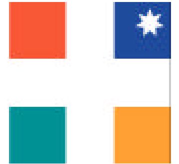
Australian Private Hospitals Association 

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Mr Elton Humphery
Secretary
Senate Community Affairs Legislation Committee
Parliament House
CANBERRA ACT 2600

Dear Elton

On behalf of the Australian Private Hospitals Association (APHA), I have attached a submission to the Committee's Inquiry into the Health Legislation Amendment (Private Health Insurance Reform) Bill 2003.

As you are aware, APHA is the peak national body representing the interests of the private hospital sector, with a diverse membership that includes large and small hospitals and day surgeries, for profit and not for profit hospitals, groups as well as independent facilities, located in both metropolitan and rural areas throughout Australia. The range of facilities represented by APHA includes acute hospitals, specialist psychiatric and rehabilitation hospitals and also free-standing day hospital facilities.

APHA is prepared to expand on this submission if the Committee resolves to hold public hearings on the Bill.

Please let me know if APHA can assist further on this most important matter.

Yours sincerely

Michael Roff

Executive Director
23 April 2003

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SUBMISSION BY THE AUSTRALIAN PRIVATE HOSPITALS ASSOCIATION TO THE SENATE COMMUNITY AFFAIRS LEGISLATION COMMITTEE'S INQUIRY INTO THE HEALTH LEGISLATION AMENDMENT (PRIVATE HEALTH INSURANCE REFORM) BILL 2003

Background

The Committee's inquiry into the Health Legislation Amendment (Private Health Insurance Reform) Bill 2003 (the Bill) addresses several specific issues. This submission from the Australian Private Hospitals Association (APHA) focuses primarily on one of these issues, namely: *"to examine the provisions of the Bill which provide wide discretion to the Minister on the operation of the industry"*.

On September 11 2002, the Minister for Health and Ageing announced the first stage of the Government's reforms to the regulation of private health insurance. This announcement was followed by a Circular issued by the Department of Health and Ageing that provided further detail on the reforms. One key reform is the proposed development of performance indicators against which health funds will be monitored. These indicators are needed promptly, as the following discussion makes clear.

Premiums, benefits and costs

Despite premium increases granted to health insurance funds averaging 6.9 per cent in 2002 and 7.4 per cent in 2003, a number of private hospital organisations are experiencing great difficulty in obtaining viable benefit increases from private health insurance funds in Hospital Purchaser Provider Agreement (HPPA) negotiations.

By way of background, hospital operators are reporting offers from health insurance funds for changes in benefit payments in 2003 in the range of –10 per cent to + 2 per cent. This is well below the CPI, let alone health-CPI. These levels of changes in benefits are clearly not sustainable, particularly when private hospitals are faced with increasing costs far in excess of the CPI, including for nursing wages and professional indemnity insurance.

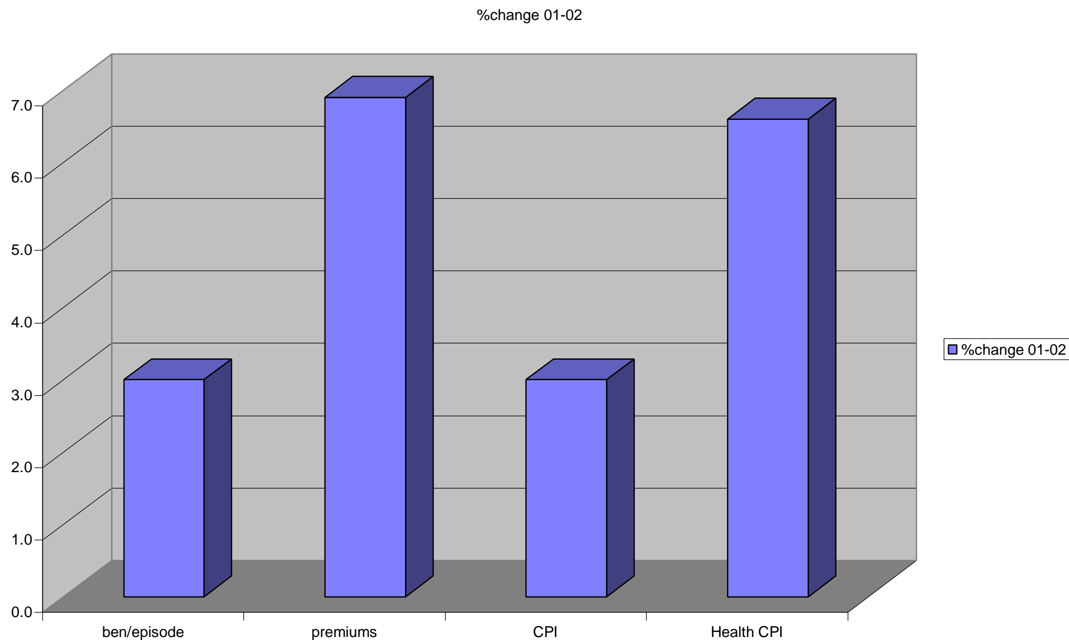
The following chart highlights the inadequacy of the level of benefits flowing to private hospitals and day hospital facilities from private health insurance funds. It compares the increase, in percentage terms, in the average benefit paid per episode to private hospitals and day hospital facilities in 2002 with:

(a) the average premium increases awarded to health insurance funds in 2002;

(b) growth in the CPI in 2002 and

(c) growth in the health component of the CPI in 2002.

