Mr Elton Humphrey
Committee Secretary
Community Affairs Committee
Department of the Senate
PO Box 6100
Parliament House
CANBERRA ACT 2600

Dear Mr Humphrey

Inquiry into Private Health Insurance Bill 2006 (provisions) and related Bills

I am writing to forward to the Inquiry the NSW Minister for Health's recent submission to the Australian Government on the above matter, and to request its consideration by the Community Affairs Committee.

NSW Health has only recently become aware of this Inquiry and I am advised that the Committee formally invited private health sector stakeholders to forward submissions. It is difficult to understand why the Committee has overlooked the public health sector as an important source of advice on this matter, given that the public health system is a significant provider of services to people who choose to use their private health insurance. There is no doubt that the legislation will have significant implications for the public health system in Australia.

The attached submission was prepared in response to the first Draft of the Bill. I understand that the second Draft contains amendments seeking to protect clinical autonomy.

I am also advised that transition arrangements for existing recognised Outreach services will be extended until July 2008. However while a longer timeframe is welcomed, this does not address the core issues associated with the provision of these types of services. There are a number of sentinel issues that continue to be of concern in the second Draft of the Bill. These are detailed in the attached submission and include:

- The ability of the public sector to provide these new services to privately insured patients
- The ability of privately insured people to choose their service provider
- The potential impact on the health workforce
- The incorporation of a payment mechanism that reflects the cost of service provision for the public sector in the absence of a contract with a private health insurance fund
- Clear provision for the retention of a patient's right to elect to use their private health insurance at public hospitals
- Enhancing patient access to privately insured services in rural areas and in areas where the public sector is the only provider
- Ensuring that PHI is aligned to the type of care rather than the site of care and in particular, using the reforms to help address the imbalance between the provision of public and private emergency services

NSW HEALTH

SUBMISSION FROM THE NSW MINISTER FOR HEALTH

EXPOSURE DRAFT
PRIVATE HEALTH INSURANCE BILL 2006

NOVEMBER 2006

CONTENTS

1. EXECUTIVE SUMMARY

NSW has been a longstanding advocate of the need to change the rules surrounding private health insurance (PHI) so that PHI funding arrangements support contemporary models of care. Accordingly, NSW is generally supportive of the thrust of the PHI reforms. There is obvious merit in the concept of extending PHI coverage to services that substitute for inpatient care and prevent hospitalisation, as well as strategies to improve consumer knowledge including the potential to improve informed financial consent and provide standard product information, and the retention of Community Rating.

There is mutual benefit in ensuring that all stakeholders (including all governments, service providers across all sectors, consumers and funders) work together to ensure that the results of the PHI reforms along with PHI arrangements generally, optimise outcomes for patients as well as support the provision of contemporary, effective and efficient health care.

NSW is concerned at the apparent lack of understanding or acknowledgement by the Australian Government that, for a number of years, the NSW public health sector has been providing care in the settings to be covered by the PHI reforms. Examples of this care include:

- a significant investment in Community Acute/Post Acute Care (CAPAC) (which incorporates Hospital in the Home programs) and other programs which cover a diverse range of health services including post-operative care, the provision of IV antibiotics for infections, facilitating early discharge of women who have had babies, the provision of home renal dialysis, and the management of acute respiratory and cardiac conditions.
- the substantial range of services, including chronic disease management, provided to people in their homes by NSW Primary and Community Health staff
- provision of many services such as chemotherapy on a non-admitted basis.

These flexible and appropriate models of care have benefited both patients and private health insurance funds. These evidence based arrangements are driven by the need to optimise patient outcomes by providing care in the most appropriate setting. They have reduced expenditure by the Funds by reducing the amount of time patients spend in more costly acute public and private hospitals. In 2004/05 the NSW CAPAC program reduced the average length of stay in hospital by 2 days per patient. In addition to providing services to public and private patients in public hospitals, many of these public health services are caring for people who had inpatient stays in private facilities.

The NSW public hospital system is a significant provider of services to people who choose to use their PHI. According to the latest data from the Australian Institute of Health and Welfare[1] (AIHW), in 2004/05 NSW public hospitals provided around:

- 20% of the total hospital (private and public) separations funded by PHI
- 32% of the total bed-days funded by PHI

As a legitimate provider of health services to privately insured patients, NSW Health has an incontestable stakeholder interest in the proposed reforms. **NSW seeks confirmation from the Australian Government that the draft Bill will be amended to ensure that the reforms:**

- **will be pursued in a fair, transparent and accountable manner, using a "level playing field" approach that does not discriminate against public health sector**

[1] Australian Institute of Health and Welfare, Australian Hospital Statistics 2004/05

involvement, constrain the opportunities available to the public health sector compared with those available to the private health sector or in any way erode the existing important role of the public health sector as a provider of services to privately insured patients

