Catholic Health Australia

Private Health Insurance Reform

CHA Position Paper on the Scope and Coverage of Private Health Insurance in Australia

Introduction

The Commonwealth Government has recently announced its intention to amend the regulatory regime that covers private health insurance. One of the key components of the announced changes is the move to widen the scope of coverage of private health insurance hospital cover to include services delivered in an out-of-hospital setting – termed "broader health cover".

This paper aims to set out Catholic Health Australia's (CHA) view as to how private health insurance coverage should operate for the benefit of privately insured patients.

CHA is Australia's largest grouping of non-government health, aged and community care providers. Further details of CHA, its membership and foundational principles are provided at Attachment A.

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.

It is the intention of this paper to set out the principles that CHA considers should underpin the scope and operation of private health insurance coverage in Australia. Each of the principles is then considered in more detail.

The paper does not seek to address the issues relating to the incentives for purchasing private health insurance – which have been previously set out in other CHA publications including CHA's Submission to the Inquiry into Health Funding

currently being undertaken by the House of Representatives Standing Committee on Health and Ageing, Submission to the Productivity Commission Inquiry into Ageing (available at http://www.cha.org.au or http://www.aph.gov.au/house/committee/haa/healthfunding/subs/sub035.pdf).

The paper also does not cover CHA's views in relation to the funding of the public health system, which we maintain must continue to be adequately funded to meet the health needs of those who are not privately insured.

Proposed CHA Principles for Determining Scope of Private Health Insurance Coverage

- Private health insurance funding should facilitate the provision of care in the most appropriate setting based on the patient's particular clinical needs;

- Private health insurers **must not** determine where treatment takes place nor the type or extent of treatment – these are clinical decisions for patients and their clinical advisers to make;

- Safety and quality **must be** paramount;

- Health insurance funding can and should play a constructive role in encouraging member participation in effective prevention programs;

- Health insurance funding can and should play a constructive role in encouraging member participation in effective disease management programs

- Effective stewardship of resources requires treatment to be evidenced based and underpinned by sound data;

- Funding models need to be sustainable (for both payers and providers) and should have regard to cost-effectiveness; and

- The operation of private health insurance should be systematically evaluated on a continuing basis to ensure that patients continue to have access to clinically appropriate treatment and prevention services that are both safe and affordable.

Each of the above principles will now be addressed in turn.

1. **Private health insurance funding should facilitate the provision of care in the most appropriate setting based on the patient's particular clinical needs**

CHA considers that health care should be provided in the most clinically appropriate setting – one that maximises the health outcomes from the patient's perspective.

Under the current regulatory environment, funding under hospital tables has been limited to admitted in patients of a hospital. The development of medical technology in recent years has significantly shortened the hospital stay required for many medical

procedures. In the private sector approximately 64% of hospital episodes now take place on a same day basis

A number of treatments such as dialysis or chemotherapy that previously needed to take place within a hospital can now, in certain circumstances, safely take place in other settings. Additionally some components of the hospital episode of care can now occur in other settings - particularly in the period after the conclusion of the major intervention. For example ongoing wound management following surgery or recovery following a birth can be undertaken under "hospital in the home" type arrangements. The current reinsurance arrangements also discourage health insurers from offering financial assistance for services delivered outside the hospital setting that can assist the patient's recovery and ongoing disease management. For example participation in a diabetes education program following a hospital stay would benefit the patient and reduce the likelihood of the need for readmission to hospital. Some Catholic hospitals provide these service notwithstanding the lack of funding support.

As funding support for treatment is currently tied to patient admission status, it may be that there are perverse incentives for some patients to remain in a hospital setting regardless of whether or not it is the most appropriate one for them to be in.

Provided that treatment is taking place in an effective, safe and cost-effective environment that meets the requirements and preferences of the patient and their treating clinician, the existence or otherwise of private health insurance funding should not be the determining factor as to where treatment takes place.

