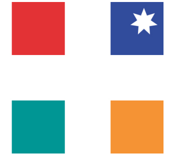

Mr Elton Humphery
Secretary
Senate Community Affairs Committee
Parliament House
CANBERRA ACT 2600

Dear Elton

Further to the supplementary submission from the Australian Private Hospitals Association (APHA) of 9 February 2007, I would like to provide the Committee with some additional information that APHA believes may assist the Committee's inquiry into the Private Health Insurance Bill 2006 and related Bills.

The responses by the Department of Health and Ageing to matters raised during the pubic hearing on 2 February reveal a fundamental lack of understanding of the role of quality assurance in the provision of health care services in general, and a complete ignorance of the current accreditation processes and systems in particular. On behalf of APHA I have attached a paper that aims to clarify the key issues in these areas.

In addition, APHA was advised yesterday during a consultation session provided by the Department of Health and Ageing that a key protection for consumers and service providers in the current *National Health Act 1953* (Schedule 1, paragraph (n) – reproduced below) will not carry through to the new legislative framework. This particular paragraph provides for a maximum period of 2 months for the payment of claims by health insurance funds. This protection will disappear from 1 April 2007 under the current proposals. **APHA recommends that this paragraph be included in the Private Health Insurance (Health Insurance Business) Rules 2007.**

(n)Where a claim for a benefit payable by the organization out of the health benefits fund conducted by it is, or has been, lodged with the organization, the organization will pay that claim within 2 months, or such longer period as the Secretary approves in a particular case, after:
(i) the date of commencement of this condition; or
(ii) the date of lodgment of the claim with the organization,
whichever is the later date.

Please contact me if APHA can assist the Committee further.

Yours sincerely

Michael Roff
Executive Director
20 February 2007

Same Service – Same Standards

The Senate Standing Committee on Community Affairs is currently conducting an inquiry into the Private Health Insurance Bill 2006. Submissions to the inquiry and evidence given at a public hearing have demonstrated a great deal of confusion and misunderstanding in relation to issues of quality and safety.

In particular, the Department of Health and Ageing has not demonstrated any level of understanding of current quality accreditation requirements and appears to support a two-tiered approach to quality and safety of privately insured services.

This paper is an attempt to clarify those issues.

Background

The Private Health Insurance Bill 2006 will allow health insurance companies to pay benefits for services provided outside of hospital (so-called Broader Health Cover) from 1 April 2007.

The Bill also introduces a condition that health insurance companies may only pay benefits in respect of services that meet (yet to be defined) quality and safety requirements. This measure does not take effect until 1 July 2008, leaving a gap of 15 months where new services can be provided without any requirement for meeting standards in relation to quality and safety.

It is anticipated that one category of these new services will be designed to substitute for existing in-hospital services. Private hospitals already adhere to a stringent third-party quality accreditation regime and the Bill mandates this requirement in clause 121-5(7). Conversely, there is no legislated requirement for the accreditation of hospital substitute or other out-of-hospital services.

It is inconceivable that the Government is willing to allow the development of health services that will have no commitment to quality improvement and no guarantee of patient safety.

The Australian Private Hospitals Association is advocating the principle of *"Same service – Same standards."* That is, the same service should be subject to the same sorts of standards regardless of the location in which it is provided. This would appear to be the minimum requirement in a 21st century health system that is often characterised as the 'best in the world'.

Current Accreditation Regimes

Although third-party quality accreditation for private hospitals and day surgeries is currently a voluntary undertaking, the vast majority of facilities undergo this assessment process in an effort to maintain continuous quality improvement. In addition, accreditation is fundamental to the provision of private hospital services because:

- Health insurance companies insist on accreditation as an essential pre-condition of entering a contract with a private hospital or day surgery

- Accreditation is a requirement for any facility to be eligible to receive 2nd tier default benefits (which apply to hospitals without a contract)

- Professional Indemnity (malpractice) insurance for hospitals would be unobtainable without quality accreditation.

APHA is a strong supporter of accreditation and hospitals must provide evidence of current accreditation to maintain their membership of the Association.

All private hospitals are either accredited or certified (see below) by an approved accreditation agency. These facilities are accredited against either the Australian Council on Healthcare Standards (ACHS) standards or the International Standards Organisation (ISO) 9001 standards.

