Australian
Private Hospitals
Association

File 15.1.6

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

Dear Mr Humphery

Thank you for inviting the Australian Private Hospitals Association (APHA) to provide a submission to the Senate Community Affairs Legislation Committee's inquiry into the National Health Amendment (Prostheses) Bill 2004.

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.

On behalf of APHA I have attached a brief submission on the National Health Amendment (Prostheses) Bill 2004.

Please contact me if APHA can assist further with the Committee's inquiry.

Yours sincerely

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A/g Executive Director
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SUBMISSION BY THE AUSTRALIAN PRIVATE HOSPITALS ASSOCIATION TO THE SENATE COMMUNITY AFFAIRS LEGISLATION COMMITTEE'S INQUIRY INTO THE NATIONAL HEALTH AMENDMENT (PROSTHESES) BILL 2004

Background

The Australian Private Hospitals Association (APHA) and its members have been greatly concerned by the deteriorating environment for prostheses and other medical devices since the semi-deregulation of Schedule 5, *Surgically Implanted Prostheses, Human Tissue Items and Other Medical Devices,* was unilaterally introduced by the Department of Health and Ageing in 2001, against the express advice and wishes of APHA and its member private hospitals and day hospital facilities.

APHA has consistently argued that the current prostheses arrangements are fundamentally flawed and require reform. These arrangements have not succeeded in improving the access of privately insured patients to prosthetic and other medical devices nor have they led to certainty in funding arrangements. On the contrary, the current arrangements have added significantly to the complexity and cost of providing prosthetic and other medical devices to patients for both private hospitals and health funds.

Reform is of these existing arrangements is therefore not optional, it is essential.

Key problems with the current arrangements

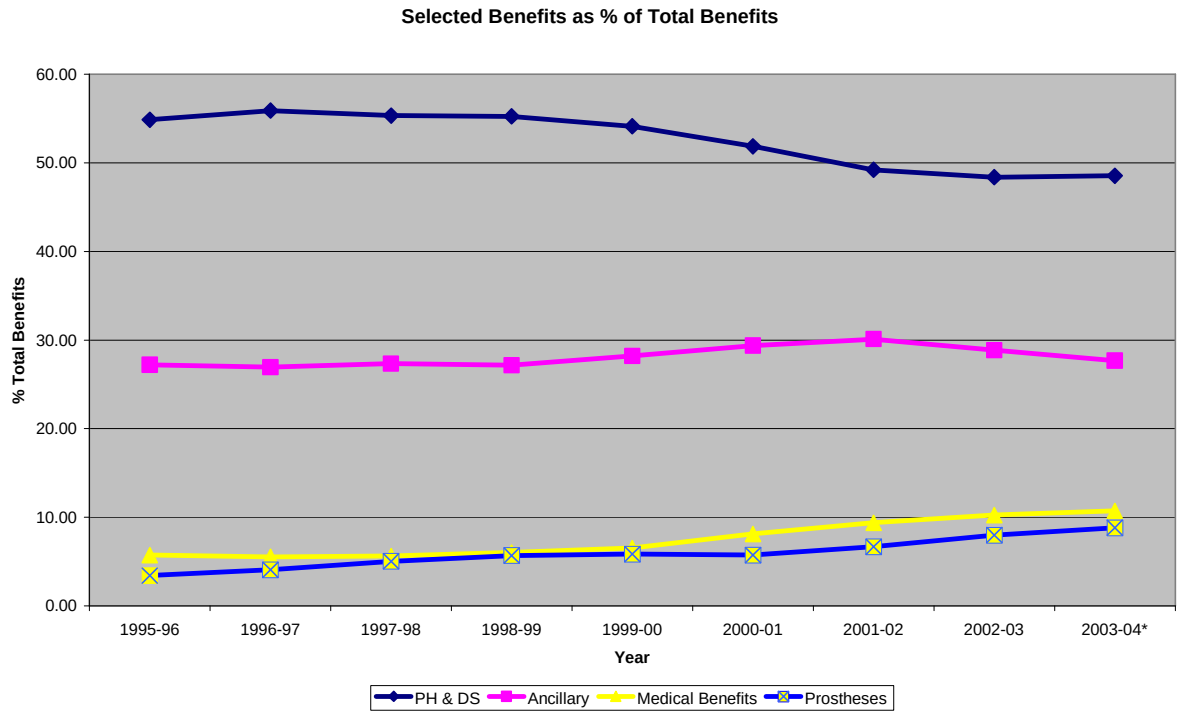
The current regulatory arrangements for the payment of benefits for items listed on Schedule 5 place private hospitals in an invidious position. Private hospitals provide the high quality facilities and well-trained staff to enable a highly skilled surgeon to treat a health fund contributor using the latest available technology. The choice of prosthesis used in a given procedure is entirely one for the treating clinician and the patient. However, neither the clinician nor the patient pays for the prosthesis of choice, rather, this duty falls to the hospital, which will, in turn, seek payment from the patient's health fund.

In those cases where agreement has not been reached between the prosthesis supplier and the health fund on the benefit payable for a particular prosthetic item, the financial risk is carried entirely by the hospital, despite it not having been involved at any stage in the negotiation process. The hospital cannot charge the patient a gap, it cannot stop a surgeon from selecting a particular supplier's products, nor can the hospital refuse to treat contributors of a particular health fund. However, suppliers are at liberty to set any price that they choose for any of their products and health funds can issue their benefit schedules that may or increasingly, may not, match those charged by suppliers.

