



*Seeking the Cure.
Providing the Care.*

Mr Elton Humphrey
Secretary
Senate Community Affairs Committee
Parliament House
Canberra 2600

Dear Elton,

Inquiry into the Private Health Insurance Bill 2006 [provisions] and related Bills

This brief submission is provided in order to assist the Senate Community Affairs Committee during its inquiry into the raft of Private Health Insurance Bills.

The Australian MS Longitudinal Study found that 70% of people with Multiple Sclerosis (MS) continue to hold private health insurance. This is at a much higher rate than the average Australian rate of 43%. The study also reports that this group of health fund members live on lower incomes than the Australian average.^[1]

People with MS hold on hard to their insurance, due to their need for choice of provider and access to better hospital (hotel) services when frequent hospitalisation is required. Living with a lifelong chronic, degenerative illness means that choice of, and guaranteed access to, hospital is of great importance.

However, the rising cost of premiums under the current private health insurance arrangements has not delivered any additional value for this group of members.^[2] It should be noted that over 80% of disease management in MS occurs in the community.

MS Australia welcomes the inclusion of hospital substitute services into the private health funds' suite of benefits. Nevertheless, it is of paramount importance that the funds give priority to the needs of the consumer or policy holder and apply high benchmarks when it

^[1] AMSLS Economic Impact of MS Working Party, Socio-economic Status of People with MS and Life Transitions Following its Onset, Working Paper no.3, MS Australia, April 2005,

^[2] Access Economics. (2005). *Acting positively: Strategic implications of the economic costs of multiple sclerosis in Australia*. Report for Multiple Sclerosis Australia, Winter 2005

comes to disease and disability management outside the traditional hospital environment. Consumer consultation and involvement are key to this approach, providing a much needed balance to the commercial interests of health professional associations.

The out-of-hospital model has the potential to improve certain elements of the system if it is well integrated into the funds' role in the public healthcare system.

Individualised funding and reimbursement for a range of services including: non PBS medications; equipment; case management and self management programs, will provide value to the consumer. Such programs also have the potential to provide a greater value-for-money return on the government investment in the health fund sector via the health insurance rebate.

We see these legislative changes as an opportunity to improve and complement existing public health and community care programs for people with a chronic illness.

In taking this view, we urge the Government to pursue efforts to make the private health system generally more affordable. It must also ensure that these changes are incorporated into improvements to the public health system.

Cost and value for money

The ongoing success of these measures will depend on a number of factors including: accessing the health workforce; intelligent management of resources by the funds; consumer participation in health-sector planning; and active interaction with the full range of health and community services sectors.

We consider that the continuing rise of premium costs forms the major threat to the reforms in the longer term.

Hospital substitute services instituted at the present time would allow customers to access a greater range of services and therefore would represent increased value at the current premium levels. This greater value will diminish relative to the overall cost of maintaining the insurance as those premiums rise in the future.

The question of value is one that will be answered by the behaviour of the funds. This will be evident in the design and application of new products, and the approaches of the funds to ensuring a wide range of options for people with chronic illnesses.

However, the introduction of substitute services will not solve the problems that health funds have had with cost control in their existing partnerships with hospital providers.

While this change will certainly have benefits for the funds, they will need to look to other provider sectors for delivery of a range of these services and not continue to rely on the same hospital sector providers for outreach services. In concert with this, government should continue to apply improvements to the public health system in order to ensure that this new group of services will be accessible to all.

Individuals' health management should not be determined by virtue of their financial status or ability to buy or maintain insurance.

Those health fund members with a progressive, degenerative condition, such as MS, lose their financial ability to maintain insurance coverage as their level of disability increases. In these circumstances, continuous vigilance of both the public and private systems is required to ensure continuity of care across the disease spectrum – even if members drop their insurance due to disease-created poverty.

Specific inclusions to the suite of hospital substitute services.

Our submission seeks to make three main points relating to:

1. Aids and equipment;
2. Case (Care) management; and
3. Health services for informal carers.

These issues are related to the fact that MS, like many chronic illnesses, is managed to the larger part within the community. The design and application of hospital substitute services must be able to cover services other than those purely of a medical or hospital nature.

1. Aids and Equipment

The definition of hospital substitute services includes *"services and goods intended to manage a disease, injury or condition."* This definition needs to expressly include aids and equipment as well as medical consumables and prostheses.

As it stands, the definition does not expressly refer to *equipment* although the drafters may have assumed that the current words cover disability equipment. This is an important point as the provision of aids and equipment to people with chronic illness is an essential part of preventing hospitalisation.