Certification

Both ACHS and ISO offer a program of Certification for new health care organisations that have not yet implemented a formal quality improvement program.

Certification requires the establishment of appropriate systems and structures to provide quality care and services and a commitment to continuous review and improvement of those services. Certification is essentially the first step on the path to accreditation.

APHA recommends that from 1 July 2007, Certification by an approved accreditation agency is the minimum requirement for any service to be eligible to receive health insurance benefits under the new legislation.

A number of parties have claimed that such a recommendation is not practical or possible. This paper explains why they are wrong.

The following is based on evidence given before a public hearing of the Senate Standing Committee on Community Affairs on 2 February 2007.

In Support of the APHA Recommendation

Australian Health Management Group

AHMG is the eighth largest health insurance company in Australia. In addition, AHMG has been delivering hospital substitution and risk and disease management programs, to its own private health insurance population, for the last eight years. They also deliver similar programs for 13 other health funds in Australia.

AHMG has full accreditation from ACHS for the health management division of the company that delivers these telephonic disease and risk management programs.

AHMG is therefore unique as a health insurance company with first hand experience of current accreditation regimes.

In his evidence to the Senate Committee, the CEO of AHMG, Mr Dan Hook, explained his recommendation that accreditation be a legislated requirement for any service from 1 April 2007;

> *"We support one of the other submissions that said at least certification, at least to say you have got a framework in place. We do not believe that someone should be able to go out next week and say, 'We are now a health management company and we will solve all your problems about diabetes.' We feel that that is not appropriate."*

In APHA's view, there is nothing in the Bill or the draft rules to prevent the situation that Mr Hook describes as "not appropriate" from occuring.

In Support of the Principle behind the APHA Recommendation

Health Insurance Restricted Membership Association of Australia

HIRMAA represents the 13 restricted health funds. In evidence to the Committee, HIRMAA President, Mr John Rashliegh, explained he was negotiating with AHMG to provide their disease management programs to HIRMAA member funds. The following exchange ensued;

Senator McLUCAS—If you do that, if you use Australian Health Management, they said that all of their services have quality assurance through ACHA (sic)

Mr Rashleigh—Yes.

Senator McLUCAS—That is why you would use such an organisation?

Mr Rashleigh—Exactly, yes.

Qualified Support of the APHA Recommendation

Medical Benefits Fund of Australia

MBF currently comprises about 19% of the total health insurance market. In evidence to the Committee, the Group Executive, Health and Financial Solutions, and Chief Medical Officer for MBF, Dr Christine Bennett, was asked about what sort of services might emerge and what sort of quality requirements they should comply with;

> *"We believe the legislation gives the opportunity for new groups of health service providers to offer services. We would again emphasise that it is evidence based; that it actually works, is adding value and improving health outcomes; that those professionals are appropriately qualified and registered et cetera; that their programs are proven to work; and, where it is relevant, that there is a form of accreditation required of those groups as well."*

The Ambiguous position

Australian Health Insurance Association

The AHIA represents the 23 open health funds. In evidence to the Committee, the CEO of AHIA, Dr Michael Armitage, explained his concerns about uniform quality and safety requirements;

> *"But I think it is important that we do not throw the baby out with the bathwater in this instance. And I am aware from previous discussions that a number of organisations have suggested that exactly the same criteria ought to apply to every facility where a health service is provided. I contend that that is a defensive mechanism because if someone's home was forced to have the same quality and safety criteria, occupational health and safety rules and so on then it might in fact make the opportunity to provide more appropriate care in a different location very difficult. So we will be looking to ensure that the people who provide the care are of the appropriate standards and that they would automatically take appropriate quality measures."*

This statement highlights the AHIA's lack of understanding of current accreditation regimes. They appear to be confusing accreditation of 'facilities' (i.e. the venue in which a service is provided) with the accreditation of the service itself.

APHA is not proposing that where a service is provided in a person's home, that the facilities within that home are the equal of a hospital. Such a proposition is patently absurd.

However, we contend that such a service should comply with standards in relation to infection control, manual handling, patient safety, incident monitoring and reporting, medication management, toxic waste disposal, continuity of care, consumer rights, privacy etc. These are examples of some of the issues covered under existing accreditation programs and they should apply to any health service – regardless of where the service is delivered.