While multiple problems exist with the current arrangements from a private hospital perspective, they can be summarised as:

- Administrative problems;
- Supply/handling charges;
- Arrangements for items deleted from Schedule 5; and
- Lack of cost effectiveness

In addition, and as noted above, the current arrangements have led to unsustainably large increases in benefits paid by health funds for prostheses. The upward trend in the payment of benefits for prostheses since 2001 and the accompanying declining share of benefits accruing to the private hospitals sector is clearly evident in the chart below:



Source: PHIAC Annual Reports and Quarterly data

The moves towards a new regulatory environment for prostheses

APHA has participated constructively in the development of the new regulatory arrangements for prostheses. It supports considered measures that will rein in the escalating benefits paid for prostheses by health insurance funds and welcomes an increased focus on cost effectiveness introduced under the new arrangements.

A fundamental concern that APHA has held concerning the new arrangements is that there has been inadequate evidence available to inform the development of policy in this area. It is unclear, for example, the degree to which utilisation, technology or price have led to the increasing benefit costs to health insurers. Accordingly, it is not completely clear how, or whether, the new arrangements will work to limit the rate of increase in health fund benefits in the near and medium term.

That said, several aspects of the new arrangements, particularly the assessment of items by clinicians in Clinical Advisory Groups appears to be a very worthwhile

exercise. Similarly, the Ministerially-appointed Prostheses and Devices Committee appears to be functioning well in its role of overseeing the new arrangements. At the time of writing, the second crucial aspect of the new arrangements, the benefits negotiation process, is yet to commence in earnest. The success or otherwise of this element of the new arrangements will be critical.

A further aspect of the new arrangements that is yet to be fully worked through is an assessment of the best means of reimbursing hospitals for the actual costs incurred in the supply, handling and management of the provision of prostheses to privately insured patients. This aspect of the arrangements will also be critical from the private hospital perspective.

Informed Financial Consent

In his Second Reading Speech on the Bill, the Minister observed that:

"where the patient has an out-of-pocket cost, information should be provided by the patient's fund and doctor that will allow the patient to make an informed decision about the choice of prostheses."

This process will become necessary because some prostheses are likely to attract a gap or out-of-pocket cost to patients following the introduction of the new arrangements. Exactly how many devices will be affected and the magnitude of the gaps are unknown at this time and, necessarily, this will be dependent on the outcome of the benefit negotiation process.

At the time of writing, the process by which health funds and doctors will inform patients of likely out-of-pocket costs for prostheses has yet to be finalised. It is acknowledged that work has been undertaken in this area by the Australian Medical Association and the Informed Financial Consent Taskforce. The role to be played by private hospitals where IFC has not been obtained prior to admission of a patient is similarly yet to be finalised.

It should be emphasised that gap or out-of-pocket costs are nothing new for privately insured consumers. For example, out-of-pocket costs may be incurred for medical fees; also, many health funds impose a daily co-payment for contributors to certain policies; excesses are a feature of the majority of health fund policies (59%); and all pharmaceuticals under the Pharmaceutical Benefits Scheme require a co-payment.

Indeed, arguably the only area where a privately insured patient is *unlikely* to face a co-payment is the charges levied by the private hospital (eg for accommodation and theatre). However, this situation is likely to change, given the declining share of benefits flowing to the private hospitals sector evident in the chart above, together with the unsustainably low rates of increases in benefits paid by health funds to private hospitals (notwithstanding the increasing costs faced by hospitals from areas such as nursing wages and indemnity insurance).

Exclusionary products

One concern that APHA does have with the Bill is that it further entrenches the decidedly unhealthy practice of exclusionary policies that are offered by health insurance funds.

In his Second Reading speech on the Bill, the Minister states that: "health funds will not be required to pay benefits for a prosthesis, where a member has made an election not to be covered for the hospital procedure." APHA's fundamental objection to these exclusionary products is that consumers do not have any objective means of assessing their risk of developing a particular condition and/or sustaining an injury and therefore cannot make an informed choice whether to sign up to a policy that excludes hospital treatment for a particular condition.

These exclusionary policies continue to be inappropriately marketed by health funds and it has never been clear to APHA how these types of policies actually meet the needs of consumers.

Indeed, APHA believes that where, for example, a health fund provides a policy to an elderly person that excludes cardiac or orthopaedic services, the fund may be in breach of the 'fit for purpose' provisions of the *Trade Practices Act 1974*. APHA has recommended to the Australian Competition and Consumer Commission (ACCC) that it undertake an investigation of the provision of exclusionary health insurance products with a view to establishing if any systemic breach of the *Trade Practices Act 1974* is occurring.

As well as placing patients' actual as well as financial health at risk, exclusionary policies are also a particular problem for private hospitals because the accurate assessment of a patient's health insurance status is still fraught with difficulty, particularly after hours and on weekends, and in the context of emergency admissions.

In APHA's view, exclusionary health insurance products should be prohibited.

Concluding Comments

As stated earlier, the current arrangements for prostheses were poorly conceived and are badly flawed. Reform is therefore essential.

Together with other stakeholders, including consumers, the medical profession, health insurers and suppliers, APHA has participated constructively in the development of the new regulatory arrangements for prostheses. APHA supports considered measures that will rein in the escalating benefits paid for prostheses by health insurance funds and welcomes an increased focus on cost effectiveness that is introduced under the new arrangements.