Australian
Private Hospitals
Association

File 20.2.1.1

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

Dear Elton

Thank you for forwarding advice of the availability of the proof Hansard of the 15 May hearing of the Committee's inquiry into the Health Legislation Amendment (Private Health Insurance Reform) Bill 2003.

I do not wish to make any corrections to the proof Hansard, however, on behalf of the Australian Private Hospitals Association (APHA), I would like to take the opportunity in the attached supplementary submission to clarify and comment upon several aspects of evidence provided by others.

Yours sincerely

Michael Roff
Executive Director
5 June 2003

SUPPLEMENTARY 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

The following supplementary submission from the Australian Private Hospitals Association (APHA) responds to comments made by others in evidence during the Committee's public hearing on 15 May 2003.

Hospital benefits and the regulatory environment

Mr Schneider, representing the Australian Health Insurance Association, spent much of his opening statement commenting upon, and disputing, aspects of APHA's submission to the inquiry. I believe that some of these comments are, at best, misleading and may have been intended to question the veracity of APHA's submission, thereby placing some doubt in the minds of the Committee about the arguments and proposals advanced by APHA.

APHA provided a preamble in its submission on the state of the industry from the private hospitals perspective. APHA took this course of action in order to inform the Committee on how the current regulatory regime is operating. Regulation does not operate in a vacuum and APHA believes that in order for the Committee to evaluate the proposed reforms to the regulation of private health insurance, as contained in the Bill under examination, it needs an indication of the effectiveness of the current regulatory environment.

On page 2 of its submission, APHA provided a simple illustration of the impact of the current regulatory regime on private hospitals. In evidence, Mr Schneider criticised this simple approach and provided the Committee with a long list of facts and figures, prefaced by the remark *"the true situation as far as the utilisation of hospitals is concerned is as follows"*. (p.CA 1)

There are, of course, any number of ways in which relationships between different factors may be highlighted. APHA could have chosen some or even all the figures provided by Mr Schneider. However, the result would have been a complicated and not particularly enlightening set of data. To clarify, the way in which APHA chose to illustrate the impact of the current regulatory regime was to calculate changes in the average benefit paid by health funds for an episode of care in private hospitals and day hospital facilities. An episode of care is a common and well-understood concept. APHA compared the change in this benefit in calendar 2002 with the change, over the same period, in the CPI, the health component of the CPI and the average premium increase awarded to health insurance funds. APHA maintains that this is a simple, but nonetheless completely valid, illustration of the way in which the current regulatory environment is working to the detriment of private hospitals.

Professional indemnity

APHA has provided information to the government and health funds clearly indicating that recent significant increases in private hospital professional indemnity (PI) premiums and

excesses are in no way related to the safety records of hospitals. For example, a hospital that had not experienced a claim in 15 years received a premium increase of 300% in 2002. In addition, international indemnity insurance underwriters have advised APHA that the clinical risk management and claims history of Australian private hospitals is as good, if not better, than any other country in the world.

In evidence, Mr Schneider of the AHIA demonstrated the ignorance of health funds concerning the real world in which private hospitals operate with regard to PI insurance:

"I note with some sadness that, in their argument, the hospitals do not say that the indemnity insurers failed to acknowledge their presumably demonstrable safety record via lower indemnity insurance premiums. If that were the case, the hospitals would have a very legitimate argument to come here, and we would support them, in seeking legislative action to require indemnity insurers to provide those hospitals with lower premiums." (p.CA 2).

The reasons for PI premium increases being experienced by private hospitals are directly related to a hardening in the global insurance market and the exit of domestic providers of indemnity insurance. Consequently, private hospitals have been forced to source off-shore providers of indemnity cover. This fact alone makes a mockery of the AHIA's suggestion that legislative action be taken in relation to requiring indemnity insurers to provide lower premiums.

Performance measures for health funds

Since the Government's reforms to private health insurance, private hospitals have taken a substantial patient load off the public hospital system. The ability of private hospitals to continue this vital contribution is inextricably bound to their funding. The Bill before the Committee proposes to provide the Minister for Health and Ageing with additional discretionary powers. APHA has argued in its submission and in evidence that the Parliament, not the Minister, should set performance measures and sanctions for health funds.

With this in mind, APHA proposed a performance measure whereby health funds would be required to pay a minimum proportion of total benefits to private hospitals and day hospital facilities. It is clear from the evidence of both Mr Schneider and officials of the Department of Health and Ageing, that this performance measure has been misunderstood. This performance measure and its companion measure which would require consultation with stakeholders as part of the premium application process, are clearly required because of the failure of health insurance funds to adequately price their products.

The reason that the proportion of benefits paid to private hospitals and day hospital facilities have fallen over time is not due to a fall in the number of services, which have clearly risen. This increase in services was even referred to by Mr Schneider in the long list of figures provided in his opening statement. The reason why the proportion of benefits has fallen is simply because the benefits paid for medical gap payments and prostheses have increased dramatically.

When the arrangements for medical gap products were introduced, most health funds provided these products to their members within hospital tables, at no additional cost.

Similarly, when the prostheses arrangements were changed by the Department of Health and Ageing in 2001, at the express urging of health funds, no additional contribution was sought from health fund members. The financial impact of both measures was clearly underestimated by health funds in pricing their hospital table insurance products.

Together, these two expenditure items now account for more than 25 per cent of the benefits paid by health funds under their 'hospital tables'. Although these benefits are paid under 'hospital' insurance tables, not one cent is actually paid to private hospitals. That this is misunderstood is clear from the evidence provided by the Australian Consumers Association, which stated:

…our argument against this kind of funding is not an argument against private hospitals. It is certainly an argument in favour of getting better cost control and better value for money out of private hospitals, but that is something that the Minister herself is recognising with the move towards justifying cost effectiveness, for example, in prostheses. (p.CA 11)

This view is completely incorrect. The current prostheses arrangements have added an enormous administrative load to private hospitals and have placed them at considerable financial risk in cases where agreement on price is not reached between suppliers and health funds. Hospitals have no possible role in garnering efficiencies under the current prostheses arrangements. Efficiencies can only be provided by health funds and suppliers.