Just because the people providing the care are *"of the appropriate standards"* does not guarantee that *"they would automatically take appropriate quality measures,"* as Dr Armitage implies. To do so requires a systemic approach to quality improvement – this is exactly what quality accreditation entails.

The AHIA seems to be suggesting that some types of service are not appropriately covered by accreditation, However, Mr Hook of AHMG (see above) also stated;

> *"We have full accreditation from ACHS for the health management division of our company that delivers all these telephonic programs. So the accreditation process actually does apply to these sorts of services."*

Furthermore, there are already numerous 'hospital-in-the-home' programs being provided by private hospitals, all of which are assessed under the framework of the hospital's accreditation. This demonstrates that existing accreditation programs are flexible enough to assess a range of services regardless of their location.

However, despite the fact that the AHIA does not want the existing accreditation regime to apply to new services, Dr Armitage went on to say;

> *"We have agreed with the APHA, which I know have made a plea about this, that the quality and safety framework perhaps should have come in earlier. We would acknowledge that, and that is why we are taking our own steps to have available advice for our contracting funds."*

The simplest and most practical way to ensure earlier implementation of a quality and safety framework is to adopt APHA's recommendation.

Against the APHA Recommendation

The Department of Health and Ageing

From the time these reforms were first announced, the DHA has demonstrated not only a total lack of understanding of current accreditation regimes, but have made no attempt to improve this level of understanding. APHA has been advised by accreditation providers that in the last 12 months, they have not been approached by the DHA to discuss the quality and safety aspects of this legislation.

In APHA's view, the DHA does not understand;

- The types of accreditation programs currently available;
- How existing programs can apply to services provided in a range of different settings;
- How existing programs may apply to new or emerging services, or
- The capacity of accreditation providers to meet additional demand.

As a result, the DHA has been totally resistant to any constructive suggestion to improve the current proposal. Rather they are simply relying on health insurance companies (many of which are similarly ill-informed) to ensure services are of appropriate quality.

During the Committee hearing, Senator McLucas asked the Department why we could not bring 'off-the-shelf' systems that are available now through the ACHS or ISO.

In his response, Mr Maskell-Knight from DHA stated;

> *"I suspect that we do not know, from a departmental level, whether the framework exists for accrediting services which do not exist yet."*

This answer is interesting in light of earlier comments from Ms Shakespeare of DHA, who, when asked if services to be offered under Broader Health Cover are already available in the public system, responded;

> *"The services that are going to be available under broader health cover are probably in two main categories. The first category is hospital substitute treatments. Already most of those are available under MBS. In fact, in the draft rules we have defined hospital substitute treatments with reference to MBS items. So they are very similar to what is available under the public system. The other area of broader health cover is the chronic disease management programs. Again, there are already chronic disease management program items under the MBS—under Medicare."*

This advice appeared to be endorsed subsequently when Mr Maskell-Knight told the Committee;

> *"Firstly, broader health cover may result in services moving around and it may result in some services now being made available through the public sector being paid for through health insurance rather than through public sector funding. But I do not think we are going to create services or the demand for services that is not currently there."*

So on one hand, DHA is saying that the majority of services to be funded under BHC already exist and they don't expect it will create services. On the other hand, they can't impose an accreditation framework because they do not know what services will emerge!

What is not acknowledged or perhaps even recognised by DHA is that all the services envisaged to be provided as hospital substitute services (and available under the MBS) are currently provided in-hospital and are subject to independent assessment of their safety and quality. APHA is merely calling for the same safeguards to apply to the same service – regardless of location.

In relation to the timing of the introduction of quality requirements, Mr Maskell-Knight explained;

> *"The government took the decision to have July next year as the date, to allow us to work with potential service providers, with existing service providers and with professionals to work out a system that would be workable and sustainable— without having the doors of accreditation institutions beaten down by 1 April with everyone trying to get themselves at least on the first step to accreditation."*

Assuming this statement is correct (see below), surely a more suitable approach would have been to establish if the current system was "workable and sustainable" and to establish the capacity of accreditation providers to meet demand, rather than taking 15 months to re-invent the wheel.

