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Private Health Insurance Default Benefit Arrangements

AMA submission to the Department of Health Consultation Paper on Private Health Insurance Default Benefits Arrangements

Via email phidefaultbenefits@au.ey.com

The AMA firmly believes that default benefits are an essential protection for patients in our private health sector. Second-tier default benefits must be retained to ensure consumers continue to have choice of service provider and are protected from large out-of-pocket costs, which are both important to the value proposition of private health insurance.

This was a view supported by many members of both the Contracting and Default Benefits Working Group and of the Private Health Ministerial Advisory Council (PHMAC) in their consideration of this topic in 2017. At the end of this process PHMAC members were divided along industry lines as to whether the second-tier default benefit arrangements should be retained in the private hospital/health insurer market.

At the end of the PHMAC process the Government considered both positions and chose to make administrative improvements to the default benefit process and leave the second-tier default benefit policy settings in place. As this policy area was considered so thoroughly only a few years ago, the AMA does not understand why we are again examining this issue. The data provided by the EY consultation paper shows that there has been no substantial change in how this policy lever is impacting on private hospital/health insurer market in recent times.

The consultation paper itself has a strong focus on improving the position for private health insurers. In previous work the AMA has outlined the financial pressures facing insurers and whilst the pandemic has reduced the immediate fiscal pressures, we acknowledge that the underlying issue of increased numbers of older, comorbid members is continually increasing insurer outlays.

However, the pandemic has significantly reduced the ability for private hospitals (and private medical specialists) to generate the same level of income that they received prior to the pandemic. While most of this reduction was caused by the sequential lockdowns in jurisdictions across Australia, many private health businesses have not returned to pre-pandemic levels of activity, due to the current workforce issues facing the Australian health sector. With the current limited consultation planned for this topic, the AMA cannot see how there will be a

different result than the one achieved by PHMAC, if anything the opposing views on this topic are more, not less, entrenched.

In order for the private health sector to innovate, the regulatory framework needs to seek out new ways for doctors, hospitals, insurers and patients to deliver care options which are safe, efficacious, cost effective and continue to deliver value for consumers of private health insurance (PHI). PHI funding should be supported to include out-of-hospital treatment options which are patient focused, clinician lead, can incentivise investment and are underpinned by standards developed by the Australian Safety and Quality in Healthcare Commission. Extending the minimum default benefits at independently assessed rates to include new care delivery options would allow delivery of services in a way that allows all hospitals to compete and continue choice as the cornerstone of private health.

Current Funding Arrangements Between Private Hospitals and Private Health Insurers

Question 1. What do you see as the current objectives for default benefit arrangements?

The AMA sees the primary objective for the current second-tier default benefit arrangements as providing an essential safety net for consumers attending non-contracted hospitals. As a flow-on effect the existence of default benefit arrangements supports a diversity in the private hospital sector and assists in managing the balance between hospitals and insurers (or insurer groups) with very large market shares.

Recent history has shown how quickly a sector can come under financial pressure. In the lead up to the COVID-19 pandemic, insurers were increasingly under fiscal threat as participation rates had dropped for 20 successive quarters and their outlays were continuously increasing. Through the pandemic participation rates have now climbed for 8 successive quarters and outlays have decreased due to the impact of lockdowns and workforce shortages. Private hospitals have now faced 3 years of decreased activity which has significantly impacted on their ability to generate income.

Second-tier default benefits play a moderating influence through these industry swings, ensuring that adequate funding is maintained to health providers to deliver a quality level of service. Second-tier default benefits also provide a safety net for hospitals facing financial hard times – they have a reasonable safety net price that prevents insurers from taking undue advantage and trying to achieve greater levels of cost control at the expense of patient outcomes.

Question 2. How well do the current arrangements meet these objectives?

The statistics provided in the consultation document demonstrate that only a small percentage of separations are out of contract, fewer than 2 per cent. This shows that default benefits are having minimal direct influence on PHI premiums. However, for those small number of patients it provides a valuable guarantee they can receive care in the hospital of their choice. This supports the underlying value proposition of PHI by providing confidence to those taking out a policy at a minimal cost. This in turn lowers PHI premiums by attracting more members.

Question 3. What other objectives should default benefit arrangements be aiming to achieve?

