Australian
Private Hospitals
Association

Submission by the Australian Private Hospitals Association to the National Commission of Audit 26 November 2013

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EXECUTIVE SUMMARY

The Australian Private Hospitals Association represents around 70% of the private hospital and day surgery sector, both for-profit and not-for-profit. Private hospitals and day surgeries care for 40% of people admitted to hospital each year across the full range of hospital services. As such the sector plays a critical role in meeting Australia's current and future health challenges.

The APHA sees immediate opportunities for increased efficiency in the use of government funds through:

- increased use of public/private partnerships to build, expand and manage hospital services;
- outsourcing of public patient services to the private sector; and
- removal of 'double dipping' that occurs when private patients in public hospitals receive government subsidisation not only for their investment in private health insurance but also for the care that that insurance was intended to cover.

The health sector presents the Commonwealth budget with significant structural risk in the form of uncapped liabilities for Medicare and the National Agreements on Healthcare. The Federal Coalition was elected on a platform which emphasised the need to increase and reward personal responsibility. In the health sector this goal can best be achieved by the implementation of a two-pronged approach:

- targeted introduction of price signals; and
- incentives for private health insurance.

The private health sector is one which is subject to complex and multiple layers of regulation. Government plays an important role in:

- ensuring that community expectations regarding quality and safety of care are assured;
- addressing imbalances in information which would otherwise place consumers at a disadvantage in identifying and purchasing services to meet their current and future health needs; and
- ensuring a sustainable private health insurance market.

The APHA is of the view that these regulatory roles remain valid and important strategies as a protection both to consumers and to the Federal Government itself as the 'first line' funder of health services. At the same time there is significant scope for rationalisation of regulation and reporting requirements to alleviate the administrative burden borne by governments (at both State and Federal levels) and private sector heath care providers.

RECOMMENDATONS

Scope of Government

- Rationalise national reporting activities in the health and hospitals sector and the agencies responsible.

- Promote national consistency in private hospital regulation, licencing, reporting reducing the need for investment by both the Federal Government and jurisdictions in separate Commonwealth and State/Territory frameworks and infrastructures to support these activities.

- Release and respond to reports commissioned by the Department of Health and Ageing (as it then was) from KPMG in 2011 and 2012(unpublished) on proposals to streamline hospital data collections(1).

- Continue the Federal Government's role in regulation of:
    - private health insurance;
    - products and price; and
    - information and consumer protection;

  while recognising the potential scope for simplifying the way in which these regulations are administered.

Efficiency and Effectiveness of Government Expenditure

- Introduce policies to curb the heavily subsidised growth in provision of services to private patients in public hospitals.

- Increase contestability of funding for the provision of hospitals services and the provision of training and internships for health professionals.

- Consolidate agencies and boards responsible for regulation and monitoring:
    - private hospitals licencing and accreditation;
    - private health insurance;
    - safety and quality of care; and
    - health sector performance.

- Introduce out of pocket contributions providing price signals to consumers using publically funded health services including:
    - self-presentations to emergency departments by low acuity patients; and
    - private patient admissions to public hospitals.

State of the Commonwealth's Finances and Medium Term Risks to the Integrity of the Budget Position

- Target incentives for individuals to invest in private health insurance products which reduce reliance on the public health sector.

- Remove the ability of public hospitals to waive excess and co-payments and medical co-payments (gap payments) payable by people who receive treatment in a public hospital as a private patient.

Commonwealth Infrastructure

- Increase the productivity of existing public hospital infrastructure.

- Facilitate timely transfer of patients to aged care, palliative care or convalescent care services once their need for acute care has ceased.

- Reduce the provision of private patient services in public hospitals and redirect capacity toward the provision of public patient services.

- Increase outsourcing of public patient services to private hospitals.

- Increase the use of public/private partnerships to build and manage new hospital services.

Public Sector Performance and Accountability

- Continue The Intergenerational Report and include within it a specific focus on the impact on demand for and affordability of health services and on consumer responsibility for future healthcare needs.

- Involve the private sector as an active participant in service planning.

- Establish a specific national agreement for highly specialised drugs funded through the Pharmaceutical Benefits Scheme.