Increases in benefits paid by health insurance funds to private hospitals and day surgeries



Sources: PHIAC, ABS

The chart indicates that the average increase in health fund benefits paid per episode to private hospitals and day hospital facilities in 2002 has only just kept pace with the CPI and is less than half the health component of the CPI. It is also well below the average premium increase awarded to health funds in 2002. It should be noted that the private hospitals sector treated an extra 74,000 patients during 2002, an increase of 4.2 per cent over the previous year.

In fact, over the period 1996-97 to 2001-02, private hospitals and day hospital facilities treated an extra 450,000 patients, an increase of 38 per cent. Over this same period, the average benefit per patient episode paid to private hospitals and day hospital facilities declined by 1.7 per cent. The sector is clearly doing more, for less.

Patient 'gaps'

Private hospitals have only 2 avenues of funding: benefits paid by insurers, principally private health insurance funds, and out-of-pocket charges levied on patients. Private hospitals have worked hard in recent years to minimise out-of-pocket costs for patients, aware that 'gaps' are a key area of concern for privately insured patients.

APHA has estimated that the ***additional*** costs imposed by increases in health sector wages and hospitals' professional indemnity insurance will add around $65 per bed day to the operating costs of private hospitals in 2003. Note that this is an average across the industry and the cost to some private hospitals could be much higher depending on their particular staffing profiles and their individual arrangements for professional indemnity insurance.

If health insurance funds continue to refuse to meet the real costs of the provision of quality private hospital services, hospitals will have no choice but to begin to charge their

patients. A ‘gap’ payment of some $65 per day is unlikely to be favourably received by many privately insured patients.

Performance indicators for health insurance funds

Proposed clause 73BEA in the Bill provides for the Minister for Health and Ageing to establish, via the regulations, “performance indicators to be used by the Minister in monitoring the performance of registered organisations”.

APHA is concerned to ensure that appropriate performance indicators are explicitly included within the *National Health Act 1953* (the Act), rather than by Ministerial discretion. APHA is aware of many instances of health insurance funds flaunting their existing conditions of registration and has no confidence of any change unless the performance measures are explicitly included in the Act, together with a regime of appropriate sanctions. APHA proposes that the following performance indicators be inserted into the Act.

Service quality and accreditation

Recommended Performance Indicator

Proportion of Registered Health Benefit Organisations accredited against the ISO 9000 series (or equivalent) at 30 June each year.

Target: 100 per cent of RHBOs.

Indicator measured annually and reported by the Private Health Insurance Administration Council.

Rationale and Discussion

One means of measuring the performance of health insurance funds could be to require them to undergo regular quality accreditation, perhaps using the ISO 9000 series. Such a measure would ensure greater consistency in health fund performance and would provide an assurance that all organisations were achieving optimal performance on behalf of their contributors. Accreditation would also enable health funds to demonstrate to critics how their administrative performance compared to international benchmarks.

Benefit benchmarks

Recommended Performance Indicator

Proportion of Registered Health Benefit Organisations paying a minimum of 55 per cent of total benefits to private hospitals and day hospital facilities in the year to 30 June.

Target: 100 per cent of RHBOs.