The AMA agrees that second-tier default benefit arrangements should not stifle innovation. We have been advocating for a reinvigorated and resilient private health system, that provides the right programs which are cost effective, clinically advantageous, medical practitioner led and insurer funded. One that focuses on continual improvement, supports new and improved clinician led models of care and the adoption of new technology.

The AMA does not see the current second-tier default benefit settings achieving this. Unlike admitted overnight hospital care, there is no provision for minimum default benefits for day programs or home-based services. Consequently, consumers can only access these programs if their insurer has contracted with the hospital to cover them, or if the insurer has a financial interest in the service.

Providing default benefits for day programs, outreach and home-based care programs for appropriate clinical care would widen consumers' care options and increase access to more efficient and clinically appropriate health services. Providing default benefits for community-based and home-based programs would support the establishment of these programs on a sustainable basis. Moreover, it would provide certainty for hospitals and other medical providers looking to invest in these new programs, which would lower the cost to support and promote further innovation in the private health sector.

The AMA would like to highlight that clinical quality must not be compromised through any reforms. Depending on how they are designed and implemented, models that shift treatment from hospitals to home and community settings have the potential to reduce the quality, safety, intensity, frequency and outcomes of that care. Robust standards need to be enshrined in clinical governance arrangements to ensure that in efforts to reduce the costs of care, that this does not result in lower quality or inappropriate standards of care. We have previously offered to work with government on developing clinically appropriate, innovative models of care for clinicians and their patients and we do so again.

Question 4 Do the current default benefit arrangements disincentivise contracting at all?

The AMA does not believe this is the case. It is not in the interest of private hospitals to enter into an arrangement that reduces their payment for the provision of health services, when the costs of those services keep rising all the time.

The AMA understands that as the second-tier default benefits are determined yearly and are no less than 85 per cent of the average charge for the equivalent episode of hospital treatment, under an insurer's contracted agreements with comparable private hospitals, this also provides little incentive currently for day hospitals to utilise second-tier default benefits in preference to contracts. Additionally, some insurers add an extra layer to this by only allowing access to their no and or known gap schemes for contracted hospitals.

Question 5. Should contracting between hospitals and insurers be the preferred model?

If so, what are the needs for regulation relating to insurer funding of hospital services?

The AMA agrees that contracting is the preferred model. A move away from the status quo would require a significant investment in data and research to analyse other options. However, currently we do not have the appropriate systems in place to support contracting in the private health sector. To achieve this, the AMA recommends constructing regulatory settings that do the following:

- Support innovation and development of clinically lead and appropriate models of care,
- Support patient access to their choice (choice of treatment options, of doctor and of health care setting and insurer),
- Support a diversity of hospital and health care settings,
- Support further innovation through the transparent application of cost data, and
- Support a geographical spread of private hospitals.

The AMA has growing concerns about the:

- Increasing use of selective contracting, which allows insurers to influence the healthcare pathways available to their customers and reduces choice for patients and medical practitioners,
- Increasing levels of vertical integration between insurers and providers, which impacts patient choice and clinical independence, and
- Formation of buying groups with substantial market power, reducing competition within the private health sector, and introduces aspects of managed care.

Contracting has the potential to impact patient choice over their doctor and hospital and can also interfere with clinical autonomy. The AMA believes that second-tier default benefits contribute to maintaining a balance which supports private patients in achieving choice and their best health outcomes.

Question 6. *Currently, the only formal data collection that we are aware of relating to the usage of default benefit arrangements is the "Hospital Contract Status" data item in the Private Health Industry data collections (Hospital Casemix Protocol 1 and Hospital Casemix Protocol 2) submitted to the Department collections under the Private Health Insurance Act 2007. What, if anything, should be done to improve the ease of data submission and the clarity and usefulness of these data collections to reflect possible payment arrangements between hospitals and insurers?*

Question 7. *Do you have any comments or reflections on the data presented in this section?*

The AMA does not hold any data, nor can we comment on data submission. However, data clarity and usefulness should be a priority to support the evidence for reform and change. We have advocated strongly for a better ability to analyse and use data across the private health sector, to deliver better policy settings and better health outcomes.