2. Private health insurers must not determine where treatment takes place nor the type or extent of treatment – these are clinical decisions for patients and their clinical advisers to make

Funding mechanisms should facilitate the provision of the optimal type and level of treatment in the most appropriate setting. Just as it would be inappropriate for health insurance regulation to encourage admission to hospital in order to attract funding for a particular treatment that could be safely undertaken out of hospital, neither should there be strong financial incentives for treatment to be provided in a sub-optimal setting just because a health fund has managed to negotiate a cheap package with a low-cost provider.

Under the US managed care system, health fund staff can have a determining role as to whether a health fund member can receive treatment, the type and quality of treatment they may receive, where the treatment would be carried out and prior steps that must first be undertaken to access treatment. Meeting budgetary targets is an over-riding factor in this decision-making process. This approach has been strongly resisted in the US and would not be acceptable in the Australian environment.

Australian health funds are currently prevented by legislation from interfering in clinical decisions. Additionally the existence of a universal public health system, where patients can access treatments free of charge at the point of service, provides an alternative that to a significant degree restricts the ability of health funds to be overly prescriptive in limiting patients' treatment options. Health insurers have no place in

determining treatment and any changes to private health insurance regulation should not compromise this principle.

3. Safety and quality must be paramount

One of the more significant risks for private patients under broader health cover may occur where services are moved from a hospital setting to another setting with lower standards of safety and quality. For example, hospitals impose accreditation and scope of practice limits on practitioners who work in their facilities, which are over and above the requirements of State/Territory legislation. Hospitals also impose strict infection control standards and policies; and have rigorous incident reporting and management protocols.

Under broader health cover, it would be possible for a medical practitioner who meets minimum qualification standards to set up in competition with a hospital and offer health funds a service at a lower cost. The lower costs could well come at the expense of the high quality and safety standards that apply in a hospital.

The health industry has not been without examples of highly entrepreneurial providers in the past. A less regulated environment could provide an opportunity for very aggressive entrepreneurial providers not averse to cutting some corners joining up with some health funds seeking to cut their own costs. In such an environment patients can be significant losers.

Safety and quality standards can also be inadvertently lowered even if it is not the deliberate intention of a health fund, for example, where services are moved from a hospital with a high volume of a particular procedure, state of the art equipment and full emergency back-up to a facility which has less volume and older equipment and less ability to provide back-up in the event of an adverse outcome.

CHA supports the implementation of minimum, uniform quality and safety standards - although care will be needed to ensure that existing standards are not compromised whilst, at the same time, the regulatory burden is not unnecessarily added to. It is imperative that health and hospital services are involved in the development of the detail of this aspect of the changes. CHA remains concerned that the quality and safety framework will not be implemented for up to twelve months following the regulatory changes.

4. Health insurance funding can and should play a constructive role in encouraging member participation in effective prevention programs

As with society at large, private health insurance members face the prospect of developing a range of chronic diseases associated with modern lifestyles. Changes to lifestyle and/or participation in effective preventive programs can reduce the likelihood of developing some debilitating chronic illnesses.

CHA considers that encouraging people to appropriately participate in such programs is positive for fund members who may be able to maintain a higher level of health status; health funds themselves; as well as other health insurance fund members whose premiums may be lower than they might otherwise have been. Where there is

clear evidence of the efficacy of these types of programs, expenditure on them should be regarded by health insurers as an investment that will result, over time, in lower future claims than might otherwise have been the case.

The ability to fund prevention programs could be used by some health funds to get around community rating principles by offering highly attractive financial incentives for general lifestyle products or services, which have only a distant relationship to prevention, that would be disproportionately attractive to lower risk members. Such a strategy is ultimately likely to be a zero sum game (there are only so many young fit people in the population) and does not really contribute to "genuine" programs to improve the health status of the insured population

In order to maintain the integrity of the community rating principle and to discourage unproductive gaming by health insurers, CHA contends that funding and access to the risk sharing pool should be restricted to preventive programs that can be shown to have a close relationship to improving the health status of the individuals receiving support. This would be the case where a patient is being managed by their GP to participate in, for example, a weight loss or quit smoking program.

