NATIONAL PRIVATE REHABILITATION GROUP

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Representing

Allamanda Private Hospital, Qld	Griffith Rehabilitation Hospital, SA	Nepean Private Hospital, Vic
Alwyn Private Hospital, NSW	Hirondelle Private Hospital, NSW	North Gosford Private Hospital, NSW
Belmont Private Hospital, Qld	Holy Spirit Private Hospital, Qld	President Private Hospital, NSW
Berkeley Vale Private Hospital, NSW	Hopetoun Private Hospital, Vic	Southern Highlands PH, NSW
Brighton Rehabilitation Centre, Vic	Hunter Valley Private Hospital, NSW	St Andrews PH (Ipswich), Qld
Canossa Care Rehabilitation Unit, Qld	Hunters Hill Private Hospital, NSW	St Andrew's War Mem Hosp, Qld
Cedar Court HealthSouth RH, Vic	Lady Davidson Private Hospital, NSW	St Luke's Private Hospital, NSW
Delmar Private Hospital, NSW	Lawrence Hargrave Hospital, NSW	Sunnybank Private Hospital, Qld
Donvale Rehabilitation Hospital, Vic	Mater Private, Rockhampton, Qld	Toronto Private Hospital, NSW
Eastern Suburbs Private Hospital, NSW	Metropolitan Rehab Hospital, NSW	Victorian Rehab Centre (Northern), Vic
Epworth Hospital, Vic	Mt Olivet Community Services, Qld	Victorian Rehab Centre (Eastern), Vic
Geelong Private Hospital, Vic	Mt Wilga Private Hospital, NSW	Wolper Private Hospital, NSW

Submission

to the Senate Standing Committee on Community Affairs

Examination of the provisions of the *Health Legislation Amendment (Private Health Insurance Reform) Bill 2003*

23 April 2003

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1. Introduction

The National Private Rehabilitation Group ("NPRG") is a non affiliated group of thirty six private rehabilitation facilities around Australia representing over a thousand (or over 90 per cent of) private rehabilitation beds. Its Steering Committee comprises industry representation from NSW, Victoria, Queensland and South Australia as well as non-voting representation from the Australian Private Hospitals Association (APHA).

The NPRG has two specific concerns in relation to the provisions of the *Health Legislation Amendment (Private Health Insurance Reform) Bill 2003*.

One very serious concern relates to the proposed abolition of the Second Tier Default Benefit Schedule, a proposal we understand is contained in a Determination associated with the principal legislation.

The other concern relates to an issue whose solution we believe should be retrospectively included in the first phase of the Government's reforms to private health insurance announced in 2002.

We propose solutions to each of these concerns and recommend these solutions be adopted by the Government. We appeal to the Committee for its consideration of and support for these recommendations.

2. Issues of concern

2.1 Abolition of the Second Tier Default Benefit Schedule

2.1.1 Introduction

The Federal Minister for Health and Ageing, Senator Patterson, in announcing the second stage of the Government's reforms to private health insurance in April 2003, stated that:

- The Second Tier Default Benefit Schedule for private hospitals and day surgery facilities across Australia will be abolished; and

- A rural and regional default benefit arrangement for rural and regional private hospitals (which provide the only services available in their communities) will be introduced.

Under this proposal, access to the new arrangements is restricted ONLY to those hospitals that meet ALL the following eligibility criteria:

- rural and regional hospitals with less than 50 beds, and
- rural and regional hospitals, where the definition of 'rural and regional' excludes significant country towns and districts, and
- where the rural and regional hospital is the sole operator in the region (yet to be clearly defined).

This change has been made without any consultation with private hospital providers or their industry representatives and, subject to not being disallowed in the Senate, it is scheduled to come into effect from 1 July 2004.

2.1.2 Background

As the Committee would be aware, since 1995 private rehabilitation hospitals have entered into individual contracting arrangements with health funds to reach agreement on the of level of cover to be provided by health funds for various private rehabilitation hospital procedures.

The Second Tier Default Benefit Schedule was introduced in 1998 in recognition of the inadequacy of the minimum default arrangements under the 'Lawrence Reforms' which led to a marked imbalance in power between dominant health funds and individual hospitals. The Second Tier Default Benefit ("the Benefit") was described on its introduction by then-Minister Dr Michael Wooldridge as "new protection for private hospitals in (the) face of selective tendering". On introducing the Benefit, the Government stated that:

> "In allowing funds to be more selective about the private hospitals they will contract as 'preferred providers' for their members, we need to ensure that non-contracted hospitals are not driven to the wall financially…This Second Tier Default Benefit will give non-contract private hospitals greater financial security…"

Dr Wooldridge was aware of the power imbalance between health funds and hospitals and that the consequences of abolition would be catastrophic for the viability of Australia's balanced health care system and patient expectations of it.