The AMA has proposed the establishment of a Private Health System Authority that would assume responsibility for the collection of data and information from insurers, as there will

need to be close examination of the data that insurers collect, how it is used, and the implications for healthcare in Australia into the future. As we continue to move towards greater data interoperability in our health system, this will ensure that there is appropriate oversight of the collection and use of patient data, and a mechanism to support the use of data to improve patient outcomes.

This function is not currently performed rigorously by the Australian Prudential Regulation Authority (as its focus is on prudential regulation), by the Commonwealth Department of Health, by the Australian Competition and Consumer Commission or the Commonwealth Ombudsman. In fact, as a strong user of data from all these sources, what we see on a year-by-year basis is the decrease of data across regulatory entities being made available and, more problematically, a decrease in the analysis of that data to highlight urgent issues that need to be considered.

Access to and Choice of Services

Question 8. *How effective are default benefit arrangements at improving PHI consumers' access to and choice of services? What other mechanisms/arrangements have an impact?*

Second-tier default benefits are a critical safety net for patients. At times of contract dispute (or termination of contract) patients have to consider moving to different insurers or different health settings to ensure they reduce out-of-pockets to a manageable level. This has a significant and stressful impact on all patients planning medical treatments, but more so for our more vulnerable patients reliant on long term relationships with their treating practitioner and health teams.

In the recent dispute between Bupa and Ramsay, pregnant women were unsure that they would be able to have their babies at the hospital they had chosen with the obstetrician they had chosen. Patients with long term conditions were suddenly unsure if they would be able to stay with the dialysis or chemotherapy support teams they had been working with. This level of uncertainty and stress for our most vulnerable patients is counterproductive and unhelpful. It was particularly stressful for many patients in regional areas where the Ramsay hospital was the only private hospital.

Question 9. *In your experience, what health services/providers are the most reliant on default benefit arrangements? a. How critical are these health services/ providers to the consumer? For example, rural/remote providers, new providers, specialised/ innovative services, providers that are unable to reach any negotiated contract agreements b. Does reliance on default benefits arrangements change over time for these providers?*

The effective operation of Australia's private hospital sector is not reliant on any one group of services or providers. Indeed, it is the diversity of different settings and approaches that provides the greatest value to the provision of health services. Whilst the data provided in the

consultation document show lesser and greater usage across different providers, this is inconclusive and somewhat irrelevant.

These data de-emphasises the role of default benefits in supporting parties to reach contracting deals. It does not look at how default benefits support the diversity of private hospital settings. For example second-tier benefits will sometimes be used for very specialised complex surgery that are performed in specific hospitals to utilise special facilities or equipment. They support the hospitals to specialise in specific equipment, surgeons to specialise in procedures, and provide cover for patients. The data also fail to demonstrate how default benefits work in concert with other approaches to deliver the current range of outcomes.

Question 10. Option for Change | Do you think default benefit arrangements should be specifically targeted exclusively for the services/providers that you identified in Q9?

For the reasons outlined above we do not support any targeting.

Question 11. Option for Change | Should future options for change have two different tiers (minimum and second)? If so, what is the benefit and/or cost associated with a two-tier scheme?

The AMA supports the retention of minimum and second-tier default benefit payments – these are essential for the protection of patients. However, the default scheme as currently configured does not adequately support changes in practice that have already happened, such as the increased use of short stay procedures, hospital-in-the-home programs and telehealth use. Furthermore, it does not provide for the innovative models of care we require to future proof Australia's private health system.

The real question that must be asked now is do we have the right model to support modern and innovative practice. The AMA believes that now is the time to explore the development of minimum default benefits for the provision of hospital-in-the-home, day programs and hospital services delivered using both face to face and telehealth/virtual modalities.

Question 12. How are default benefit arrangements important for hospitals that do have contracts with private health insurers, and how is this beneficial to insured patients at those hospitals?

Times of contract dispute are incredibly stressful for patients – the questions about when the dispute will end and what fiscal or clinical impact will it have on their health journey weigh heavily for many people. Suggestions that patients can simply change insurer or change provider and hospital are anxiety producing for many patients, but especially those with chronic or long-term conditions who have ongoing relationships with their doctor and other health providers, pregnant women with longstanding relationships with the obstetrician and midwife, people in rural and remote areas with limited choices in the first instance.