A key reason why APHA is seeking these two performance measures is the refusal of health funds to acknowledge the cost increases incurred in the real world in which private hospitals treat health fund members. I referred to the escalating costs of PI insurance earlier. Of perhaps greater concern to the private hospitals sector are the dramatic increases in wages, particularly for nurses. The AHIA's Mr Schneider implied in his evidence (p. CA2) that private hospitals had done little in this regard.

For the record, private hospitals provided submissions directly to the Industrial Relations Commission of NSW in relation to the 'special case' wage application by the NSW Nurses Association, as they do for every nursing pay claim. APHA also convened a meeting with NSW health funds to provide them with detailed information on the impact of the 'special case' wage increase on private hospitals. It appears that this advice was largely ignored by health funds who failed to factor the cost impacts of this wage rise into their 2003 premium applications.

Although APHA has received advice from the Department of Health and Ageing that a number of health funds cited nursing wage increases as justification for seeking premium increases, these funds are not providing benefit increases to private hospitals in order to cover the increased costs.

This example highlights the need for formal consultation between funds and hospitals prior to applications for premium increases, as an essential performance measure for health funds.

Mr Schneider sought to cloud this issue referring to *"collusion"* and an *"offence under the Trade Practices Act"* (p.CA 2). However, APHA's proposal is for industry-level consultation examining state-level data, which would provide a range for each area of cost increase. Individual negotiations between health funds and hospitals would focus on the

actual costs within that range, which would be dependent on the hospital's service mix, staffing levels etc.

The fact that health funds appear determined to avoid such a performance measure highlights the need for its introduction. It is essential that health fund premiums be set with a view to meeting the true costs of care rather than simply on a 'best guess' basis as is currently the case.

APHA contends that if its proposed performance measures are accepted by the Committee and are inserted into the Act, greater effectiveness and transparency can be brought to the premium application process for health funds. The current application process is completely unsatisfactory because it is not informed by the knowledge of the very sectors that will be experiencing the increased costs that health funds are applying to increase their premiums to meet!

Another performance measure advanced by APHA related to the current unavailability of 24/7 eligibility checking from all health funds. Responding to questioning by the Committee, the Departmental officials did not support such a performance measure, arguing:

"I think the government would need to be convinced that there was a significant issue with people being admitted after hours where their eligibility could not be verified. I am not aware that there is any evidence around that." (p.CA 19)

I would like to refer the Committee to the latest Annual Report of the Private Health Insurance Ombudsman (PHIO), in which the PHIO states that:

" Complaints about hospitals are almost always related to the consequences of inadequate membership verification prior to a procedure being carried out. It is absolutely inexcusable in this day and age for patients to submit to routine procedures without having been provided with up to date information as to their personal liability for expenses enabling them to make an informed financial decision on proceeding." (p.16-17)

APHA agrees completely with the PHIO and it is this context that APHA's proposal has been framed. However, in order for hospitals to be able to accurately inform patients as to their liability for any out-of-pocket costs arising from limitations /restrictions of their private health insurance policy, hospitals need to be able to verify with the relevant health fund the details of the patient's cover. If a hospital is open 24 hours per day 7 days per week to meet the needs of patients, then it must be able to obtain patient eligibility details on that same basis. Moreover, this needs to be on a standardised basis with all health funds using the same technological platform.

Sanctions

Departmental officials were also asked by the Committee for their views on sanctions. One view forthcoming was:

"I think the issue is that it is difficult to imagine sanctions on funds which do not ultimately hurt the contributors in some way." (p. CA 19)

The *National Health Act 1953* imposes a range of conditions of registration on health funds. The Minister currently only has the power to deregister a health fund breaching its conditions of registration. This is a sanction that is most unlikely to ever be enforced. The Bill proposes a useful sanction in clause 73BEL but limits its application to particular conditions of registration.

There is a continuum of action that could be undertaken in relation to sanctions, from doing nothing (as now) through to deregistration (possible now but very unlikely to ever be used). In between these two extremes, a range of possible sanctions could be developed. In its submission, APHA provided the Committee with two possible sanctions that could be applied on offending health funds that would not impact unduly upon their members. One sanction proposed by APHA is simply an extension of the sanction envisaged by Clause 73BEL in the Bill, to encompass any breach of a condition of registration by a health fund.

The other sanction proposed by APHA is a ban on accepting new members by a health fund breaching any of its conditions of registration. This sanction was proposed by APHA to specifically address the concern of the Department that sanctions not impact on fund members. Departmental officials were asked for their views on this sanction and their response was:

"That is a possibility, yes, but not one considered by the government at the time." (p.CA 19)

This comment provides an excellent example of why APHA is arguing for less Ministerial discretion. If performance measures and sanctions are explicitly detailed in legislation, the community, through its legislators, has an opportunity to provide input and suggestions for improvement, rather than leaving it all to the Minister and her Department.

APHA's position is quite simple. If health insurance funds are to be subject to a range of conditions of registration, then penalties or sanctions must apply to a breach of any of these conditions by a health fund. If no penalty applies, there is no incentive for health funds to comply with their conditions of registration. Given that nearly 9 million people are covered by health insurance products, APHA believes that it is important that an adequate regulatory regime is in place to provide for their protection. This must necessarily include penalties for breaching conditions of registration.

Concluding comments

As APHA stated in its original submission to the inquiry, 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.