The purpose of the Benefit is that when hospital and health fund negotiations fail to reach accord, a hospital can apply for the Benefit to guarantee that health funds must pay up to 85% of the average contract rate for treatment of their members. It is thus theoretically many hospitals' only hope of securing adequate returns from health funds.

In order to be eligible to receive the Benefit, private (rehabilitation) hospitals must meet strict criteria in relation to quality of care, informed financial consent and simplified billing. These criteria ensure that only hospitals providing the highest standard of care can access the Benefit.

The Benefit is many hospitals' only hope of securing adequate returns from health funds. Without it, private rehabilitation hospitals are effectively price takers and subject to 'take it or leave it' tactics of funds.

The Second Tier Default Benefit arrangements were improved in August 2001 and, as part of this improvement, the Commonwealth agreed and recommended in the applicable Determination that the Benefit calculation in relation to medical rehabilitation would be done according to AN-SNAP classes. This was in recognition of a new classification system which has been nationally recommended for private rehabilitation.

Since the inception of the Benefit the health insurance industry has lobbied intensively for its abolition.

2.1.3 Concerns

This announcement has bewildered private medical rehabilitation hospital providers which regard the proposal as a breach of faith by the Government as it will give undue power to insurance companies in restricting patient choice and limit the financial viability of private hospitals.

It appears the Government has now essentially done a 'back flip', indicating that this view was incorrect and that it now believes the default arrangements introduced by the 'Lawrence Reforms' are adequate for private hospitals.

This is particularly surprising given the estimated increasing need for rehabilitation treatment in coming years due to the ageing of the population. The need for greater access to rehabilitation has been separately recognised by the Minister for Health and Ageing and is also alluded to in the Government's *National Strategy for an Ageing Australia.*

On the information available, the NPRG's sister organisation the Australian Private Hospitals Association (APHA) has identified only one private hospital currently in receipt of Second Tier Default Benefit that would be eligible to receive the proposed 'Rural and Regional Default Benefit'. Also, it is likely that only a handful of hospitals within Australia would be eligible to apply for the dramatically wound-back benefit.

Furthermore, while AN-SNAP as a new classification system has been successfully implemented for data collection purposes, a corresponding new payment model developed as an extension of the AN-SNAP Classification System and recommended for implementation after trialling, has been rejected by health funds. This has prevented calculation of Second Tier Benefits for rehabilitation based on AN-SNAP which in effect precludes *any* private rehabilitation hospital from payment of the Benefit. This means that there are nearly forty (40) private rehabilitation hospitals around Australia which have not been able to access the Benefit because of this particular problem for rehabilitation. Therefore, the number of hospitals eligible for second tier benefits as calculated by the Department of Health and Ageing ("the Department") would be very much higher had these Second Tier Default Benefit arrangements for rehabilitation been finalised.

At least two mainstream well established independent private rehabilitation hospitals currently out of contract and which had been desperately awaiting the finalisation of the above arrangements will now become ineligible to receive the Benefit under this proposal. Using their considerable market power, the major health funds have previously refused these hospitals contracts. The only alternatives available to these hospitals will be to charge patients large out-of-pocket costs or close their doors, the latter option being the most likely.

Other smaller, independent metropolitan private rehabilitation hospitals have been unable to obtain contracts from large health funds. These hospitals perform a vital role in meeting the needs of privately insured rehabilitation patients. It is not always appropriate for patients, such as elderly stroke patients, to be transported a considerable distance from their home for private hospital treatment. Precluding these facilities from receipt of the Benefit will result in increased costs and/or inconvenience for rehabilitation patients, and very real risk of closure for the hospitals, thereby reducing access for privately insured patients.

In the Minister's announcement she stated that the Benefit is "little used". In oral advice to APHA, Departmental officials indicated this meant that "only" 10 per cent of hospitals are currently eligible to receive the benefit. Unfortunately this rationale for the abolition of the Second Tier Default Benefit is a complete furphy. The whole purpose of the Second Tier Default Benefit is that it is currently available to hospitals unable to negotiate a contract with a health fund. It is logical to expect that only a minority of private hospitals would find themselves in this position. If a large proportion of hospitals applied for eligibility, surely that would be an indication that the contracting environment was fundamentally flawed.

