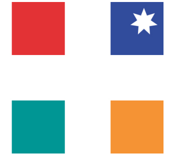
Australian
Private Hospitals
Association



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

Dear Elton

Thank you for the invitation to the Australian Private Hospitals Association (APHA) to provide a submission to the Senate Community Affairs Committee on the Private Health Insurance Bill 2006. On behalf of APHA, I have attached a submission which outlines APHA's key concerns with the Bill as presented to Parliament.

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.

Please contact me if APHA can be of further assistance.

APHA would be pleased to assist the Committee further by appearing at any public hearing that the Committee may convene as part of its inquiry.

Yours sincerely

Paul Mackey
A/g Executive Director
25 January 2007

SUBMISSION BY THE AUSTRALIAN PRIVATE HOSPITALS ASSOCIATION ON THE PRIVATE HEALTH INSURANCE BILL 2006

Background

The Australian Private Hospitals Association (APHA) has participated constructively in the consultation process on the Broader Health Cover (BHC) proposals conducted by the Department of Health and Ageing in 2006.

In its submissions to and consultations with the Department of Health and Ageing, APHA has emphasised that while it continues to support the general thrust of the Broader Health Cover (BHC) initiatives, it does remain concerned that much fine detail around the reforms is yet to emerge.

Particular concerns remain in relation to the quality and safety provisions for Broader Health Cover services, especially the interim regime that will apply from 1 April 2007 until 30 June 2008. Acknowledging that much of the detail is likely to emerge in yet to be drafted Rules, APHA is nevertheless surprised that in more than 300 pages of the Bill, only some four lines are devoted to quality assurance.

APHA is also concerned to ensure that the regulatory framework for Broader Health Cover does not stifle innovative programs that are already available and inadvertently limit choices currently enjoyed by privately insured patients. At a minimum, the regulatory framework should facilitate the availability of multidisciplinary programs offered by private hospitals and other providers and also look to encourage their further development and expansion. Aspects of the regulatory framework envisaged by the Bill appear to limit the opportunity to achieve these objectives.

Misleading statements

APHA draws the Committee's attention to misleading statements in several parts of the Explanatory Memorandum of the Bill. For example pages 8-9 of the Memorandum canvass the consultation process undertaken by the Department of Health and Ageing to date, in which (as noted above) APHA has participated constructively. The Memorandum goes on to claim that *"all of the industry representatives have expressed strong support for the types of improvements proposed under these options."*

This statement misrepresents the stance that APHA has adopted throughout the consultation process. That is, APHA has supported the broad thrust of the reforms while drawing the Department's attention to (a) the lack of fine detail and (b) the fundamentally flawed regime envisaged to ensure the quality and safety of privately insured services.

In addition, the table on page 23 notes against Option 1D in relation to service providers that there are *"ranging levels of support across the industry"* for this

option. APHA is not aware of ‘ranging levels of support across the industry’ for a uniform approach to quality and safety of privately insured services, however, APHA has certainly raised concerns regarding shortcomings in the Department’s proposals.

APHA’s concerns regarding specific aspects of the Bill are canvassed below.

Safety and Quality Issues

Division 81 Quality Assurance requirements

APHA restates its surprise that in more than 300 pages of the Bill, only some four lines are devoted to quality assurance and notes that these merely point to the fact that quality assurance will be addressed in yet to be drafted regulations.

APHA notes that the potential exists for a uniform regime of quality and safety standards to apply to all privately insured services which will be articulated in the yet to be drafted Private Health Insurance (Accreditation) Rules. Section 13 of the Transitional and Consequential Amendments Bill 2006 provides that this regime does not apply until 1 July 2008, as previously announced by the Government. However, as yet there is no detailed information available as to the parameters of the anticipated quality and safety regime.

APHA is most concerned that there is no attention paid in the Bill to the quality and safety regime that is to apply for the 15 month period from 1 April 2007 other than ensuring that a hospital is accredited (proposed subsection 121-5(7)(d)).

There is nothing in the Bill (or in any of the consultation documents released by the Department to date) that offers any comfort to APHA that there is an understanding of the current accreditation system for hospital-based services, nor the nature of the relationship between admitting doctors and private hospitals, including credentialling and defining the scope of practice, nor to the complex system of liability insurance.

In particular, it appears the Bill makes an artificial distinction between the accreditation of facilities and the qualifications of service providers. The gap created by this distinction is the lack of any requirement for accreditation of ‘services’. That is, while there are some elements of current hospital accreditation requirements that go to facilities (such as physical environment, fire safety, waste management etc.) the fundamental purpose of accreditation is to ensure compliance with standards and continuous quality improvement of the services provided within that facility.

Specifically, ensuring a practitioner is qualified gives no guarantee of the quality of a program or service delivered, in whole or in part, by that practitioner.

APHA therefore proposes that the uniform safety and quality requirements apply to organisations, facilities, service providers (practitioners) and services. This is particularly relevant when many of the services proposed to be covered by BHC products would not necessarily be delivered within a ‘facility’.

For example, under the proposals as they currently stand in the Bill, a home dialysis service provided by a doctor and/or a nurse, would appear to meet the safety and quality requirements if the practitioner delivering the service were registered with the appropriate professional registration body (although APHA contends this would still not cover issues such as scope of practice). However, this would provide no assurance that the service provided complied with relevant standards in relation to issues such as infection control, manual handling, patient safety, incident monitoring, continuity of care, policy and procedures, medication management, consumer rights and responsibilities, privacy, legislative compliance etc. All of these issues (and many others) are covered under existing accreditation programs.