PART ONE

Scope of Government

Regulation, Licencing and Reporting - Private Hospitals

The Federal Coalition has stated that it wishes to alleviate duplication in government processes and to reduce the regulatory and reporting burden placed upon business.

The private hospital sector is subject to duplicate government processes in the areas of regulation, licencing and reporting as summarised in the table below:

	Commonwealth	**States**
Regulation		
	National Standards are defined by the Australian Commission on Safety and Quality in Health Care (ACSQHC).	Private hospitals must also meet a range of State specific requirements as a condition of licencing some of which directly duplicate Commonwealth requirements.
Licensing		
	Private hospitals must be granted a provider number through the Department of Health.	Private hospitals must also be licenced by the State within which they operate.
Reporting		
	Private hospitals report data through the Hospital Case-mix Protocol collection, the Private Hospital Data Bureau collection and the Morbidity Data Collection. Many hospitals submit billing data through the Electronic Claim Lodgement and Information Processing Service Environment system. Private hospitals participate in the Australian Bureau of Statistics survey of private hospitals. Private hospitals participate in the National Hospital Cost Data Collection on voluntary basis. Private hospitals participate in public reporting of performance data on a voluntary basis.	Each State requires different reporting timeframes. This makes data management unnecessarily complex and resource intensive. States also mandate various additional reporting requirements including: • Sentinel event/adverse outcome reporting; and • Clinical registry reporting

This burden is further increased by differences between jurisdictions which impact on companies providing services across multiple jurisdictions.

The private hospital sector accepts consumer and community expectations of transparency in the use of public funds and the need for rigorous accountability within the health sector for quality and safety. At the same time regulation, licensing and reporting activities need to be streamlined and 'fit for purpose'.

Recommendations:

- Rationalise national reporting activities in the health and hospitals sector and the agencies responsible.
- Promote national consistency in private hospital regulation, licencing, reporting reducing the need for investment by both the Federal Government and jurisdictions in separate Commonwealth and State/Territory frameworks and infrastructures to support these activities.
- Release and respond to reports commissioned by the Department of Health and Ageing (as it then was) from KPMG in 2011 and 2012(unpublished) on proposals to streamline hospital data collections(1).

Regulation of Private Health Insurance

The private health insurance industry is regulated by the Federal Government in a number of key areas that impact directly on the private hospital sector:

- scope of policy coverage;
- premium setting;
- benefits payable for hospital services
    - Default Benefit;
    - Second Tier Benefit; and
    - The Prostheses List; and
- community risk rating.

These functions are not duplicated at state level. These regulations provide consumer protection and ensure access to affordable health services while at the same time supporting competition in the private hospital sector by lowering barriers to market entry for private hospitals and manufacturers of health technology(2).

The Second Tier Benefit - Ensuring a Competitive Private Hospital Market

The Second Tier Benefit provides market entry for smaller hospitals and day surgeries with which health funds elect not to contract. The Benefit thereby prevents excessive consolidation in the private hospital market. The Benefit also provides consumers with assured continuity of service and choice of provider. The Second Tier Benefit is responsive to market prices and set at a level which strongly incentivises private hospitals to contract with health funds.

The Second Tier Benefit forms the basis of funding for an estimated 1% of episodes annually. Claims that the Second Tier Benefit constrains competition by imposing a floor price in the market are unsubstantiated, because:

- the share of services funded through this benefit is small;
- it does not preclude health funds from negotiating a lower price; and
- hospitals are not privy to Second Tier Benefits until negotiations with health funds have failed.

The Prosthesis List – Ensuring a Sustainable Market for Health Technology

The Federal Government, in cooperation with private sector stakeholders, regulates the market for implantable devices used in the private hospital sector through the Prostheses List. The Prostheses List has provided a proven means of ensuring consumer access to health technologies at price which is sustainable for manufacturers, hospitals and health funds. The List recognises devices of proven clinical benefit and economic value relative to available alternatives. The List provides a minimum benefit payable by private health insurance funds for their use in private hospitals.

Without this process, upwards pressure on costs would return to historical levels in excess of 10% per annum and drive up private health insurance premiums. In consequence the budget risk to the Federal Government increase. Ultimately access to these health technologies in the private hospital sector would become unaffordable.