In summary, should the Benefit be abolished:

- privately insured rehabilitation patients will be denied access where hospitals close, while others will incur out-of-pocket costs of up to $350 a day to keep rehabilitation hospitals viable;

- many rehabilitation hospitals unable to secure a contract will be unable to survive on the mandated 'basic' default benefit. As a result, they will be forced out of business;

- smaller-to-medium-sized independent rehabilitation hospitals, lacking the bargaining power of larger hospital groups will also be at risk of complete closure.

It needs to be emphasised that the Benefit arrangements cost the Government nothing. They do not impose an undue regulatory burden on health funds and, in fact, it is private hospitals that have borne the considerable costs of additional accreditation processes during the very short period of the operation of the Benefit arrangements.

2.1.4 Proposed solution

The NPRG understands the Government is keen to de-regulate the health insurance industry and we do not support regulation for the sake of it. We recognise that certain 'free market' conditions are favourable to the provision of appropriate care, such as premier location, good facilities, capacity to attract doctors, technological developments, supply of rehabilitation specialists, and cost efficiency.

Certain free market conditions however, such as inequitable risk shifting to rehabilitation hospitals, excessive market power of health funds, cost shifting to the public sector – which are precisely what this proposal represents - are highly unfavourable to the provision of appropriate private rehabilitation care and result in serious access problems and vastly limited health outcomes. This impedes the provision of appropriate rehabilitation care and if not addressed will continue to do so in the future when the demand and need for rehabilitation will be greater.

Therefore, while over-regulation could lead to a risk-averse and possibly stagnant industry, the appropriate degree of regulation is paramount for desirable rehabilitation access in Australia, particularly over coming years. Anything less simply represents very bad health policy.

The NPRG's 36 member hospitals appeal to the Committee to recommend the Government re-considers this illogical and damaging proposal.

2.1.5 Recommendation

The NPRG recommends in the strongest possible terms that:

- The decision to abolish the Second Tier Default Benefit Schedule is reversed immediately; and that

- In the absence of the current inability to calculate the Benefit for medical rehabilitation according to AN-SNAP classes, until such time as the Benefit can be accurately calculated based on AN-SNAP classes, calculation of the Benefit be done according to the arrangement that existed before the Commonwealth stipulated calculation according to AN-SNAP classes, ie, based on 85% of the average benefit currently paid by fund, for the previous six months, based on DRG for that class, in a comparable private hospital or day hospital where the fund has an HPPA or similar arrangement, in the state and territory where the treatment occurs.

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2.2 Requiring compliance with the mandatory cover legislation for private rehabilitation

2.2.1 Introduction

In 1995 resulting from amendments to the *Health Legislation* (Private *Health Insurance Reform) Amendment Bill 1995* during its passage through Parliament where contracting between private hospitals and health funds was introduced, mandatory coverage for private psychiatric, palliative care and rehabilitation services was introduced. This required that that health funds provide for benefits to be payable in respect of psychiatric, palliative care and rehabilitation in every health insurance hospital table. The relevant legislation ("the Legislation") is contained at Schedule 2, 98 (bf) of the *Health Legislation (Private Health Insurance Reform) Amendment Act, 1995*.

This was a welcome development in relation to private rehabilitation services as it recognised that provision and funding of private rehabilitation can be more uncertain than other areas of health care as it is usually longer term, less predictable and often more expensive relative to other services.

2.2.2 Concerns

Since this time, health funds have introduced a range of practices as disincentives to the funding of rehabilitation episodes which have acted to circumvent the spirit of the Legislation. This has created problems in relation to consumer access to private medical rehabilitation and further marginalised rehabilitation as a service offering.

As a result, private rehabilitation patients have been progressively excluded from coverage in the following ways:

- They have generally experienced reduced choice in and access to the rehabilitation care they need;
- Some contributors have been placed at risk of permanently reduced functional capacity at a time when they are particularly vulnerable;
- Rehabilitation has become unattainable or delayed, risking patients' further functional loss and disability;
- Consumers have been subject to the disadvantages of long waiting lists, lower quality rehabilitation care, and shorter than necessary periods of hospitalisation;
- There has been a risk of intolerable cost shifts to the public sector;
- Private rehabilitation has been either eliminated or substantially reduced at a time when it is in increasingly higher demand;
- Day rehabilitation programs, mostly provided in the private sector, have been at risk of diminished service provision.

In September 2002 the Health Minister's office confirmed that the mandatory cover for rehabilitation will not be removed by this Government. This was confirmed in

correspondence from the Department on 26 February 2003. This was welcome news as it gave the NPRG the opportunity to inform the Government that the spirit of the legislation is being routinely circumvented.

The NPRG believes that unless the spirit of the legislation is complied with, the problems listed above will continue and health funds will continue to limit the funding of rehabilitation episodes.