A matter of minutes later, when specifically asked what the government's rationale was for the 15 month delay in introducing the quality requirements, Mr Maskell-Knight said;

> *"I am not sure. I would have to go back to the press release to see what the— "*

For the record, there was no rationale for the 15 month delay provided in the Minister's media release or in the accompanying fact sheets.

When attempting to explain what would happen in the period before 1 July 2008 if new services did emerge, the DHA's lack of understanding was obvious, when Mr Maskell-Knight said;

> *"As diabetic management services emerge, I imagine they will go to the Australian Council of Healthcare Standards, who will say, 'How do we accredit people like you?' I don't know that there is a framework out there.*

DHA "*does not know that there is a framework out there*" because they have made no attempt to find out. Had they done so, they would have discovered existing accreditation systems would cover services such as diabetes management.

Notwithstanding the fact that DHA don't understand the current system, they are expecting health insurance companies to insist on accreditation before July 2008. For example, Mr Maskell-Knight said;

> *"There will not be external accreditation necessarily available, but if there is I am sure they* (the health funds*) will say, 'Well, you can go and get yourself accredited; why don't you go and do that before we start paying our contributors' money to you?'*

Unfortunately, this expectation runs counter to the statement from Dr Armitage of AHIA who does not think that external accreditation should apply, even if it is available (see previous).

A further excuse used by DHA to resist the APHA recommendation is that the Australian Commission on Safety and Quality in Healthcare is currently undertaking a review of healthcare accreditation arrangements, so it would be inappropriate to impose any requirements prior to the finalisation of this review.

When responding to a question about why (particularly if stakeholders were happy) the accreditation framework could not be implemented earlier than proposed, Mrs Hancock from DHA told the Committee;

> *"And we would not wish to pre-empt the work of the Australian Commission on Safety and Quality in Health Care. The accreditation work is presently under way and that will likely form the basis of the standards which will eventually be put into the rules."*

This argument is disingenuous. Simply imposing a requirement that, to be eligible to receive health fund benefits before 1 July 2008, in no way impinges on the implementation of whatever standards may be imposed following that date.

Indeed, if the review being conducted by the Commission does recommend changes to the current accreditation regime, depending on the nature of those changes, it is highly unlikely they will be implemented before 1 July 2008. This fact makes the introduction of an interim regime all the more important.

In its evidence to the Committee, APHA proposed that if its recommendation was not adopted, it would mean that a lower standard of quality and safety was provided in one location as opposed to another. If this was the case, patients should be fully informed of this fact.

When asked for a view on such a proposal, the DHA once again resisted any change to the legislation by arguing it would be unconstitutional. Mr Maskell-Knight explained there would be difficulties in mandating providers to do certain things;

> *"We have constitutional power over health insurance. We can make insurers jump through hoops and walk backwards down George Street wearing blue hats, but our power is insurance power; it is not physiotherapy power."*

This statement conveniently ignores the fact the government will be imposing a number of specific obligations (including a requirement for accreditation) on hospitals as a condition of receiving a Commonwealth provider number.

Furthermore, any programs provided under Broader Health Cover can only be done with the specific approval of a health insurance company. Therefore, if DHA's constitutional argument is correct, they could simply require health insurance companies to advise their members that a service they are about to access is not subject to third-party quality accreditation.

Conclusion

In the discussions about Broader Health Cover, much has been made of the fact that a range of services previously provided only in hospital can now be safely delivered outside of hospital. For example, in his Second Reading Speech on the Bill, the Minister for Health and Ageing stated;

> *"Broader health cover will apply to services that can safely be delivered outside a hospital and which substitute for or prevent hospital care. This will potentially include a wide range of services, such as dialysis and chemotherapy, allied health services and domestic nursing assistance."*

The safety of such services has been demonstrated by hospitals through hospital-in-the-home and other approved outreach services. These services are all accredited by independent, third party accreditation agencies.

What is envisaged by the Bill is for such services to now be provided by any provider with no legislated quality and safety provisions, at least for a period of 15 months.

It appears the Government is more concerned about ensuring that the new services envisaged under the Broader Health Cover reforms are available to the insured population without delay, rather than ensuring they will be delivered safely.