Objections that the List impedes negotiation of efficient prices between hospitals and health funds or between hospitals and health technology manufacturers are unfounded. The List provides nothing more than a reference point around which contracts can be negotiated.

Regulation of the scope of policy coverage, premium setting and community risk rating have been essential in ensuring that the private health insurance industry develops and maintains a meaningful value proposition for consumers who have, as an alternative, access to public hospital services through Medicare. Were the market to fail in achieving these objectives,

the risk would have to be absorbed by government health budgets to avoid massive expansion in hospital waiting lists. Market research shows an entrenched scepticism regarding the value of private health insurance and concern regarding its affordability even amongst consumers who desire it(3).

At present division of responsibilities within government for the regulation and collection of data and information impede analysis of and response to industry trends and policy impacts. For example, both the Federal Governments and the sector face difficulty of gaining a true understanding of the impact of policy exclusions and restrictions and of the consequent risk to the Federal budget.

Relevant agencies are:

- The Private Health Insurance Administration Council (PHIAC);
- The Private Health Insurance Ombudsman (PHIO); and
- The Department of Health (DOH).

Recommendation:

- Continue the Federal Government's role in these areas of regulation while recognising the potential scope for simplifying the way in which these regulations are administered.

Regulation of Products and Price

The services covered by private health insurance are indirectly regulated through:

- The Medical Benefits Schedule (MBS);
- The Pharmaceutical Benefits Scheme (PBS); and
- The Therapeutic Goods Administration (TGA).

The regulatory processes underpinning the TGA, the MBS and the PBS serve to protect consumers from unproven and untested medical treatments. The MBS and PBS also indirectly influence growth in demand for medical services towards services of greater efficacy and efficiency. Health funds will only provide benefits for services for which there is an associated MBS fee. Health funds do not provide benefits for the cost of PBS listed drugs.

The Medical Services Advisory Committee (MSAC) and Pharmaceutical Benefits Advisory Committee (PBAC) apply both clinical and economic criteria in their decision making. As such they provide a mechanism for containing both direct (uncapped payments for MBS and PBS funded services) and indirect (government incentives linked to private health insurance premiums) budget risk for the Federal Government.

These processes provide an essential framework for ensuring the sustainability of both public and private health sectors. They can be further improved by:

- analysis of pricing and competition across both public and private sectors to ensure that both markets operate at maximum efficiency;
- comparison of Australian and international markets to ensure that Australian consumers are not disadvantaged; and
- further cooperation and linkage across the TGA, MSAC, PBAC and PLAC to smooth the administrative burden for government and sponsors and enable joint evaluation of economic value, ie the potential for increased expenditure in one area to provide efficiencies in another.

An objection that these regulatory processes inhibit competition is not borne out in evidence. Specifically the prices set by MSAC and PBAC provide a framework around which health funds, manufacturers, private hospitals and medical practitioners are able to negotiate.

Recommendation:

- Continue the Federal Government's role in these areas of regulation while recognising the potential scope for simplifying the way in which these regulations are administered.

Provision of Information and Consumer Protection

The Commonwealth collects and disseminates information about private health insurance to enable consumers to make informed choices.

Relevant agencies are:

- The Private Health Insurance Administration Council (PHIAC);
- The Private Health Insurance Ombudsman (PHIO); and
- The Department of Health (DOH).

APHA market research conducted in April 2013 indicates that private health insurance is a complex product about which Australian consumers are often confused:

- more than half (52%) of people surveyed did not know what if any exclusions were contained in their private health insurance policy; and
- one in four 18-24 year olds were not sure what was covered by their health insurance(3).

As at 30 June 2013, over 47% of private health insurance policies held had some form of exclusion or restriction on the level of cover provided(4). Common exclusions include not only pregnancy and fertility treatment but also:

- heart surgery;
- eye surgery;
- hip and knee replacements;
- rehabilitation services;
- psychiatric services; and
- plastic and reconstructive surgery.

The information and complaint resolution services provided by the Federal government provide an independent source of information and advice as is evidenced by a sharp increase in utilisation over the past twelve months.

The entry of aggregators, such as iselect, http://www.iselect.com.au/, into the Australian private health insurance market has provided consumers with additional information services. However these services are not independent and they further add to the cost of insurance premiums through charges that are passed back to participating health funds.

