Suite 2, 37 Geils Court, Deakin ACT 2600 PO Box 24, Deakin West ACT 2600
Fax: (02) 6232 4434 Phone: (02) 6232 4433 Email: pcainc@pallcare.org.au
ABN: 85 363 187 904

Palliative Care Australia

Senator Humphries
Chair
Community Affairs Committee
C/- Department of Senate
PO Box 6100
Parliament House
Canberra ACT 2600

6 February 2007

Dear Senator Humphries

Thank you for your invitation to provide further comments to the Community Affairs Committee on the Private Health Insurance Bill 2006 and related Bills.

Palliative Care Australia welcomes moves towards broader health cover and wishes to emphasise the importance of the provision of appropriate hospital-in-the-home and hospital substitute services for palliative patients under these proposed arrangements.

Broader health cover promises to provide access to "modern care opportunities" allowing patients to receive the most appropriate care in the most appropriate setting, thereby improving health outcomes. These programs can ensure patients have choice in their healthcare options at the end of life: choice of care settings, choice of care providers, and choice of service options. The current private health insurance arrangements fail in many areas to deliver the promise of choice for privately insured patients and their families. Being privately insured can, in many circumstances, result in a reduced choice in access and quality.

Dying is different. Palliative patients and their families have no time to be on waiting lists. They require continuity of care which provides needs based coordinated access to a multidisciplinary team which may consist of doctors, nurses, allied health professionals and counsellors. Health financers continue to struggle with palliative care, conceptually thinking of it as a high cost and poor return spend, in contrast to an investment that contributes to health outcomes.

The model funded by private health insurance companies at Cabrini Hospital in Melbourne clearly demonstrates that high quality care meeting the unique needs of palliative patients can be provided in multiple settings in a cost effective manner. We would note that the Cabrini model can be implemented under the current legislative arrangements. This highlights the urgent need for private health insurance companies and private hospitals to review their focus to providing services to their current membership as a way to sustain private health insurance participation rates, rather than solely focussing on new horizons.

Palliative Care Australia has three main concerns in relation to the broader health cover issue. First, PCA is concerned about the absence of dedicated rules for broader health cover and notes they have been included briefly in the Private Health Insurance (Health Insurance Business) Rules and the Private Health Insurance (Risk Equalisation Policy) Rules.

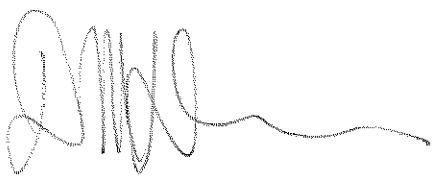
The absence of dedicated rules gives rise to PCA's second concern: the preoccupation of private health insurance companies with the possibilities of "innovative" work around chronic disease management programs. Palliative Care Australia is concerned hospital-in-the-home and hospital substitute services which are potentially of most benefit to palliative patients will be of a lower priority. As noted in our address to the Committee, private health insurance as it currently stands often does not meet the needs of palliative patients. This legislation offers no real incentive for private health insurance companies to go beyond chronic disease management programs.

Third, PCA would like to see quality and safety standards applied to all broader health cover products. The principles of quality and safety apply not only the product itself – they apply equally to the appropriateness of the program or intervention for the patient. Palliative patients require products that are specifically tailored for their unique needs. Further to this issue, care coordination can only be appropriately delivered by a health care professional, not a health fund administrator.

Palliative Care Australia is also alarmed at the suggestion from the Health Insurance Restricted Membership Association of Australia that palliative care be classed as a pre existing ailment and subject to a greater waiting period than two months. A terminal illness cannot be predicted and is not a pre-existing ailment. It is appropriate that palliative care continues to be classified for a two month waiting period with rehabilitation and psychiatric care.

Thank you for the opportunity to provide further evidence to the Committee. Should you require clarification or expansion on any point, please do not hesitate to contact me.

Yours sincerely



Donna Daniell
Chief Executive Officer