Default benefit arrangements provide a strong safety net for these vulnerable patients in stressful times. Second-tier default benefits mean they can choose to stay with their choice of doctor, health team, hospital and not be subject to impossible out-of-pocket costs.

Disputes between insurers and hospitals may not occur every year, but when they do they have the potential to impact on millions of patients:

- Ramsay and Bupa 2022 – Ramsay private hospitals admits more than 1.1 million patients per year[1] and Bupa PHI policies cover more than 3.5 million Australians[2]
- Calvary and Medibank 2015 – The Calvary Group (which includes 4 public and 10 private hospitals) admits nearly 300,00 patients a year[3] and Medibank covers more than 3.6 million Australians[4]
- Calvary and Australian Health Service Alliance (AHSA) funds 2018 – AHSA provides services for 23 different PHI funds[5].

Additionally, what is less visible and anecdotally more prevalent are the times where contract negotiations have come to the brink of termination. The role second-tier default benefits play in preventing disputes is difficult to quantify but should not be undervalued.

Question 13. Are you aware of examples where hospitals go from in contract to out of contract (and thus have to rely on default benefits)?

One of the strengths of the second-tier default benefit arrangements are that they support a safety net being in place and this works in the background to help parties settle disputes without significant adverse impact on patients. At 85 percent (of the preceding year's prices as each insurer calculates its second-tier default benefit rates yearly, based on its negotiated contractual agreements in force on 1 August each year and these rates apply to admissions between 1 September of that year and 31 August the next year) hospitals have a strong financial imperative to enter into contracts and increase this return rate.

The AMA understands second-tier default benefits do not provide the same imperative for insurers, but the ease with which patients can transfer to another insurer does provide some pressure to maintain contract arrangements that work in the best interest of their customers. During the recent contract dispute with Bupa, Ramsay provided media statements highlighting that one-way patients could increase their certainty regarding their medical costs during the disputed was to change to a different insurer.[6]

Question 14. How effective are default benefit arrangements at impacting the predictability of and reducing hospital and medical out-of-pocket costs for consumers?

[1] https://www.ramsayhealth.com/Our-Businesses/Ramsay-Australia#:~:text=With%2072%20hospitals%20and%20day,employs%20more%20than%2031%2C000%20people.
[2] https://www.apra.gov.au/operations-of-private-health-insurers-annual-report
[3] https://www.calvarycare.org.au/wp-content/uploads/2022/04/Calvary-Fast-Facts-as-at-31-Dec-2022.pdf
[4] https://www.apra.gov.au/operations-of-private-health-insurers-annual-report
[5]
[6] https://www.ramsayhealth.com.au/News/ProtectNews/Deadline-approaches-for-end-of-Ramsay-Health-Care-and-Bupa-contract

Question 15. Option for Change | What mechanisms could be introduced to impact the predictability of and reduce hospital and medical out-of-pocket costs for consumers?

The AMA does not think that the default benefit arrangements that are currently in place impact significantly on medical out-of-pocket costs for consumers. As we outline annually in our Private Health Insurance Report Card the key factors include:

- varying PHI benefit schedules;
- different payment rates in different regions or states;
- the linking of gap payments to facility contracts;
- different policy details and fine print;
- the operation of gap and known gap rates, in particular the massive reduction in rebate paid if a doctor's fee is even a small amount over these rates; and
- continual inadequate indexation of the MBS and consequently, insurance benefit schedules.

To address the issue of out-of-pocket costs the AMA had called on Government to commit to looking at a new, more appropriate indexation model for the MBS, less variation in insurer rebates and some standardisation around offering a known gap product. Furthermore, the AMA calls for insurers to stop the practice of linking gap rates to facility contracts – a process that has simply added complexity for patients and practitioners alike.

Affordability of PHI Products

Question 16. How do default benefit arrangements impact on agreed contract rates?

As outlined earlier the AMA does not view second-tier default benefits as inflationary. The second-tier rate of 85 per cent of the preceding year's prices is calculated yearly by each insurer. This means that if a hospital is to rely on second-tier rates, they are in effect accepting less than 85 per cent due to inflation.. As such, hospitals have a strong financial imperative to enter into contracts and increase this return rate. This is especially true currently with the financial impact of putting in place pandemic measures and the increased inflation rate.