- **will not diminish the primacy of clinical decision making**
- **will allow consumers choice of service provider and enhance access to privately insured services in rural areas and in areas where the public sector is the only provider. Confirmation of this commitment must include agreement to consider a suitable payment mechanism that reflects the cost of service provision.**

NSW remains committed to patient choice and wishes to work with the Australian Government to ensure that the reforms optimise outcomes for patients. The above specific assurances are sought by NSW in light of a number of concerns regarding the provisions of the draft exposure Bill. These concerns are summarised as follows:

- The approach taken by the Australian Government appears to be private sector centric with little if any consideration having been given to the legitimate and important role of the public health sector as a provider of health services to people with PHI. Potential consequences of this absence of consideration (whether deliberate or inadvertent) include further de-funding of public hospitals by the Australian Government. NSW wishes to ensure that the reforms do not financially or otherwise disadvantage the public sector in terms of its ability to provide services to people with PHI.

- Reinforcing the above point, it is noted that Commonwealth conditions contained in the current Australian Health Care Agreement (AHCA) impose constraints and limit the flexibility of the NSW public health sector to respond effectively to the opportunities presented by the proposed reforms. Taken at face value, this could suggest that the Australian Government is not interested in adopting a “level playing field” approach to the reforms.

- The combination of the erosion of clinical decision making in determining patient care, the transfer of power to Funds and a reduction or limitation in the choice of service provider will adversely affect patient outcomes. This will decrease the ability of people to elect to use their PHI in different settings and undermine the ability of patients to access services based on clinical need.

- The Bill does not contain robust provisions to ensure the primacy of clinical decision making in determining patient care. On the contrary, it appears to confer very substantial power on the Funds. Any Fund which abused this power could limit consumer choice and detrimentally limit service provider discretion. This potentially could jeopardise patient outcomes by subordinating the interests of individual patients to the interests of individual Funds.

- The Bill could operate to interfere with a patient’s right, reinforced in the AHCA, to choose to be either private or public. Further, the provisions potentially curtail private patients’ choice of service provider and transfer that prerogative to the health Funds. This could also undermine one of the fundamental rights of patients as set out in the AHCA – the right to access services based on clinical need.

- The Bill and the associated provisions have the potential to cut across the statutory responsibilities of states and territories in relation to patient safety, clinical quality and accreditation. The Bill also creates a potential conflict of interest between, on the one

hand, Funds' goals to minimise costs and on the other hand, consumers' and service providers' strong desire to ensure quality services.

- The effect of the draft Bill may be that the Commonwealth Minister is able to declare which facilities are hospitals for the purposes of receiving reimbursement for the treatment of privately insured patients against a yet unspecified set of criteria. This is a potentially significant and highly controversial change to current arrangements, and is strongly opposed by NSW. In short, compared to current arrangements, it would place at risk the ability of the public sector to provide services to people who wish to utilise their PHI.

- The proposed reforms are metro-centric. In many outer-metropolitan, rural and remote areas of NSW, the public health system is either the only health care provider, or the only provider of comprehensive health services across the continuum of care. Any erosion in the public health sector's role in providing services to privately insured patients would reduce access to required health care by people living in these areas.

- The apparent failure to address emergency department services in these reforms is a key missed opportunity to redress the imbalance in the provision of emergency services by the public and private sectors respectively. PHI arrangements should be aligned to the type, rather than the site of care.

- There is also a range of health workforce and patient access issues arising from the reform proposals. The Broader Health Cover provisions assume that there is sufficient health staff to provide the range of services covered. In reality there are significant national health workforce shortages in nearly all clinical areas.

2. INTRODUCTION

The purpose of this submission is to provide preliminary comments on the Exposure Draft of the *Private Health Insurance Bill 2006* ("the Bill"). This submission builds on the two recent submissions made by NSW Health in July and September 2006.

It is difficult to accurately assess the full impact of the draft Bill in a definitive way as the detail (for example Private Health Insurance (PHI) Business Rules) has not been released by the Australian Government. This submission provides advice on a number of possible interpretations and implications of the draft Bill and the policy framework of Broader Health Cover (BHC). Issues examined include:

- the inter-relationship between the reforms and the Australian Health Care Agreement
- the provision of Emergency Department services
- the possible impacts of Section 121-5 of the draft Bill on the provision and inclusion of public health services
- access to public health services by people with PHI
- impact on the role of PHI Funds and clinical decision making
- the consequences of mandating provision of Hospital Casemix Protocol data

Issues that require a response from the Australian Government along with recommendations are highlighted in "boxes" throughout this submission.