Recommendation:

- Continue the Federal Government's role in these areas of regulation while recognising the potential scope for simplifying the way in which these regulations are administered.

Efficiency and Effectiveness of Government Expenditure

Efficiency and effectiveness of government expenditure on acute and sub-acute hospital services could be increased by promoting contestability of public hospital services. This would enable governments to:

- purchase more efficient services;
- respond more flexibly to growth in service demand; and
- reduce pressure on capital programmes.

Allowing for variation between facilities, the private hospital sector as a whole is more productive than the public sector (5). Public hospitals managed by private entities are on average more efficient than other public hospitals (6).

Efficiencies Provided by Contestability

The Department of Veteran's Affairs has shown that government is able to contract comparable services to those provided by the public sector from the private sector at below

public hospital 'cost-recovery' prices (7, 8).

In 2009 the Productivity Commission identified potential for a 20% increase in productivity across the hospital sector as a whole (9).

Effectiveness of government expenditure could also be improved by introducing policies to curb the heavily subsidised growth in provision of services to private patients in public hospitals. Private patients treated in public hospitals receive treatment that is heavily subsidised by both Commonwealth and State governments. APHA estimates that Commonwealth subsidisation exceeds $1.3 billion (10, 11). Often these patients could be more efficiently treated in the private sector with a considerable saving to both Commonwealth and State governments (9).

Other areas of health sector expenditure could also be made more efficient through:

- increasing contestability of funding to support long term private sector investment in training and internships for health professionals is needed to efficiently respond to growth in demand; and
- consolidation of agencies and boards responsible for regulation and monitoring in relation to:
    - private hospitals licencing and accreditation;
    - private health insurance;
    - safety and quality of care; and
    - health sector performance.

Recommendations:

- Introduce policies to curb the heavily subsidised growth in provision of services to private patients in public hospitals (eg removal of the private health insurance rebate from 'public hospital only' health insurance products).

- Increase contestability of funding for the provision of hospitals services and the provision of training and internships for health professionals.

- Consolidate agencies and boards responsible for regulation and monitoring in relation to:
    - private hospitals licencing and accreditation;
    - private health insurance;
    - safety and quality of care; and
    - health sector performance.

Privatisation of Commonwealth Assets

Privatisation of Medibank Private is not a matter on which APHA has a view other than to observe that such a move must contribute to increased competition and innovation in the private health insurance industry in order to maintain and promote the value proposition of private health insurance to the Australian public.

Price Signals and Incentives

Price signals and incentives including targeted out of pocket contributions for public hospital services would diminish the moral hazard posed by Medicare. Mitigation of the moral hazard through the introduction of out of pocket contributions providing price signals to consumers using publically funded health services including:

- self-presentations to emergency departments by patients of low acuity; and
- private patient admissions to public hospitals.

While targeting of price signals for presentations to emergency departments would be challenging it is necessary to ensure consistency with the market for equivalent services in the primary care sector and maximise the productivity of valuable emergency department resources.

Notwithstanding arguments that consumers, as taxpayers are entitled to public hospital services, it is neither fair nor efficient for State government funds to be used to provide consumers with private health insurance with an additional subsidy (ie waive of excess and co-payments and medical co-payments) thereby meeting costs associated with a product that the consumer has knowingly purchased and which would normally apply were an insurance claim made in any other setting.

Experience has shown that effectiveness of government policies designed to encourage the uptake of private health insurance and hence relieve government budget risk by containing growth demand for public hospital services is negated without the provision of price signals in the public sector.

Recommendation:

- Introduce out of pocket contributions providing price signals to consumers using publically funded health services including:
  - self-presentations to emergency departments by patients of low acuity; and
  - private patient admissions to public hospitals.

State of the Commonwealth's Finances and Medium Term Risks to the Integrity of the Budget Position

The Federal Coalition has a stated commitment to supporting consumers who choose to take responsibility for their future health needs through investing in private health insurance. This policy has a double benefit in mitigating medium and longer term risks to the Commonwealth budget through:

- uncapped liabilities for recurrent funding of growth in public hospital services through the National Agreements on Healthcare; and
- future liabilities for investment in capital infrastructure for the health sector.