Question 17. How does variation in contract structures and in prices agreed for similar treatments impact on prices paid for PHI by consumers?

Like many stakeholders and every single patient, the AMA has no clarity on the variation and contract structures and payment arrangements. One of the key issues that the AMA has with the current regulatory and governance arrangements covering the private hospital/PHI sector is the lack of transparency and visibility of the operation of contracts and whether this is impacting negatively on the effectiveness and efficiency of providing services. This is one of the key reasons that the AMA continues to call for a new independent Private Health System Authority which would address gaps like this in the current regulatory environment and oversee the private healthcare system.

Question 18. Option for Change | What would be the implications of a published set of independently produced minimum or second-tier default benefits, from which insurers/hospitals could agree loadings/discounts in contracts? How feasible is this option and what data could be used to inform the published benefits?

The AMA has been calling for increased transparency in the private health sector and as such supports further exploring this idea. Even if these prices were not published more broadly, they should be provided to and overseen by an independent expert entity. This would allow for the interest of patients and other stakeholders impacted by these deals and negotiations to be better represented and considered.

Patients struggle with the lack of clarity in the private hospital and PHI sectors and more needs to be done to improve this situation.

Question 19. What impact do other policies or institutional frameworks have on default benefits and contracting? E.g., the National Procedure Banding Committee.

The regulation, legislation, and rules that underpin the interactions between private health insurers, private hospitals, healthcare providers, and patients is complex. There are currently five bodies responsible for overseeing different aspects of the private healthcare system.[7]

Additionally, as both the policy making body and regulator of private health insurance arrangements, the Department suffers from an inherent conflict in situations such as this one, where it is required respond as a regulator to issues arising as a result of Departmental decisions.

The National Procedures Banding Committee (NPBC) is the industry steering committee represented by equal numbers of private hospitals and private health insurer representatives to oversee the management, maintenance and update of the procedure banding system. There is little transparency and accountability in such a model. The AMA strongly supports this committee becoming more transparent and accountable and having clinical representation. The AMA believes that the operation of the NPBC outside of any of the current regulatory or governance arrangements in place for the private hospital sector further demonstrates how the current arrangements are not fit for purpose.

Quality and Appropriateness of Services

Question 20. To what extent do you think the current arrangements support the safety and quality of health services?

The current arrangements ensure hospitals have a safety net that supports a base price for delivering quality health services. Price setting should not erode patient outcomes but should be able to support effective and efficient practice. The AMA has seen no evidence that the existing safety net is inappropriate for delivering quality of service.

[7] https://www.ama.com.au/form/whole-of-system-approach

Question 21. What role does legislation and/or contracts play in ensuring quality and safety of service?

Legislation along with evidence and data are critically important in underpinning the safety and efficacy of Australia's private health sector. However, as outlined previously the lack of quality evidence and analysis is undermining the ability of this sector to perform at an optimum level.

Furthermore, the lack of transparency about the contracts used in the sector undermines the value people see in the PHI product and whether the best evidence-based services have been adequately supported. The AMA understands that contracting needs to provide enough room to allow development and implementation of innovation, but it needs to also provide enough certainty to patients that their outcomes and safety are paramount in any process.

There needs to be understanding that while innovation can lead to lower costs over time, in the early days sometimes there are upfront costs to develop the evidence base and transition practices. An agreed price helps establish the incentive for providers during early adoption phase with appropriate review points once services become more common. These could be time-based reviews (sunset clause), or number of service reviews.

Question 22. Option for Change | Should quality requirements for hospitals be broadly comparable regardless of contract status? If so, how should this be achieved?

Appropriate contracts need to support appropriate clinical standards. Difference in quality requirements should relate to risk of procedure and service – and maybe even different settings not contracting or price points.

Innovation and Market Dynamics

Question 23. Please explain any impact the current default benefit arrangements may have on the supply or demand of private hospital accommodation services?

The primary role of hospitals is to facilitate procedures that improve health outcomes of patients. Private hospitals are rarely in 'excess supply' and so always have an incentive to return patients to their homes as soon as is practical. In fact, having a patient remain in a bed longer than necessary reduces the flow of patients through the hospital and reduces the revenue potential of the hospital, this also limits operating options for doctors and patients.