3. THE REFORMS AND THE AUSTRALIAN HEALTH CARE AGREEMENT (AHCA)

The NSW public health sector should be able to respond to these reforms in the same manner as the private health sector. Accordingly, NSW seeks confirmation that the Australian Government will:

- **not impose a compliance penalty on NSW if the operations of the AHCA are found to constrain the adoption of the reforms by the public sector**
- **not hinder any NSW Health plans or penalise NSW Health if as a result of the reforms the configuration of existing public hospital of other health services needs to change**
- **remain committed to Clause 38 of the AHCA which facilitates patient choice to be either private or public, and to the fundamental concept of access to services based on clinical need**

NSW is also seeking advice on how the Australian Government intends to manage:

- **the potentially perverse and costly outcome arising from the removal of a suitable payment mechanism for the provision of accredited Hospital in the Home services**
- **issues relating to the inter-relationship between informed financial consent, the AHCA and patients' ability to accurately predict their health costs.**

Discussion of Issues

A key issue is whether the new provisions will facilitate a level playing field between the private and public sectors.

To provide hospital substitutable services, the reforms will require providers to be sufficiently flexible to change the mix and location of services offered. The public hospital system is currently more constrained than the private sector in this regard due to limitations imposed by the AHCA with respect to changes in service mix, its narrow focus on inpatient (admitted) services and the ability to refer people to other services. Will access to the types of services covered by the reforms be denied to those privately insured people who may first come to the public hospital system for treatment?

If NSW does not secure contracts with Funds for the admitted component of BHC products where patients remain formally admitted to hospital but receive treatment at home and in the absence of any other payment mechanism, then it will be difficult to fulfil the obligation imposed by Clause 38 of the AHCA which states that patients are to be given a choice to be either private or public.

The AHCA limits the ability of patients to change their elected admission status. This means that unless there are extenuating financial circumstances, once a patient has elected to be private, they remain private for the relevant episode of care. Currently the existence of a specific Outreach (which includes hospital in the home services) default benefit means that private patients can access Outreach services as long as they hold hospital cover.

However in the absence of a default benefit (if it is to be abolished for Outreach services) and a contractual arrangement with Funds (who may choose other service providers), there will be no avenue for public hospitals to include private patients in Outreach services.

Perversely, this may result in Funds having to pay a higher inpatient fee than they otherwise would have if the patient had been able to access the Outreach service. Currently in NSW the accommodation rate for private patients in public hospitals is $269 per day for a shared room and $451 for a single room. The default rate for patients in an Outreach service is $162. It also needs to be noted that this effect may be felt by private hospitals as well because NSW public health services often cater for people who have been in private hospitals.

NSW remains committed to ensuring equitable access to public hospitals and health services, based on clinical need, for people who wish to utilise their PHI. The reforms put in doubt the ongoing commitment of the Australian Government to ensuring this access is maintained. With NSW public hospitals providing around 20% of all separations funded by PHI in NSW and in the context of the Australian Government's significant financial commitment to PHI, any move to reduce the access of privately insured people to public hospital services is of concern. This is further discussed in Section 7 below.

The AHCA contains numerous Clauses relating to informed financial consent. The draft Bill and its associated Guide as well as the Commonwealth's BHC Discussion Paper show that for some BHC services that substitute for hospitalisation, privately insured patients will essentially have a choice between either:

- claiming against their cover for BHC services involving a blended Medicare rebate and a fund payment; OR
- not claiming against their cover in which case the Medicare rebate payable will be 85% of the schedule fee and the patient's out of pocket costs for the professional service will count towards the extended safety net.

This is potentially confusing for the patient and will not improve informed financial consent. For example, how will patients accurately predict what their out of pocket Medicare costs will be (and therefore when they will reach the safety net threshold) given that it is often not possible to anticipate what health services will be consumed over the 12 month period that applies to the safety net?

4. EMERGENCY DEPARTMENT (ED) ATTENDANCES AND EMERGENCY ADMISSIONS

NSW recommends that the Australian Government:

- **Ensures that PHI is aligned to the type of care rather than the site of care**
- **Uses these reforms to address the balance between the provision of private and public emergency services**

NSW seeks confirmation/ advice concerning:

- **whether services provided in an ED are included in the PHI reform provisions**
- **the distinction between ED services and similar BHC services provided as substitutes for hospitalisation**
- **whether in relation to ED services, the public health system will be able to pursue the provision of hospital substitute services in the same way as the private sector, given constraints in the AHCA**

Discussion of Issues

The draft Bill does not specify whether EDs are included in the definitions of hospital treatment or hospital-substitute treatment. One of the stated aims of BHC is to introduce products that cover services that are part of a hospital episode or prevent or substitute for hospitalisation. NSW Health maintains that some ED services clearly fit within the scope of BHC.

It is assumed that the Australian Government shares NSW's interest in ensuring that PHI is able to respond comprehensively and systematically to changes in models of health care. To avoid further fragmentation of the health system generally and to ensure that care is provided in the most appropriate setting, consideration must be given to changing PHI arrangements so that all hospital based non-admitted care is covered and to ensure that funding is provided on the **type rather than the site** of care.