The NPRG therefore regards it as *critical* that mandatory cover for private in-hospital rehabilitation *not only remain in place* in all private hospital insurance tables *but is effective*. This is because:

- Consumers continue to customarily rate too low their risk of needing rehabilitation;
- Most consumers are uninformed about the rehabilitation option in hospital insurance tables and rarely read policies to understand about exclusions, etc;
- There is little public education by health funds about the availability or necessity of cover for rehabilitation;
- As mentioned, the provision and funding of private rehabilitation can be more uncertain than other areas of health care as it is usually longer term, less predictable and often more expensive relative to other services;
- There will be intolerable cost shifts to the public sector if rehabilitation becomes unavailable in the private sector;
- The need for rehabilitation is likely to increase over the next 30 years as the baby boomer generation reaches middle and old age. Indeed, The NPRG has long argued the relevance of medical rehabilitation to the Government's core policy propositions for healthy ageing set out in the *National Strategy for Ageing* and long recognised the increasing community need for high quality medical rehabilitation over the next few decades. Medical rehabilitation plays a powerful role in keeping people of all ages functional and independent, assisting people to better utilise important skills for sustained economic growth and contributing to healthy and positive ageing across the life course;
- The need for rehabilitation consumers to be protected from market forces (which due to the unique nature of rehabilitation treatment have historically marginalised private rehabilitation consumers) remains.

2.2.3 Proposed solution

Resulting from meetings with the Health Minister's office and the Department, it was recognised that the Interdepartmental Review on Health Insurance Regulation represented a timely and appropriate opportunity to ensure some effectiveness regarding compliance with the spirit of the Legislation. The possibility of retrospectively including an expectation of compliance in the New Arrangements for Health Fund Product Regulation (referred to on page 2 of the Commonwealth Circular HBF 796 PH 525) was discussed. It was thought the Minister would be sympathetic in principle to retrospective changes. It was suggested the NPRG draft a strategy to propose both a way to measure non-compliance and an indicator against which to assess health funds' performance in this regard. It was felt that there may be scope to retrospectively incorporate recommendations from such a strategy into the recommendations of the IDC review.

The NPRG developed a strategy which is currently under discussion with the Department.

The strategy includes a requirement in Commonwealth Circular HBF 796 PH 525 that compliance with the Legislation be one of the performance indicators against which health funds will be assessed as part of the new Product Regulation arrangements; a mechanism for private rehabilitation providers and consumers to report legislative non-

compliance; the Private Health Insurance Ombudsman ("PHIO") as the central reporting and validation point; guidelines to assist PHIO to validate reported claims; a means by which the Government can measure alleged non-compliance; and sanctions regarding non-compliance.

The following expands on these points.

1. **Establishing the expectation of legislative compliance**. The NPRG proposes that an expectation of compliance with the Mandatory Cover Legislation be included as a policy/performance indicator in the New Arrangements for Health Fund Product Regulation referred to on the second page of Commonwealth Circular HBF 796 PH 525.

2. **Reporting legislative non-compliance.** The NPRG will implement a process amongst its members to assist them to routinely and consistently report incidents of legislative non-compliance.

3. **Establishing a central reporting point regarding legislative non-compliance.** The NPRG proposes that "PHIO" be regarded as the central point to receive reports of legislative non-compliance. In so doing PHIO would also validate the reported examples, record them, draw up statistics on them, regularly report them, make recommendations regarding compliance to the Minister and/or Department, and publish aggregate data on non-compliance. The suggestion of PHIO being the central reporting point is supported by the greater powers being given to PHIO in the New Arrangements for Health Fund Regulation to enforce dispute recommendations.

4. **Measuring legislative non-compliance**. The NPRG proposes the Department both:

   - uses the above data collected from PHIO; and
   - on a quarterly basis by accessing health fund data compares the number of patients transferred from acute hospitals to rehabilitation hospitals by DRG class.

5. **Penalising non-compliance**. For health funds deemed to be in regular non compliance with the Mandatory Cover Legislation according to validated incidents reported by PHIO and according to trends becoming apparent from the Department's comparison of transfers from acute to rehabilitation hospitals, the Minister and/or Department would ascertain appropriate sanctions according to the severity or frequency of the non-compliance in a similar way to its treatment of breaches of the private health insurance policy objectives referred to in the New Arrangements for Health Fund Regulation (HBF 796; PH 525).

2.2.4 Recommendation

The NPRG seeks the Government's agreement to implement a process as proposed above to scrutinise health fund practices against the mandatory cover Legislation to ensure compliance, and intervene in cases where non-compliance is demonstrated.

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3. Recommendations

1. The NPRG recommends in the strongest possible terms that:

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