The private hospital sector is better placed to explain the factors prohibiting the flow of patients from exiting the hospital. The AMA believes that there should be a robust transparent process in place to ensure minimum defaults do not penalise hospitals nor reward them for patients remaining in hospital longer.

Question 24. How do the current default benefit arrangements and contracting impact the supply of other private health services, and their alignment with demand for those services? Please consider the development and provision of innovative

private health services, such as HITH services, hospital-substitute treatment, and preventative care.

As stated earlier the current second-tier default benefit settings achieve this. Unlike admitted overnight hospital care, there is no provision for minimum default benefits for day programs or home-based services. Consequently, consumers can only access these programs if their insurer has contracted with the hospital to cover them, or if the insurer has a financial interest in the service.

Providing specific default benefits for day programs, outreach and home-based care programs for appropriate clinical care, would widen consumers' care options and increase access to more efficient and clinically appropriate health services. Further providing specific default benefits for community-based and home-based programs would support the establishment of these programs on a sustainable basis. Moreover, it would provide certainty to hospitals and other medical providers looking to invest in these new programs, which would lower the cost to support and promote further innovation in the private health sector.

Question 25. How can government support the sector in ensuring that evolving consumer health needs are continued to be met by the best health services and technology available at the time?

The AMA's body of policy work is outlined in the following documents:

- The 2021 *AMA Prescription for Private Health Insurance* (https://www.ama.com.au/articles/ama-prescription-private-health)
- Annual *AMA Private Health Insurance Report Cards* (https://www.ama.com.au/articles/ama-private-health-insurance-report-card-2021)
- AMA's 2022 *Discussion paper: A whole of system approach to reforming private healthcare* (https://www.ama.com.au/form/whole-of-system-approach)
- AMA Private Health System Summit (https://www.ama.com.au/media/ama-president-and-vice-president-ama-private-health-summit-and-failure-government-extend).

The AMA is always open to discuss issues facing Australia's private health system further.

Question 26. Option for Change | Does legislation relating to contracting have a role in promoting innovative health services such as HITH and how can the current legislation be improved to support innovation?

The AMA believes the legislation needs to better support innovation. We refer to our previous discussion, particularly in Questions 20, 24, for more details about this issue.

Equity Between Consumers of PHI

Question 27. Which consumer groups need additional support to access private hospitals?

Question 28. *To what extent do default benefit arrangements support consumers to access private hospitals? Is it reasonable to expect default benefits could give more support to consumers given other limiting factors?*

Question 29. *Option for Change | What more could/should default benefit arrangements do to support equitable access to privately insured services, or are there more appropriate arrangements to promote equity? If so, what are these arrangements?*

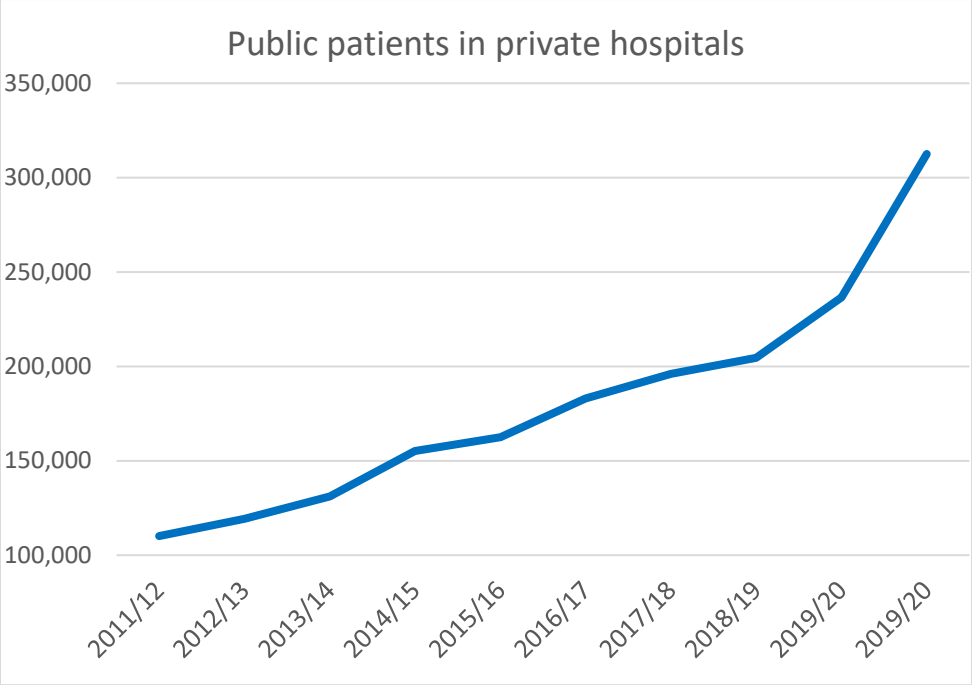
The AMA strongly supports the continuation of default benefits for independent and regional and remote hospitals as we understand that these hospitals are often less viable having a smaller customer base. There is also a stronger imbalance between independent and rural and regional hospitals and especially the larger health insurance funds. These hospitals can be crucial to rural and regional communities and provide critical services that must be supported to continue. Moreover, smaller hospitals support private practice which in turn enables and supports the provision of public services.

