31 January 2007

Committee Secretary
Senate Community Affairs Committee
Department of the Senate
Parliament House
CANBERRA ACT 2600
Email: community.affairs.sen@aph.gov.au

Private Health Insurance Bill 2006 [provisions] and related Bills

Dear Committee Secretary

Please find below a submission from CHA in relation to the above Bills.

Please accept our apology for the late submission.

If you require any further information please contact Patrick Tobin on 0418 251 509 or myself on 02 6260 5980 or email: franciss@cha.org.au.

Yours sincerely

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The Catholic health, aged and community care sector

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Private Health Insurance Bill 2006 [provisions] and related Bills – CHA submission

Catholic Health Australia (CHA) broadly supports the thrust of the provisions contained in the Private Health Insurance Bill 2006.

CHA's approach to private health insurance reform is set out in a Position Paper, which was released late last year - a copy of which is provided as an attachment for information.

CHA cautiously welcomes the Government's move to broader health cover on the basis that privately insured patients will potentially be able to receive funding support under hospital tables for the more comprehensive treatment of their medical conditions - whether as an admitted hospital in-patient or whilst remaining in the community. The benefits of extending private health insurance cover to outside the hospital environment are seen to include:

- enabling provision of funding for privately insured patients to be treated in the most appropriate setting;
- reflecting the contemporary understanding of optimal health care delivery (as care which takes place along a continuum from prevention and primary care management through to acute care); and
- making health insurance more attractive.

CHA also welcomes the extension of cover to preventive health programs.

The extension of private health insurance coverage beyond hospital based treatment does however raise a number of concerns. These include the risks that:

- cost-cutting by health insurers may become a major determinant of the services for which a patient can receive funding support;
- possible reductions in safety and quality standards may occur where services that are normally best performed within a hospital are undertaken in a non-hospital setting; and
- the risk that the existing health insurance funding pool is stretched ever more thinly – to the point that existing service providers including hospitals are not able to be adequately funded.

In relation to the Bill which has been introduced into the Parliament, we would make the following general observations.

Firstly, much of the detailed operation of the new arrangements will be contained within the Rules which are still being drafted and have yet to be released. CHA's ultimate approach to the legislation will depend on the final form of the Rules.

Secondly, CHA takes the view that the definition of hospital treatment contained within Clause 121-5 of the Bill should be broadened to also include the provision of goods or services that are intended to prevent a disease, injury or condition.

A number of Catholic hospitals have advised that they currently provide a range of services that could be characterised as preventive. These include services such as diabetes education classes, mental health, drug and alcohol outreach services. Other

hospitals have indicated an intention to commence such services. Not all of the participants in these types of programs would necessarily sustain a diagnosis of having a disease, injury or condition but they may be at risk of developing a disease, injury or condition.

The paper does not make it totally clear how some of the services that are currently, or may potentially be, provided by hospitals fit within the legislation.

Take for example the case of a mental health patient who is participating in a hospital in the home program.

The requirement that the treatment provided under a hospital in the home program must be a substitute for treatment that would otherwise be provided in the physical hospital requires that the patient be suffering a sufficient degree of severity of illness that would require hospital treatment. For a mental health patient this may imply that they may need to be seen by a psychiatrist on say at least two occasions per week together with ongoing support from hospital psychiatric nursing and/or hospital in the home clinical staff.

A patient who falls just below this threshold and who could be prevented from deteriorating to the point where they become eligible for hospital or hospital substitute treatment from say one visit per week by a psychiatrist, together with the ongoing support from hospital psychiatric and/or hospital in the home clinical staff would presumably not be able to be covered under hospital treatment (but could be covered under general treatment from a non-hospital provider). The reality is that a mental health patient may vary in the degree of severity of their illness and regularly and repeatedly cross the line of eligibility/non-eligibility for hospital treatment. It would make more sense for that patient to able to be able to maintain continuity of provider and if that provider is the hospital then that should also extend to preventive treatment.

As the intent of the legislation is to prevent and minimise the need for patients to be admitted to hospital, it should not matter whether a provider of preventive services is a hospital or another provider altogether. CHA would therefore support a change to Clause 121-5 in the Bill to include the provision of goods and services by hospitals that are intended to **prevent** as well as manage a disease, injury a condition.

Thirdly, CHA is disappointed that uniform safety and quality standards for privately insured services will not become part of the regulatory framework until 1 July 2008. We recognise the intention of the Department in the interim period is to ensure that providers of hospital substitute treatment, chronic disease management programs and ancillary services will be required to meet the provisions of relevant State or Territory laws or will be required to be a member of a professional association with uniform national registration requirements.

It will be important that these requirements are codified.

Nevertheless, given the lack of uniformity in State and Territory laws in this area, there remains the risk that even if these requirements are complied with there may still be gaps in the interim period. This issue remains a concern due to the financial interest that health funds have in preferentially funding non-hospital providers who may offer hospital substitute services at lower cost achieved through reducing the safety and quality standards that hospitals are required – and chose to - operate under. Whilst most health

funds will be keen to only contract with high quality providers, this cannot be guaranteed across the whole industry in the absence of clear regulatory guidance.

Finally, given the very significant change to the regulation of private health insurance that is envisaged with this legislation, CHA considers that it would be prudent to conduct a review of the impact of the changes sometime in 2009.