In NSW in 2004/05[2]:

- around 97% of ED non-admitted occasions of services or attendances are at public hospitals compared to 3% at private hospitals. This equates to around 633,235 ED occasions of services at public hospital EDs compared to only 23,024 at private hospitals. This means that NSW public hospital EDs are providing 28 times the level of ED services as are provided in private hospitals, and proportionately even more when account is taken of the higher casemix complexity of the public hospital ED presentations
- at NSW public hospitals 47% of all public hospitals admissions were classified as emergency compared to only 3% at private hospitals
- 97% of total separations related to emergency admissions were at public hospitals compared to only 3% at private hospitals.

With around 43% of the population being covered by PHI it is disappointing that the Commonwealth is not using these reforms as an opportunity to address the imbalance between the provision of public and private ED care and admissions. Such a high level of public sector ED activity and admissions negatively impacts on the capacity of public hospitals to meet the demand for elective/booked admissions. It also means that current PHI arrangements have done little to "reduce the burden" on the public hospital system.

The omission of ED services undermines the aim of BHC as services provided at ED often prevent hospitalisation and/or substitute for hospitalisation. Services provided by EDs are also consistent with many of the items detailed in the Medicare Benefits Schedule that are applicable to hospital substitution services. For example one of the items listed in the applicable section of the MBS concerning substitutes for hospital relates to "*restoration of cardiac rhythm other than in the course of surgery*". This does not always necessitate an admission to hospital but is a service provided at an ED.

The omission of ED care from the proposed reforms means that PHI arrangements will continue to be much more strongly aligned with the location or site of care provision rather than the type of care provided. The illogical consequence of this can be illustrated as follows: a person with unstable diabetes who presents and is stabilised at an ED without requiring admission to hospital will not be covered by their PHI. The same person receiving the same treatment as part of a BHC product at a different site (for example an entity contracted by a health fund) will be covered. This clearly undermines one of the

[2] ibid

stated goals of BHC to "*reflect contemporary clinical practice in Australia facilitated by advances in medical practice and technology."* (p1).

BHC documentation identifies a "single medical service" as a service that substitutes for hospitalisation. A single medical service includes the range of medical treatments and operative procedures that can now be provided in alternative clinical settings. This includes doctors' surgeries where minor operations/procedures which require local, or no, anaesthesia can provide clinically appropriate alternatives to hospital admission. EDs at hospitals already provide "single medical services".

The effect of Clauses 39 and 44 of the AHCA is that ED patients must be treated as public patients and cannot be referred to other appropriate services. There is only scope to treat a patient as non-public if a third party payer agreement is reached, with limited ability to refer on to other services.

It is conceivable that private facilities with EDs will be able to refer people presenting at their ED onto a service that would fit the definition of a hospital substitutable services or a single medical service and therefore be able to access PHI benefits. For example, a person presenting at a private ED who requires minor stiches could be referred onto a hospital substitutable service located near the ED. NSW is concerned that due to constraints imposed by the AHCA, this same opportunity will not be provided to the public health system. This raises the pivotal question of whether the public health sector will be allowed the flexibility to respond to the proposed reforms in the same way as the private health sector.

5. SECTION 121-5 OF THE DRAFT BILL AND THE INCLUSION OF PUBLIC HOSPITALS IN THE DRAFT BILL

NSW seeks confirmation as to whether public hospitals are included for the purposes of Section 121-5. If public hospitals are included, then NSW proposes that the:

- **current arrangements relating to "recognised public hospitals" be included in the Bill in a manner that will facilitate the provision of services by all public hospitals to people who choose to use their PHI**
- **provisions relating to the proposed unilateral ability of the Commonwealth Minister to declare a facility to be a hospital (for the purposes of providing hospital treatment) be applied only to private hospital sector**

Or if public hospitals are not included, then NSW seeks confirmation of the mechanism that will ensure that all public hospitals can continue to provide services to people who elect to use their PHI.

In relation to the proposed Safety and Quality regime NSW recommends that:

- **Consistent with COAG's objective of avoiding unnecessary regulation and pursuing principles of good regulation, a thorough and transparent evaluation should be undertaken of the need for any proposed national quality standards for privately insured services, factoring in existing State/Territory based regulatory regimes affecting these services**
- **Any proposed national safety and quality standards for privately insured services will be developed cooperatively by jurisdictions and the Australian Commission on Quality and Safety in Health Care, to ensure that there is no unnecessary regulation or duplication or overlay of regulatory requirements, and that all options for the implementation of new standards (including adapting existing regulatory systems if required) are thoroughly examined**.

Discussion of Issues

NSW is concerned about the potential impact of the Section 121-5 of the Bill concerning hospital treatment. This potentially represents a significant change in Ministerial power from current ranges as discussed below.