Under the National Agreements on Healthcare, the Federal government share of expenditure on public hospitals for each additional service will rise to 45 % in 2014-15 and 50% in 2017-18.

Recommendations:

- Target incentives for individuals to invest in private health insurance which reduce reliance on the public health sector. It should be noted that while the provision of financial incentives can sometimes involve an open ended budgetary commitment, this commitment is matched by a proportionally greater commitment by individuals to the costs of their own health care. For this reason targeting of such incentives should be refined to:
    - remove incentives for private health insurance products which only provide cover for public hospital services;
    - retain and strengthen incentives for individuals to invest in private health insurance through-out their lives;
    - repeal legislation introduced by the Federal Labour Government to index the private health insurance rebate by the lower of the Consumer Price Index or premium increases; and.
    - provide additional incentives including employer subsidisation and equity release.

- Remove the ability of public hospitals to waive excess and co-payments and medical co-payments (gap payments) payable by people who receive treatment in a public hospital as a private patient.

- Introduce targeted out of pocket contributions for public hospital services.

PART TWO

Commonwealth Infrastructure

Hospital infrastructure needs are projected to increase significantly placing demands on the Commonwealth budget to meet these infrastructure needs. Recent developments, for example the new Royal Children's Hospital, Melbourne (334 beds, $1 billion) and the new Gold Coast University Hospital (750 beds, $1.76 billion) in Queensland show that capital expenditure in the public hospital sector is between two and three million dollars per bed.

In 2009, the Productivity Commission concluded that the capital cost per case mix separation in the private sector was just a little over half that for the public sector (9).

Recommendations:

- Increase the productivity of existing public hospital infrastructure.
- Facilitate timely transfer of patients to aged care, palliative care or convalescent care services once their need for acute care has ceased.
- Reduce the provision of private patient services in public hospitals and redirect capacity toward the provision of public patient services.
- Increase outsourcing of public patient services to private hospitals.
- Increase the use of public/private partnerships to build and manage new hospital services.

Public Sector Performance and Accountability

Intergenerational Report

It is essential that Commonwealth budgeting arrangements be strengthened by continuation of the Intergenerational Report. It is crucial to ensure that the economic decisions of government are informed by a clear focus on the impact of the ageing of the Australian population and its impact on:

- demand for health services;
- workforce capacity;
- taxation revenues; and
- intergenerational wealth transfer.

All of these factors impact on the health sector and capacity of both public and private sectors to provide timely, accessible and affordable services.

Just as previous reports have led to specific government initiatives focusing on workforce participation and provision of aged care so too, further attention is needed on the impact on the ageing of the Australian population on demand for and affordability of health services and on consumer responsibility for future healthcare needs.

The Productivity Commission has shown that taking account of current policy settings and consumption patterns, the impact of the ageing population on health expenditure falls disproportionately on the public sector. Their most recent report further highlights the need for policy reform to encourage and enable greater user contribution to health care needs(5).

The challenges posed by the ageing population are of such magnitude that they require a joint approach and collaboration between both public and private sectors.

The National Pharmacy Agreement

One area of Federal budget expenditure that is receiving increasing scrutiny is the Pharmaceutical Benefits Scheme (PBS). The performance of the public sector in ensuring consumer access to drugs at an affordable price has been called into question when compared internationally. This task is made more complex by the growing diversity and complexity of pharmaceutical products. It is increasingly difficult to formulate policy and administer an agreement that is intended to govern the PBS as a whole and the delivery of listed drugs across both community and acute care settings.

As more and more sophisticated products come onto the market including highly targeted therapies and "personalised medications" a more transparent approach is needed to the funding of highly specialised drugs through the PBS. This approach needs to include:

- introduction of specific funding arrangements for chemotherapy and other highly specialised drugs thereby removing reliance on complex cross-subsidisation arrangements and enabling more transparent price monitoring and implementation of price disclosure; and
- roll-out of paperless prescribing and claiming to improve efficiency in PBS administration for private sector pharmacies, hospitals and government.

Recommendations:

- Continue the Intergenerational Report and include within it a specific focus on the impact on demand for and affordability of health services and on consumer responsibility for future healthcare needs.

- Involve the private sector as an active participant in service planning.

- Establish a specific national agreement for highly specialised drugs funded through the Pharmaceutical Benefits Scheme.

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