During the Department's consultation forums, the ill-informed view was expressed that while it was acceptable to expect a large hospital to be accredited, this requirement would be too onerous for small services. However, the Australian Council on Healthcare Standards (ACHS), for example, currently accredits everything from large teaching hospitals to single practitioner day surgeries and small community health services.

Therefore, APHA contends that any accreditation requirement must apply to all services funded under BHC (including for example, telephone advice lines) in both the public and private sectors.

Furthermore, APHA strongly opposes any 'reforms' that would put in place a multiplicity of quality and safety requirements that are determined by each individual health insurance fund. This is neither efficient nor effective.

APHA is strong supporter of accreditation of private hospitals and day facilities and evidence of current accreditation is a condition of APHA membership. APHA also strongly supports current registration of practitioners, their credentialing by facilities to establish the scope of their practice at the facility and that each practitioner holds current medical indemnity insurance for all services included within the practitioner's scope of practice.

The Bill proposes that the requirement for accreditation will apply from 1 July 2008. Currently, it is not possible to achieve accreditation without a track record of outcomes. However, both ACHS and ISO offer a process of 'Certification' whereby a new service can demonstrate they are implementing standards compliance and quality improvement programs that would, subject to satisfactory assessment, ultimately lead to accreditation.

As there are existing mechanisms that would provide some level of quality assurance for new services established under the BHC regime, APHA can see no valid reason why these mechanisms should not be a legislated requirement, pending the introduction of a uniform quality and safety regime on 1 July 2008.

Therefore, in addition to the requirement of achieving accreditation by 1 July 2008, APHA proposes that for a service to be eligible to receive benefits under BHC, if it is not already accredited, it must be Certified by an industry recognised accreditation agency by no later than 1 July 2007.

The absence of such a requirement raises the prospect of services being funded under BHC for 15 months with no commitment to quality improvement and no guarantee of patient safety. This would clearly be inconsistent with the intent of the proposed safety and quality requirements.

Hospital treatment

Clause 121-5 Meaning of *Hospital treatment*

The definition of 'hospital treatment' in subclause 121(5)(1) is unnecessarily restrictive and does not reflect the scope of services provided in or by the private hospitals sector. For example, many private hospitals provide services across the continuum of care, a feature that is not encompassed by the proposed definition. In particular, private hospitals would appear to be excluded from providing services that prevent hospitalisation and assist patients in managing their condition.

For example, private hospitals currently provide a range of services designed to assist patients manage chronic and ongoing conditions. These services are usually provided as part of an acute program and include, for example, 'healthy heart' programs, stomal therapy, and relapse prevention programs, all of which are designed to assist patients better manage their condition. The definition of 'hospital treatment' in the Bill, on the surface at least, would appear to prohibit these types of programs.

It is important that the BHC reforms to private health insurance do not restrict choices that patients currently enjoy, such as these and other programs to assist patients manage their condition, which are designed by their treating clinician(s) and included as part of the patient's acute treatment program.

It would be an extraordinary outcome if reforms that are designed to improve patient choice actually restrict treatment programs that are already meeting the needs of patients. Accordingly, APHA recommends that the definition of 'hospital treatment' in clause 121-5 be amended to include the term 'prevent' to reflect current practice, as follows:

Hospital treatment is treatment that is intended to manage or prevent a disease, injury or condition and…

In addition, APHA notes that subsection 121-5(7)(d) will introduce a requirement for a facility to be accredited in order for the Minister to declare that the facility is a hospital. As APHA requires its members to hold current accreditation, APHA supports such a provision and believes that this provision will apply to **all** hospitals and day facilities providing privately insured services, both private and public.

As noted above, currently, it is not possible to achieve accreditation without a track record of outcomes. However, both ACHS and ISO offer a process of 'Certification' whereby a new service can demonstrate they are implementing standards compliance and quality improvement programs that would, subject to satisfactory assessment, ultimately lead to accreditation. APHA recommends that these issues be taken into

consideration if accreditation is to become a condition of allocation of a Commonwealth provider number to hospitals from 1 April 2007.

General treatment

<u>Clause 121-10 Meaning of *general treatment*</u>

APHA is concerned at the complete contrast of requirements on facilities/services/providers offering ‘general treatment’ as compared with ‘hospital treatment’. As general treatment will include hospital-substitute treatment, such as office-based surgery, APHA finds it quite extraordinary that there is not a requirement in the Bill for accreditation nor for any consistent regime of reporting on the outcomes of treatment for patients receiving hospital-substitute treatment such as office-based surgery.

APHA strongly believes that current accreditation be a similar requirement for **any** facility/organisation/provider providing privately insured services, for example, office-based surgery, to ensure a seamless regime of quality and safety for privately insured consumers.

Protection of clinical discretion

<u>Clause 172-5 Agreements with medical practitioners</u>

APHA welcomes the provisions of this proposed clause but cautions that it will have only limited impact in protecting clinical freedom because it applies only in those circumstances where there is an agreement between a medical practitioner and a health insurance fund.

Under the current arrangements, clinical discretion is protected in the *National Health Act 1953* under both section 73 BDA(2)(d), which applies to Medical Purchaser Provider Agreements (ie agreements between medical practitioners and health insurance funds) and section 73BDAA(1)(d), which applies to Practitioner Agreements (ie between medical practitioners and hospitals). Therefore, the provisions in the Bill for clause 172-5 to apply only to agreements between health insurance funds and medical practitioners would appear to be a diminution of the current level of protection of clinical discretion.

APHA recommends that the protection of clinical discretion should be a requirement of all agreements between health insurance funds and all service providers, including hospitals.