The Bill revolves around the concept of "*health insurance business*", which is defined by reference to "*hospital treatment*" and "*general treatment*". It is highly unlikely that Funds would be willing to do business with a public hospital or provider unless it provides "*hospital treatment*" or "*general treatment*". In order to provide "*hospital treatment*" a hospital must now be declared by the Commonwealth Minister. There is no such restriction on "*general treatment*".

Subsection (7) provides that in deciding whether the Commonwealth Minister declares a facility a hospital (or to revoke such a declaration), the Commonwealth Minister must have regard to a number of specified criteria, and must consider all of them.

It is difficult to fully and accurately assess the impact of these criteria as the Private Health Insurance (Health Insurance Business) Rules (the Rules) have not yet been developed.

However there is some ambiguity as to whether public hospitals are included in the definition of "*hospital treatment*".

It is arguable that the criteria listed are applicable only to private hospitals and not to public hospitals as well. For example, it is nonsensical to talk of the "*necessary approvals by a State or Territory*" in respect of a public hospital. On this basis, it is arguable that the definition of "hospital" is not intended to include public hospitals. Is this the Australian Government's intention?

Under current provisions the following occurs:

- Under subsection 23EA(1) of the *Health Insurance Act*, the Commonwealth Minister may declare premises specified in the declaration to be a **private hospital** for the purposes of the *Health Insurance Act* and the *National Health Act 1953*. The criteria associated with this are similar to those included in draft Bill and also include the provision of Hospital Casemix Protocol data by private hospitals to health Funds. This does not apply to public hospitals.
- The provisions of the *Health Insurance Act* relating to the Australian Health Care Agreement (S24) and grants of financial assistance (S26) apply to "*public hospital services*". This term is defined in section 23(E) to mean a hospital service provided in a "*recognised hospital*". The term "*recognised hospital*" is defined in section 3(1) of the *Health Insurance Act* to mean "*in relation to a State that is party to an agreement – a hospital in that State is a recognised hospital for the purposes of that agreement*". The agreement is the Australian Health Care Agreement (AHCA).

Under these current arrangements there does not appear to be any formal link between the process of recognising a public hospital and the criteria for private hospitals (such as provision of Hospital Casemix protocol data). This means that public hospitals can receipt PHI benefits by being a "recognised public hospital". However the draft Bill may potentially change this arrangement.

The effect of the draft Bill may be that the Commonwealth Minister is able to declare which facilities are hospitals for the purposes of receiving reimbursement for the treatment of privately insured patients. This will be assessed against a yet unspecified set of Private Health Insurance (Health Insurance Business) Rules.

This is a potentially significant and highly controversial change to current arrangements, and is strongly opposed by NSW. In short, it would place at risk the ability of the public sector to provide services to people who wish to utilise their PHI.

In addition to the above, NSW supports and shares the significant concerns recently discussed at the Australian Health Ministers' Advisory Council regarding the Australian Government's proposal to introduce an industry-wide uniform regime for Safety and Quality standards for privately insured services, working with the Australian Commission on Quality and Safety in Health Care.

It is likely that these proposed standards will apply to all facilities and providers offering privately insured services and, as these services are provided in both the public and private health sectors, the implementation of such a regime directly impinges on long-standing state statutory responsibilities.

There has been little effective consultation with NSW over this proposal and there are a number of issues that would need to be addressed. These include the potential for

unnecessary regulations, an undermining of the principles of good regulation, and the impact on existing state and territory regulatory responsibilities.

6. IMPACT ON ACCESS TO PUBLIC HEALTH SERVICES BY PEOPLE WITH PRIVATE HEALTH INSURANCE (PHI)

NSW seeks confirmation that the Australian Government:

- **remains committed to Clause 38 of the AHCA which requires that all patients are given the choice to be treated either as public or private patients**
- **is committed to ensuring that access to public health services by people who wish to utilise their PHI is not constrained by the PHI reforms**
- **will ensure that people who wish to use their PHI to receive clinically appropriate and required health services will retain the right to choose their service provider regardless of whether there is a contract with a Fund or not. This will need to be underpinned by an appropriate payment mechanism that reflects the cost of service provision.**
- **will ensure that public health services will be eligible to receive payments from health insurance funds under the reforms regardless of whether there is a contract in place**
- **will ensure that privately insured patients will be able to use their health insurance to access public health services that substitute for hospitalisation that are provided on a non-admitted basis**
- **will explicitly recognise the public health system as a legitimate provider of services to people who choose to use their PHI cover**
- **will ensure that in relation to programs offered by public health services such as diabetes management services, patients will be able to access these programs as private patients if they choose and that Funds will not be able to restrict access to particular service providers and therefore also influence the types and quantum of services provided**
- **will ensure that patients in rural areas who hold PHI will be able to access hospital-substitutable services funded by PHI, including and particularly in areas where the public health sector is the only provider of services.**

Discussion of Issues

The potential increase in the unilateral power of the Commonwealth Minister to determine the ability of public hospitals to attract PHI benefits is of concern to NSW, given the implications for patient choice and the lack of substitutability between services provided at public and private health facilities.