A list of evidenced based approved preventive programs should be developed by a "National Eligibility Committee" with representation from all private health stakeholders – this will be further addressed in the section on CHA's proposal for industry governance arrangements.

5. Health insurance funding can and should play a constructive role in encouraging member participation in effective disease management programs

Participation in effective disease management programs can improve patient outcomes and prevent (or delay) the need for future hospitalisation. Many patients with chronic illness encounter difficulty in participating in or maintaining their treatment regimes. There are many reasons for this difficulty ranging from lack of motivation, difficulty in accessing medical staff, through to economic constraints.

Whilst a patient's primary source of health care advice and management should be provided by their doctors, health funds can play a supplementary role in providing potential financial support and encouragement for participation and continued involvement in disease management programs. Health insurer support could be provided in various ways. For example, it could be provided in the form of a financial subsidy to enable a member to participate in the program or it could be a program run or funded directly by the health insurer. To avoid potential abuse, CHA considers that health insurance benefits for chronic conditions should require a referral from the patient's treating doctor.

Health funds may also have the resources to work closely with their members as they access their programs and could follow-up with members if they encounter difficulty in staying on the program. This would be a valuable service given that Australia does not perform as well as some other Western countries in ensuring that patients with chronic illnesses are followed up to ensure they are continuing to conform to the

requirements of their treatment programs[1].

Health funds could also use their knowledge of their members' use of "sentinel" medical procedures to flag the existence of a chronic disease in order to offer them the opportunity – provided the patient's doctor agrees - of joining a program which may assist in improving the medical condition or at least preventing further deterioration. For example a patient who has received treatment for a heart attack or chronic artery disease could be followed up by the health fund to provide ongoing assistance with diet, exercise etc. Again the patient's usual doctor should be closely involved in this process.

A recent presentation by Bernard Tyson, Senior Vice President of US health fund Kaiser Foundation Health Plan to the Australian Health Insurance Association indicated that around 6% of members of that health plan with multiple chronic conditions accounted for 30% of benefit payments. It is little wonder that health funds are attracted to the idea of working more effectively with that group to ensure their conditions are well managed.

It should be noted however that there is considerable evidence in the literature that a greater focus on a "disease management" approach (which presumably includes patients' use of services provided outside the hospital setting) does not necessarily decrease health expenditure and may indeed increase it[2]. Nevertheless to the extent they do lead to better health outcomes, they are supported by CHA.

6. Funding models need to be sustainable (for both payers and providers) and should have regard to cost-effectiveness

Private health insurance in Australia is a voluntary product which competes with the taxpayer funded public health system whose services are largely provided without charge at the point of delivery.

The operation of the Community Rating Principle (which CHA supports), in an environment where most health care is used by members over 55 years of age, means that the majority of contributors pay higher premiums than their own individual risk profile would otherwise justify.

This means that premiums health funds can charge will remain a sensitive issue and health funds need to ensure their contributors are able to gain value for money.

On the other side of the ledger, patients expect hospitals to be there when needed and to provide the highest standards of quality, safety and amenity. Hospitals are subject to cost pressures that generally rise faster than CPI. These include wages for nurses and other clinical staff, medical equipment, devices and consumables and pharmaceuticals.

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[1] C Schoen et al., "Taking the Pulse of Health Care Systems:Experiences of Patients with Health Problems in Six Countries," Health Affairs, 3 November 2005

[2] B Fireman et al, "Can Disease Management Reduce Health Care Costs By Improving Quality?", Health Affairs 23, No 6(2004): 63-75

CHA supports the need for hospitals to continue to improve efficiency, however, to the extent that hospitals do not gain funding adequate to cover the costs of essential inputs, they become unable to maintain the investment required to offer the services that the insured population expects.