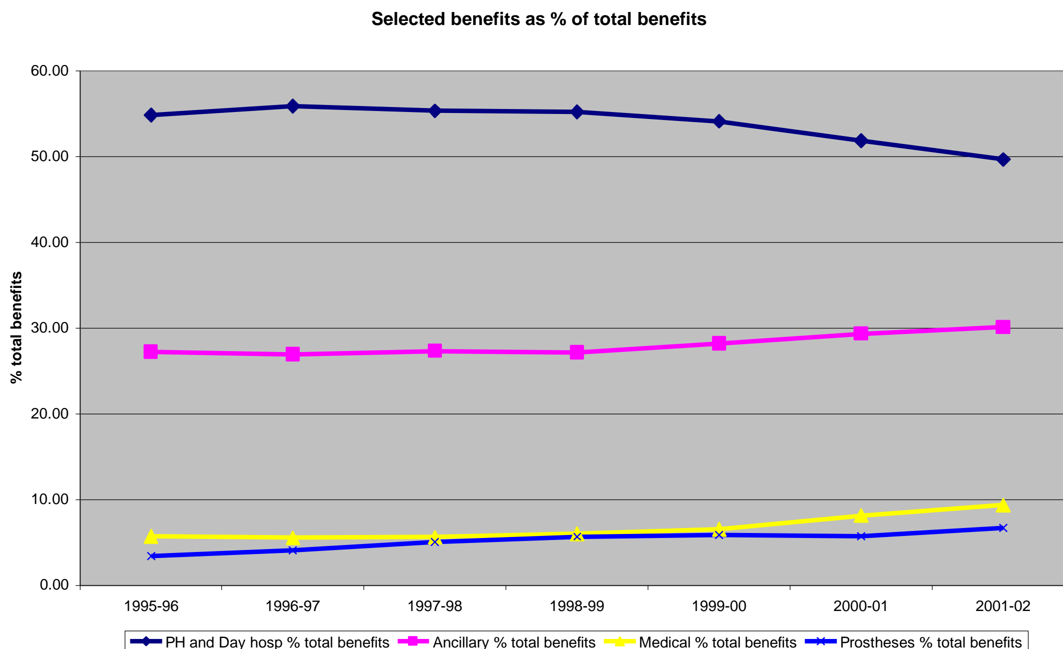
Indicator measured annually and reported by the Private Health Insurance Administration Council.

Rationale and Discussion

APHA proposes that consideration be given to establishing a benchmark proportion of benefits that flow to private hospitals as one of the performance indicators that could be used to monitor health fund performance. Such a benchmark is urgently required, as the following discussion and chart makes clear.

In 1995-96, private hospitals treated less than one-third of all hospital patients. By 2000-01, this had grown to 38 per cent. Over the period, private hospitals have treated an extra 692,000 patients, an increase of 42 per cent, while public hospitals increased their patient numbers by only 8 per cent and actually experienced a decline of 0.1 per cent in the number of patients treated in 2000-01 over the previous year. Private hospitals have therefore resoundingly delivered on the Government's stated aim of taking the patient load off the public hospital system.

APHA has previously advised the Minister for Health and Ageing that since the introduction of the Government's reforms to private health insurance and notwithstanding the substantial cost increases faced by private hospitals in relation to nursing wages and professional indemnity insurance, the share of benefits from private health insurance funds that are directed to private hospitals and day hospital facilities for the provision of care and accommodation of patients has fallen quite sharply. It is now below 50 per cent of total benefits paid by private health insurance funds (down from more than 55 per cent prior to the introduction of the 30 per cent rebate). Benefits for ancillary services have increased to 30 per cent of benefits paid, while medical benefits and benefits for prosthetics have increased their share of benefits paid by private health insurance funds by almost 100 per cent in the period since 1995-96.



Source: PHIAC, Annual report, various years

APHA recommends that the benchmark proportion of benefits that flow to private hospitals and day hospital facilities be restored to, and maintained at, a minimum of 55 per cent of total benefits paid by health funds each year.

Consultation with stakeholders

<u>Recommended Performance Indicator</u>

Proportion of Registered Health Benefit Organisations that have consulted with the private hospitals sector prior to lodging their application for premium increases, as at 30 March each year.

Target: 100 per cent of RHBOs.

Indicator measured annually and reported by the Department of Health and Ageing.

<u>Rationale and Discussion</u>

Circular 805, issued by the Department of Health and Ageing on 1 November 2002, contains details of the application process for health funds seeking increases in contributor premiums. One of the factors that must be addressed by health funds is the assumptions underlying any expected increases in benefit costs.

Health funds will not always be privy to the detail of current and prospective costs impacting on private hospitals and other stakeholders and therefore applications for premium increases may be framed without full possession of all the facts. Crucially, funds may be unable to accurately estimate the impact on benefits of such factors as wage increases for nurses and other health professionals and professional indemnity insurance. Costs in these areas alone are estimated to increase by some $65 per bed day in 2003.

An effective means of achieving reform in this area is to require health funds to consult with relevant stakeholders such as private hospitals, the medical profession and allied health practitioners prior to the development of applications for premium increases. APHA demonstrated its good faith in this area by convening earlier this year a meeting of representatives of private hospitals and health funds in NSW at which detailed information was presented for health funds on prospective increases in nursing wages in NSW and the expected impact on private hospitals.

APHA believes that a formal consultation process underpinned by regulation would provide greater certainty that all current and prospective cost increases are factored into applications by health funds for premium increases.

Eligibility verification

<u>Recommended Performance Indicator</u>

Proportion of Registered Health Benefit Organisations that provide a facility for private hospitals to verify the eligibility of patients, 24 hours per day, 7 days per week

Target: 100 per cent of RHBOs.