Clause 38 of the AHCA states that "*NSW will ensure that all eligible persons elect to receive admitted patient hospital services as a public or private patient".* If the Commonwealth Minister chooses not to allow a public hospital to provide services to private patients, this would be a clear breach of the AHCA and would also bring into question the Australian Government's commitment to the AHCA. Equally significantly, and much more controversially, such a decision could also prevent people with PHI from accessing required public hospital care.

Relevant issues here include the following:

- People using their PHI in public hospitals have more complex diagnoses and costly treatment requirements than privately insured patients in private hospitals. AIHW data[3] shows that the average cost weight per separation for people funded by PHI at private hospitals in NSW is 0.89. By comparison the average cost weighted separation by people funded by PHI at NSW public hospitals is 1.23. Further, 97% of all NSW separations classified as emergency are provided by NSW public hospitals.
- Given the above, any curtailing of the public health sector's ability to treat people who elect to be admitted as private patients would severely limit access by private patients to more complex care including emergency admitted care. This would inevitability raise serious questions about the value of holding insurance.
- In many areas, particularly in rural areas, the public health system is the only provider of many of the services that will be covered by the reforms. In addition where public health services are already providing BHC type care a number of patients are accessing this care after an inpatient stay in a private hospital.
- Compared to the private sector, the public health sector has been stronger and more successful in efforts to ensure that patients are treated in the most clinically appropriate setting. For example in the public health sector patients requiring chemotherapy are usually not admitted. This directly contrasts with the private sector where patients are admitted so that PHI benefits can be paid. Another example is the growing provision of home renal dialysis provided by public health services.

In addition to the above, access by private patients to BHC services will potentially be limited by the absence of any safety net payment arrangements and the fact that the public sector is already providing care in more appropriate settings.

In summary, If people are not able to access public hospital and other health services as private patients this would result in a two tiered system, raise questions about the value of holding PHI and potentially penalise the public health system for already providing contemporary care in the most appropriate setting. This is particularly important given that there are a number of core health services that are not provided in the private health sector and there is a lack of substitutability between services provided in the public and private sectors, particularly in the areas of complex and emergency care.

The absence of any reference in the Commonwealth's policy documents to the role of the public health sector in providing BHC services to people utilising their PHI is a matter of serious concern. It implies that BHC will only apply to people accessing services at private facilities or provided by private providers. Does this mean, for example, that if BHC removes the financial incentive for private hospitals to admit people for chemotherapy, people will only be able to use their PHI if they receive chemotherapy on a non-admitted basis from a private provider but not through the public system?

Given the issues associated with the transfer of decision making powers to Funds outlined in Section 8 below, it is not sufficient to say that the public health system can provide these services to the privately insured if they have a contract with a Fund. If the Australian Government is genuinely committed to ensuring that care is provided in the most appropriate setting, that PHI represents value for money and that contemporary health care is accessible to people who wish to use their private health insurance, then a safety net reimbursement mechanism is required that reflects the cost of care.

[3] ibid

The BHC Paper states that it will be "*open to insurers to contract with medical practitioners to supervise or provide disease management or health care management programs as long as no charge is made to the patient*" (p9). The specific use of contracting with a medical practitioner rather than a medical service and the lack of a default benefit for these services implies that the public health system will not be able to provide these services to people if they elect to use their PHI. Clarification is sought as to whether this is the intention.

The draft Bill and associated policy documents do not adequately reflect the current practices at many public hospitals and health services. For example chemotherapy, wound management, mental health programs and home dialysis are already provided by many public health services on a non-admitted basis. In many areas of NSW the public health system is the only provider of these services. NSW seeks confirmation that privately insured patients will be able to access these services as private patients if they so choose. If this does not occur, the BHC reforms may result in reduced access to services for private patients and lack of ability to access a doctor of choice.

NSW is particularly concerned that the reforms appear to be metro-centric. In reality there are very few private providers outside major metropolitan areas who could provide the range of services covered by the reforms. For example in many rural areas the public health system is the only provider of chemotherapy and renal dialysis services. The reforms must facilitate service access by rural people as privately insured patients if they so choose.

A major incentive in the recruitment and retention of clinical and particularly medical staff in the public sector is the ability of these staff to access rights of private practice. Concerns are:

- Any undermining of the public sector's role in providing services to people who wish to utilise their PHI will also adversely affect the public sector's ability to ensure that it can maintain a sufficient number of appropriately skilled staff in the right locations to address the population's health needs.
- Any erosion of clinical incomes by decreasing access to rights of private practice arrangements will either result in an additional, significant cost impost on the public sector (to make up the shortfall in clinician earnings) or result in a transfer of clinicians to the private sector.
- The reforms assume that there is sufficient health staff to provide the range of services covered. In reality there are significant national health workforce shortages in nearly all clinical areas.