7. **The operation of private health insurance should be systematically monitored and evaluated on a continuing basis to ensure that patients continue to have access to clinically appropriate treatment, disease management programs and prevention services that are safe and affordable**

Allowing health funds to cover services in a broader range of settings will take place in a less regulated environment than has previously been the case.

Given the substantial public investment in private health insurance through the operation of the 30% rebate, together with the wider public interest in the health care that is provided to the privately insured population, CHA considers it would be appropriate for health funds to be required to report to the Private Health Industry Administration Council (PHIAC) on a quarterly basis for each of their out of hospital products, including details of the general nature of the service, volume of services and the benefits paid – these reporting requirements would be additional to those that already apply in respect of their existing reporting requirements. Reporting arrangements should also provide information on the clinical effectiveness and cost effectiveness of out of hospital services – so that it can be clearly shown that services provided as part of, in substitution for or prevention of hospital care are actually doing what they claim.

This data should also be publicly available consistent with current arrangements and will enable industry as well as consumers to highlight at the earliest opportunity any developing problems with the new arrangements.

Other Matters

Industry governance arrangements

The introduction of such broad changes within a relatively short time frame may potentially result in unforeseen and possibly unintended consequences.

In order to minimise the potential adverse impact for both the insured population as well as the population at large, CHA suggests that the introduction of the proposed reforms are accompanied by the establishment of an oversighting committee – the National Eligibility Committee - comprising representatives from each of the stakeholder groups which would develop criteria for providing coverage, approve types of services to be covered, monitor the impact of the changes and provide a sounding board should any unforeseen consequences which may arise.

Economic Impact on Hospitals of Private Health Insurance Reform

Depending on the approach taken by health funds, the potential for the dilution of funding across a wider range of providers could impact particularly hard on hospitals and may render some hospital services non-viable. Funding for medical gaps had the effect of significantly reducing the proportion of private health insurance benefits that were paid to hospitals – these proposals may well have a similar impact. Indeed to some extent that is the intention.

Of concern have been comments by some stakeholders in the industry consultative forums to the effect that a significant underlying driver of the reforms – particularly the move to broader health cover - has been a more rapid increase of private health insurance premiums as compared to health inflation. CHA contends that whilst expenditure on health care needs to be undertaken with prudence and premiums kept affordable, cost minimisation must not become the sole measure of success.

As highlighted in the submission by the AHIA to the current House of Representative Inquiry into Health Funding[3], there are a number of factors contributing to a more rapid increase in health insurance premiums. These include: the ageing of the insured population, increases in volume of services provided, increases in the costs of medical technologies as well as cost increases associated with nurses.

CHA considers that these factors will necessarily continue to operate and continue to result in premium increases in excess of normal CPI and health inflation. Indeed the Australian experience of private health insurance premiums increases that average under 5% per year since 2000 compares favourably with the US record of over 11% in the same period. General inflation levels in the US have been 3.6% per annum over the same period - meaning that health insurance premiums in the US have been rising at more than three times the rate of inflation.

Providers in Australia should be recognized for delivering a high quality health system with only modest price increases rather than being the objects of implicit and

[3] Submission No 16, House of Representatives Standing Committee on Health and Ageing *Inquiry into Health Funding*, accessed at http://www.aph.gov.au/house/committee/haa/healthfunding/subs.htm 8 July 2006

explicit blame. Certainly, given the cost pressures facing many providers, there is little scope for reducing their revenues without negatively impacting on their ability to provide the care expected by privately insured members.

CHA also notes that the reform proposals allow health insurance funds to become general insurers – at their request. It would be natural to expect that over time those health funds moving to become financial institutions are likely to move focus from health care to the provision of more general financial products.

CHA takes the view that the management of health care needs should be undertaken by organisations that are health care experts – not primarily financial services organisations.

CHA contends that the primary driver of the reforms should be added value to private health insurance members. "Value" in this context should be defined in its broad meaning – that is at least an equal focus on what the member receives from the product by way of its scope, depth of coverage and contributions to health outcomes as there is on the cost of the product.