Indicator measured annually and reported by the Private Health Insurance Ombudsman.

Rationale and Discussion

Private hospitals continue to experience problems with notification by health funds of the eligibility of patients for private hospital care. The wide and confusing array of hospital tables, together with exclusionary and front-end deductible products, means that many privately insured patients are unsure of exactly what their cover actually provides in the event of hospitalisation.

Verification of a patient's eligibility is a central element of the hospital's ability to provide the patient with informed financial consent prior to admission. Therefore, quick and accurate verification of a patient's level of cover by a health fund is essential prior to admission of the patient to hospital. It is essential that verification of a patient's eligibility is available from all health funds 24 hours per day, 7 days per week.

In his report for 2002, the Private Health Insurance Ombudsman (PHIO) noted that *"complaints about hospitals are almost always related to the consequences of inadequate membership verification prior to a procedure being carried out"* (p.16). APHA believes that the vast majority of these cases arise from the failure of health funds to provide timely and accurate verification of their members' eligibility.

APHA therefore recommends the adoption of a performance indicator that requires health funds to provide a facility for private hospitals to verify the eligibility of patients, 24 hours per day, 7 days per week. The PHIO should oversee these arrangements and report to the Minister on annual basis.

Sanctions

The so-called 'Lawrence reforms' introduced in 1995 and their subsequent amendment, have entrenched an imbalance of power in the relationship between private hospitals and health funds. As a result of the power imbalance, some health funds have effectively ignored legislatively-imposed conditions of registration, safe in the belief that effective and enforceable sanctions are not in place. This behaviour has been evident across a wide range of areas, such as the second tier default benefit arrangements and mandatory cover for psychiatric, rehabilitation and palliative care services.

Schedule 1 of the *National Health Act 1953* imposes a large number of conditions of registration but no effective sanctions are in place to ensure compliance by funds with their obligations. APHA proposes that the following measures be inserted in the Act as a means of addressing the ongoing problem of health funds breaching their conditions of registration.

Deregistration

The Commonwealth Government ultimately has the power to deregister a health fund that breaches its conditions of registration but such a move would be likely to impact unfairly on the fund's members. However, there are any number of possible sanctions that could be adopted and perhaps applied on a sliding scale to reflect the severity of the offence.

Ban on accepting new members

A simple but very effective means of ensuring that health funds do not breach their conditions of registration is for the Government to ban any offending fund from accepting new members for a specified period of time. The period so specified could be linked to the severity of the breach.

Ban on premium discounts

Proposed clause 73BEL in the Bill provides the Minister with the power to revoke a RHBO's status as a participating fund, in relation to offences against community rating. This measure means that an offending health fund would no longer be able to offer the 30 per cent rebate as a premium reduction for its contributors. The rebate would remain payable to those contributors through the taxation system or the Health Insurance Commission.

APHA proposes that the Minister's powers be widened to enable this sanction to be applied against any RHBO breaching its conditions of registration.

Transparency

APHA believes that some improvement could be gained from greater transparency of the link between health funds' conditions of registration and the requirements placed on funds under particular aspects of the Commonwealth regulatory framework. At present, although much Commonwealth regulation of private health insurance occurs under the powers of the *National Health Act 1953,* changes are not always explicitly spelt out in the Act or its regulations but rather are made via Ministerial determination.

If health funds' conditions of registration were reorganised around priorities and a sliding scale of sanctions developed and applied for breaches, transparency would be greatly enhanced. For example, conditions of registration such as community rating, mandatory cover for psychiatric care, rehabilitation and palliative care, and second tier default benefit arrangements could be Priority 1 conditions and a severe penalty developed to address breaches of these conditions by health funds. The exact detail of each of the conditions could be spelt out in determinations by the Minister but transparency would be improved if all conditions of registration were listed, together with the penalty applying for breaches of each condition, in Schedule 1 of the *National Health Act 1953*.

Concluding comments

The Government's reforms to private health insurance have made the industry's products more affordable for a wide cross section of the Australian community. The private hospital sector has embraced the challenge of treating an extra 250,000 patients in 2000-01 and continues to deliver on the Government's objective of taking pressure off the public hospital system.

The regulation of private health insurance is a vital responsibility of the Commonwealth Government. While APHA does not support unnecessary regulation, it believes that the private heath insurance industry has shown itself unable to meet the high levels of self-discipline that are essential for the protection of its 9 million contributors in a less regulated environment.

APHA therefore does not support the wide discretion accorded to the Minister for Health and Ageing by the Health Legislation Amendment (Private Health Insurance Reform) and calls upon the Committee to recommend to the Senate that specific and binding performance indicators, together with accompanying sanctions, be established explicitly in the *National Health Act 1953* to ensure the appropriate and enforceable monitoring of health insurance funds.