7. PRIVATE HEALTH INSURANCE FUNDS AND CLINICAL DECISION MAKING

If the Australian Government is committed to ensuring that the clinical needs of patients are the primary consideration in determining patient care, then the legislation should include a specific mechanism to protect the rights of consumers and clinicians.

Discussion of Issues

The draft Bill will potentially modify and expand the role of insurers from that of an arm's length third party payer to that of decision maker in relation to, eg. the type of care that will be provided, to whom, by whom, where and for how long. This represents a level of interference in clinical decision-making processes that could jeopardise patient outcomes by subordinating the interests of individual patients to the interests of individual Funds.

The *National Health Act 1953* provides a degree of protection for clinical decision making in instances where a hospital or day hospital facility has entered into an agreement with a medical practitioner relating to the rendering of professional services by that medical practitioner. The Act at Section 73BDAA states that "*the practitioner agreement requires the hospital or day hospital facility to maintain the medical practitioner's professional freedom, within the scope of accepted clinical practice, to identify appropriate treatments in the rendering of professional services to which the agreement applies*". The draft Bill contains no such provision.

The draft Bill requires Funds to ensure that any health insurance they provide is in the form of a complying health insurance product. To be a complying health insurance product, a product will have to meet quality assurance (QA) requirements. A product will only meet QA requirements if it prohibits the payment of benefits for a treatment that does not meet the standards in the PHI (Accreditation) Rules. With this scenario:

- It is evident that the Commonwealth intends to set standards which apply to privately insured services provided by state bodies or regulated at state level.
- The Bill appears to give the Commonwealth Minister very broad powers to make rules regarding QA or "accreditation" standards and what constitutes a complying health insurance product.
- If enacted in its current form the draft Bill would enable indirect regulation of all providers or privately insured services by imposing quality and safety or accreditation standards.
- Furthermore it will be a criminal offence for health funds to provide any product that is non-compliant.

Therefore the Bill places the onus on the Funds to satisfy themselves that health services are compliant with the quality and safety or accreditation standards. In this way the Bill confers very substantial power on the Funds, which may be used to limit consumer choice and detrimentally limit service provider discretion.

There appears to be no provision in the Bill to protect the rights of consumers to receive treatment based on clinical decisions.

There is a risk that unless managed appropriately, changes to PHI arrangements will significantly undermine the capacity and obligation of doctors to make decisions about each patient's treatment and care on the basis of their expert assessment of the patient's clinical needs. Any threat to this fundamental precept of the Australian health care system must be taken very seriously and guarded against assiduously.

The BHC Directions Paper makes a clear statement that the "*government believes that health insurers that wish to offer cover for broader health care services are best placed to determine which health care services provide value for money, both in terms of cost outlays and health outcomes for their members*". (p4) This is of concern given that it is usually clinicians in consultation with patients who are best placed to determine which health services provide the best health outcomes.

The above statement also indicates a potential conflict of interest for for-profit PHI Funds whose goal to maximise profits may result in business decisions which compromise the patient/clinical goal of accessing/providing services that optimise patient outcomes. "Normal market forces" do not prevail in the health services industry to provide any protection against this risk. The statement also points to the likelihood of a restriction in patient choice of service provider and there is no guarantee that Funds will choose through contractual arrangements the most effective service over the cheapest.

The proposed increased power of Funds will jeopardise patient care. This is already occurring in NSW. Several PHI firms are rejecting claims made by public hospitals for the treatment of private patients after the treatment has been received (i.e. retrospectively). Of particular concern are claims being rejected because the Fund disagrees with clinical decisions made by treating doctors. These clinical decisions are made in the best interests of patients to achieve optimal health outcomes and the fact they are currently being challenged in some instances underscores one of the key risks involved in extending the role of Funds.

The BHC paper also shows that insurers might require the program of services to involve a plan. This implies some kind of treatment approval process by a health insurance Fund where the Fund rather than the treating clinician determines the course of treatment. Some of the items included under BHC products can have lengthy or indeterminate non-admitted treatment programs that are clinically appropriate. It is not clear how this will be managed by Funds. For example will Funds be able to cap the number of treatments despite clinical appropriateness? What happens to a BHC patient if their clinical needs extend beyond the fixed cap?

NSW is committed to the AHCA principles that mean that access to public hospital services is to be based on clinical need. The increased power of Funds and the potential erosion of the primacy of clinical decision making that may arise from the reforms would undermine this undertaking and raise serious questions as to whether the Australian Government remains committed to this approach.