In summary, CHA cautiously supports the thrust of the proposed changes but remains alert to the prospect of adverse unintended consequences arising from the proposals. As the implications of the changes become more apparent – particularly at the level at which services are delivered, CHA will further develop its advocacy position.

Attachment A

About Catholic Health Australia

Catholic Health Australia (CHA) is the largest non-government provider grouping of health, community and aged care services in Australia, nationally representing Catholic health care sponsors, systems, facilities, and related organisations and services.

Through its encompassing ministries, the Catholic health, community and aged care sector touches the lives and encounters the hopes, aspirations, struggles and difficulties of many Australians on a daily basis. The Catholic health ministry is broad, encompassing many aspects of human services. Services cover aged care, disability services, family services, paediatric, children and youth services, mental health services, palliative care, alcohol and drug services, veterans' health, primary care, acute care, non acute care, step down transitional, rehabilitation, diagnostics, pathology, preventative public health, and medical and bioethics research institutes.

The sector takes seriously its responsibility to be a voice for the disadvantaged as well as an advocate for a just, equitable, compassionate, excellent, secure health system that is person-centred in its delivery of care. The sector continually espouses to government and the Australian community, the value of health care as an essential social good, not merely a commodity that is used to maximise return on investment to meet the economic interests of private shareholders.

The Catholic sector includes:

73 hospitals:

- 53 private hospitals and 20 public hospitals
- approx 6,200 hospital beds in the private sector (representing 25% of the private hospital sector)
- approx 2,500 hospital beds in the public sector (representing 5% of the public hospital sector)
- 7 teaching hospitals
- 8 dedicated hospices and palliative care services.

Approximately 485 Approved Aged Care Services:

- 18,100 residential aged care beds (11.6% of the total residential aged care sector)
- 4,788 Community Aged Care Packages and thousands of people assisted through the Home and Community Care (HACC) Program and other community care support (17% of the community care sector)

- the Catholic sector is the largest church based sector in Australian aged care delivery across both residential aged care and community care.

Catholic hospitals and aged care facilities are located in each Australian State and in the ACT.

CHA Comments on Other Components of PHI Reform Proposals

CHA strongly supports the simplification of the legislation and underpinning regulatory instruments. It is important that all private health stakeholders are able to readily gain a clear, accessible and unambiguous understanding of their statutory obligations.

The changes to Lifetime Health Cover will have varying impacts. Although weakening the financial incentives for those below 31 years of age to take out private health insurance, the proposed changes will reduce the disincentives to taking out private health insurance for those over 31 years of age who may consider that they had 'missed the boat' and may never have taken out private health insurance membership. **On balance CHA considers the proposed changes to Lifetime Health Cover to be a net positive** – although any impact on the age profile of the privately insured population will need to be closely monitored.

The adoption of uniform quality and safety standards is welcomed – although care will be needed to ensure that existing standards are not compromised whilst, at the same time, the regulatory burden is not unnecessarily added to. It is imperative that health and hospital services are involved in the development of the detail of this aspect of the changes.

Regulating the compliance of products rather than funds should enable more effective regulation. It is obviously easier to enforce compliance in relation to a particular product than threatening to de-register an entire fund, a sanction that is unlikely to be used except in extreme cases given its draconian nature and adverse impact on contributors.

CHA supports the requirement for the provision of standardised product information by each fund, which should enable consumers to make more informed choices about the range of health insurance products on offer.

CHA also supports any measures that can improve the provision of financial information to patients prior to their undertaking a medical procedure which might involve the payment of out-of-pocket costs. Catholic hospitals are committed to ensuring that this information is available in relation to hospital charges. However it is unrealistic to expect hospitals to be held accountable for any out of pocket costs charged by other providers over whom they have no control and whom they do not employ. It is doctors who control the flow of patients to a particular hospital – hospitals do not control the flow of patients to a doctor. **CHA strongly opposes any move to impose on hospitals requirements that they take responsibility for provision of medical IFC** – an obligation that rightly falls on the parties who actually provide a service for which their charging.