurance industry develop a "Quality of Advice Code" to improve the industry's performance in advising consumers about private health insurance products. The code will provide an effective means of improving performance and achieving uniformly higher standards of private health insurance product disclosure. It is expected that the industry will implement the new code shortly.

Portability

The portability provisions of the legislation enable health fund members to transfer between funds to broadly comparable products, without having to re-serve waiting periods. The provisions were essentially designed to support the movement of individuals between funds.

These provisions were tested in an unprecedented way in September 2003, when BUPA health fund fell out of contract with the Healthscope private hospital group. During the subsequent dispute, a number of BUPA members transferred to other funds, particularly Medibank Private and Australian Unity. To protect itself from a potentially unmanageable influx of imminently claiming ex-BUPA members, Australian Unity changed its rules to apply a 12-month benefit limitation period for psychiatric and rehabilitation services on members transferring from other funds. After the twelve month period, transferring members would be entitled to full contract rates.

The BUPA/Healthscope dispute highlighted the fact that the current legislation is not designed with large-scale transfers of members in mind. While there have been no other cases of funds introducing benefit limitation periods for transferring members since that time, the government and the industry remain concerned about the potential impacts on consumers, particularly uncertainty and out-of-pocket costs.

The Australian Government and the industry are presently working together to clarify members' entitlements should they wish to transfer, particularly where the move is prompted by a contract dispute. The Government is keen to facilitate discussions with industry groups to resolve these issues. However, the Minister for Health and Ageing recently noted in a speech to the Committee for Economic Development in Australia on February 25 2005, that doctors, funds and hospitals need to do more themselves to make treatment in private hospitals more attractive to patients. The government is also committed to fostering a dialogue between the mental health community and the private health sector about what is expected from all parties on the needs of health fund members with psychiatric conditions, including mechanisms to resolve related uncertainties and disputes.

Limited cover for episodes of care

Currently, private health insurance funds' hospital tables can only cover medical and hospital costs when their members are admitted to hospital. There is a trend however, for services previously provided on an admitted patient basis to be provided on a non-admitted basis as outpatient services. Privately insured patients may no longer be covered for these services and must pay a gap between whatever the doctor charges and the MBS rate. This may be perceived by patients as a reduction in the value of their private health insurance hospital product.

Health funds, doctors and private hospital representatives recently discussed options that allow funds to develop products to cover medical and ancillary services provided outside hospital,

where the services are part of an admitted hospital care episode, or substitute or reduce the need for admitted hospital services. For example, such products could cover an entire episode of cancer care including surgery in hospital, and associated radiotherapy outside hospital; dialysis services provided outside hospital; or joint replacement surgery in hospital and associated physiotherapy outside hospital.

This proposal would increase the value of private health insurance to patients and provide them with better continuity of care. There would, however, be a number of issues that would need to be considered in developing such a scheme, such as structuring and pricing of these products. Currently, only in-hospital services are reinsurable. This proposal would also mean that the additional services covered by the new type of product will need to be added to the reinsurance pool.

Reinsurance reforms

In 1997, the Industry Commission (the Commission) Inquiry Report on Private Health Insurance recommended changing reinsurance from the current system that shares the cost of large benefit payments among funds to one that shares the risk of future large payments. The current system is a form of "utilisation based reinsurance". The Commission recommended a system of "composition based reinsurance" where the main driver is the composition of each fund's membership. In October 1999, a review of reinsurance recommended a form of "composition based reinsurance" known as Risked Based Capitation (RBC). In December 1999 the Health Minister deferred the introduction of RBC to allow the industry to adjust to the introduction of Lifetime Health Cover and other major PHI reforms.

In 2003, after considering the recommendations of the PHI Regulatory Review, the Australian Government decided to implement RBC in 2005 to improve industry efficiency. In late 2004, the government agreed to defer implementation to 2006 to allow for the development of new data collections to support RBC. The government and industry are currently considering what form the final RBC arrangements should take.

Billing arrangements

People recovering from hospital treatment can sometimes be confused and inconvenienced by: receiving accounts from various medical specialists; claiming separately from Medicare and a health fund; and uncertainty over their rebate entitlements and out-of-pocket expenses.

The Australian Government provided funding of $48 million over four years in the 2003-04 Budget to develop and maintain the IT system that will support the introduction of the Electronic Claim Lodgement and Information Processing System Environment (ECLIPSE). The system is currently being developed by the Health Insurance Commission and is expected to provide an electronic interface between all stakeholders involved in the provision of private in-hospital medical services including medical specialists, hospitals, health funds and the HIC.

The ECLIPSE system is expected to reduce the involvement of the patient in the claiming and payment process and will provide people with private health insurance up-to-date information on likely costs of in-hospital medical procedures before they receive treatment. This will allow fund members to make a fully informed choice about their care.

Nursing home type patients

An issue has been raised with the Department of Health and Ageing regarding private health insurance and patients that are classified as nursing home type patients (NHTP).

The arrangements for the reclassification of long term hospital patients as a nursing home type patient after 35 days continuous hospitalisation has operated for some time.

All hospital patients are classified as "acute" for the first 35 days of hospitalisation (hospitalisation is considered to be continuous if there has not been a break of seven days or more). From Day 36, a patient's classification for health insurance purposes changes to NHTP status unless an Acute Care Certificate (ACC) is provided by a medical practitioner stating that the patient is in need of continuing acute care.

When classified as a NHTP, the patient is required to make a contribution to their care in the same way as nursing home residents. The patient contribution is in recognition of costs such as food and accommodation which the patient would otherwise incur bearing in mind that the hospital or nursing home often becomes the permanent residence for these patients.

The rule applies to both public (Medicare) patients and privately insured patients and the patient's age is not a criterion. If privately insured, an NHTP receives a lower level of health insurance benefits, commensurate with the reduced fees and level of service applicable to such patients.

In many cases the patient is not aware that they will receive a lower level of benefit from their fund and that they are then liable for any out of pocket charges by the hospital while awaiting placement in residential care.