8. HOSPITAL CASEMIX PROTOCOL (HCP) DATA

It is difficult to assess the full impact of the Bill as the PHI Business Rules have not yet been drafted. This absence significantly disadvantages all those making submissions in relation to this Bill. However previous discussions with the Commonwealth have indicated that there will be a requirement for all hospitals to provide HCP data. Currently this applies only to private hospitals

Extending this requirement to public hospitals would arguably breach Clause 16 of the AHCA which states, "*Recognising the co-operative relationship between them, the Commonwealth and New South Wales agree they will not institute or sanction arrangements which unreasonably impose an additional financial burden on the other party".*

Complying with a requirement to provide HCP data will cost the NSW Health system an additional $7 million (estimated) per year. NSW Health – and the NSW population – are highly resistant to the idea of diverting these funds from the provision of frontline health services to "fill in forms". As the body seeking to introduce these new arrangement, the Commonwealth must explain how they would avoid breaching Clause 16 in taking this action.

Other issues relating to the HCP are:

- Implementing the Protocol manually through the National Private Patient Hospital Claim Form will cost the NSW Health system between $4 -$7million per year depending on utilisation.
- As an alternative, NSW Health has offered Funds, through the Australian Health Insurance Association, electronic provision of diagnostic data on a cost recovery basis. These costs would only be a fraction of the manual collection costs identified above and would provide a superior product to Funds. To date no response has been received to this offer.
- PHI Funds only partially fund the cost of accommodation for private patients in public hospitals. Making Fund payment contingent on the provision of diagnostic and procedures information inappropriately links two very different processes.
- Clinicians operating with rights of private practice treat private patients at NSW public hospitals. NSW Health is not able to dictate to private clinicians the type of information they provide on claim forms. However the draft Bill suggests that public hospitals (if they are included in the reforms) may not be able to receive PHI payments if this data is not provided. Will this also mean that Medicare Australia and private health Funds will not pay clinicians for the clinician component of care if casemix data is not provided? It would be anomalous if part of the costs of care (the clinical component) were paid but not the accommodation component.
- The current claim form may not meet patient privacy requirements of patients and does not ensure that consent to disclose information is informed. Patients will require additional details regarding the nature of the information they are agreeing to allow to be disclosed.
- If accommodation payments were rejected by Funds because hospitals were unable to complete all details in a large quantity of forms, then a patient having elected to be private may be liable for the costs. This could lead the patient to question the merits of holding PHI and also undermine the concept of informed financial consent.

Subsequent to the release of the second Draft of the Bill, the Business Rules were released. NSW is still analysing these Rules, however our major initial concern (in addition to those relating directly to the Bill) arises from rule 7 of the Private Health Insurance (Health Insurance Business) Rules**.** This concern is summarised at Attachment B.

I would appreciate confirmation of the receipt of this submission, and your assurance that the Committee will carefully consider its contents.

Yours sincerely

Robyn Kruk
Director-General

ATTACHMENT B

Private Health Insurance (Health Insurance Business) Rules

- Rule 7(b) provides that in deciding whether a facility is to be declared a "hospital" for the purposes of the Bill, the Minister must have regard to "whether or not the declaration of the premises would materially affect reasonable access by public patients to a reasonable range of services".

- The above paragraph is not worded in a way that appears to be consistent with NSW's obligations under the Australian Health Care Agreement (AHCA). The AHCA requires NSW to "ensure that eligible persons are able to access public hospital services, free of charge, as public patients". The term "public hospital services" is defined to mean "services of a kind or kinds (including admitted patient services and non-admitted patient services) that are currently provided, or were so provided on 1 July 1998, by hospitals that are wholly or partly funded by a State (whether those services are provided directly or via one or more intermediate persons or bodies)."

- Specifically, there are three problems with the requirement in rule 7(b) that the Minister must consider whether the declaration of an individual NSW public hospital would affect "reasonable access" to a "reasonable range of services":

    1. The requirement for individual public hospitals to ensure "reasonable access" to a "reasonable range of services" for the purpose of declaration as a "hospital" under the Bill has the effect of imposing a new substantive obligation on public hospitals in NSW which is separate from and additional to the obligations on the State of NSW under the AHCA. It is inappropriate for such an obligation to be imposed on NSW public hospitals outside the AHCA framework in this way.

    2. It is the State of NSW which is a party to and subject to the obligations imposed by the AHCA, not individual public hospitals. The way in which resources are allocated and services provided by individual hospitals in the NSW public health system is a matter for the NSW Health Department. To impose further obligations on individual hospitals is inconsistent with the AHCA framework.

    3. The State of NSW's capacity to provide public health services is limited by the level of financial assistance provided by the Commonwealth under the AHCA. Again, it is not clear whether the wording in the rule that a hospital is required to provide "reasonable access" to a "reasonable range of services" is intended to take these matters into account, and the extent to which they may be taken into account.

For these reasons, NSW suggests that rule 7(b) should be removed. The rule is effectively an attempt to vary the terms of the AHCA which, according to clause 4 of the AHCA, may be varied only by the further written agreement of the parties.