Items such as pressure mattresses, wheelchairs, cushions and air conditioning units are all items that can relieve MS symptoms and prevent untimely admission to hospital or shorten a potentially long, debilitating – and expensive - hospital stay.

As a case in point, air conditioning units may not appear to constitute medical equipment as the term is commonly understood. However, in the case of MS, heat intolerance can be a severely debilitating symptom of the condition which may only be managed through the use of air conditioning equipment.

In order to keep the health funds from further confusing existing equipment supply programs, new health fund product schedules should include a range of agreed items that can assist in preventing hospitalisation. This is one of a number of areas where the funds will need to consult closely with their policy holders, stakeholders and the provider sectors in order to develop good benefit policy.

Although there exist various State aid and equipment programs, there have been many instances in which people with MS have been forced into hospital while waiting for the supply of an essential piece of equipment from such a finite resource.

The funds need to be able to supply a limited range of equipment that falls into the *"prevention of hospitalisation"* definition. This would include the hire or purchase of items where there is urgency or where the immediate unavailability of equipment compromises the health of the individual. Clearly the reliance solely on the State programs would unnecessarily expose the funds as well as the individuals to risk.

Equipment such as pressure mattresses, scooters, hoists, and independent living aids for the home should be provided as required.

Other non-traditional equipment that is not provided through State schemes (such as air conditioners) should also be available where a clear health benefit can be demonstrated.

For this component, we would recommend the inclusion of the words *"aids and equipment"* within the definition of hospital substitute service in the legislation in order to ensure that there is no ambiguity about the scope of the definition.

2. Case (care) Management

In the context of managing chronic disease, expert case management is needed to navigate existing complex arrangements across health and disability systems.

If the best outcomes are to be achieved through the application of hospital substitute services, then the health funds must be able to provide/purchase care management services that can interact with both the public health and community care sectors.

The Committee is well aware of the difficulties people with chronic illness are faced with when attempting to access public aid and equipment schemes. The Committee is also aware of the variable quality and effectiveness of community case management.

Health funds share risk with policy holders who have a chronic illness, and may need to initiate service episodes where necessary. In some instances this would require an episode of case management where none currently exists. Alternatively, it may require the provision of specialist equipment to prevent hospitalisation - even if it is to short circuit long waiting times and product restrictions in the public/State aids and equipment systems.

The flexibility to intervene across the care/case management spectrum must be made explicit in the legislation. If funds are forced to rely on parts of the public system that are already stretched and of uncertain quality, then they will not be able to effect the best outcome for their members.

MSA recommends that specialist case management for people with chronic illness should be obtained from specialist community providers who already work in and have comprehensive knowledge of the public health and community care systems.

3. Health services for informal carers

The role of carers and families in the management of chronic illness and disability has been both well recognised and documented in recent years. In the case of MS, the replacement cost of informal care comprises nearly half of the direct cost of the disease in Australia. Access Economics reports that unpaid carers provide an average of 12 hours care per week to people with MS. This is a significant burden.

In terms of disease management, families provide important support and care that needs to be supported by every health care sector. The introduction of hospital substitute services will see people go home earlier from hospital – and their families will be a vital component of the home care episode and follow up management.

Across the disease cycle, families provide varying levels of support. However, in the early stages of the illness they often do not identify as a carer and so do not engage with the carer support programs provided by the Commonwealth and State Governments.

The health funds can provide targeted health related carer supports that can be an introduction to the broader carer network for these members. In the same way that the funds will need to integrate their new benefits with the public healthcare system, they also need to engage with the carer movement.

The health funds are well placed to support family carers of people with chronic illness because they offer family policies. The range of self management and health promotion activities that are promoted to individual members should also be offered to carers.

It is worth noting that the burden assumed by many informal carers can result in negative health outcomes for those individuals. These outcomes can include physical injuries, such as a back condition triggered by moving a family member with limited mobility. In addition, mental health problems may also arise in response to the stress associated with chronic illnesses – uncertainty about their family member's declining health, concern over financial strains and fears of inadequacy in their role as carer may also be brought to bear.

It is in the interests of the health funds to put in place mechanisms to deal with such instances and thereby prevent a chronic disease state developing in the carers, especially where such conditions would exert greater pressure on the funds' resources.

The Committee may wish to refer to the recent MS Australia submission to Commonwealth/State Disability Agreement for examples and discussion about aids and equipment, carers and case management that are pertinent to the design of out of hospital services. ^[3]

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^[3] MS Australia (2006) Submission to the Community Affairs Committee Inquiry into the Operation of the Commonwealth/State and Territory Disability Agreement.

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