The AMA is also aware that there are a number of services across the private hospital sector that are very costly and are difficult to maintain in the face of reducing margins. Services such as ICUs are also critical to the health of all Australians and funding of private hospitals needs to ensure these services are funded appropriately so they can be retained.

Second-tier default benefits operate as a safety net for all patients but especially for patients with long term relationships with doctors and health teams. Patients must know they can continue accessing these services without facing unrealistic expenses in cases of disputes.

At an individual level, the AMA believes that restoring the PHI rebate for targeted groups to make private health hospital insurance affordable for younger Australians and those in the workplace on lower incomes is likely to have a more significant impact on supporting equitable access to privately insured services.

The AMA is also aware that the number of public patients in private hospitals was increasing significantly before COVID but the last 2 years have seen this rate further increase (see figure below). The AMA calls on the government to undertake further research to see what impact this trend is having on private patient waiting lists.

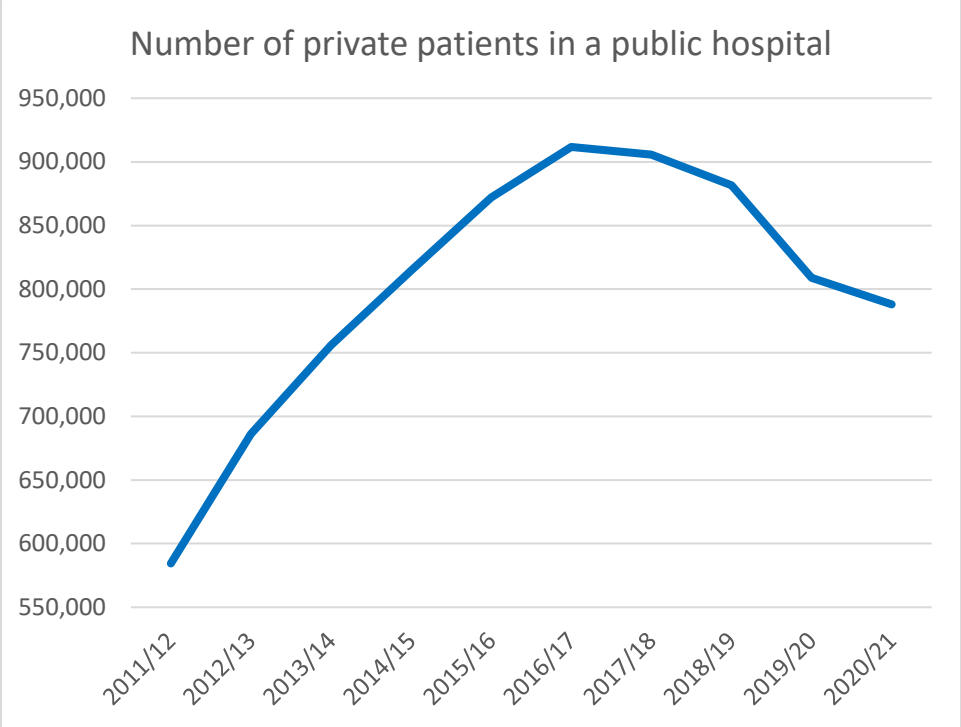


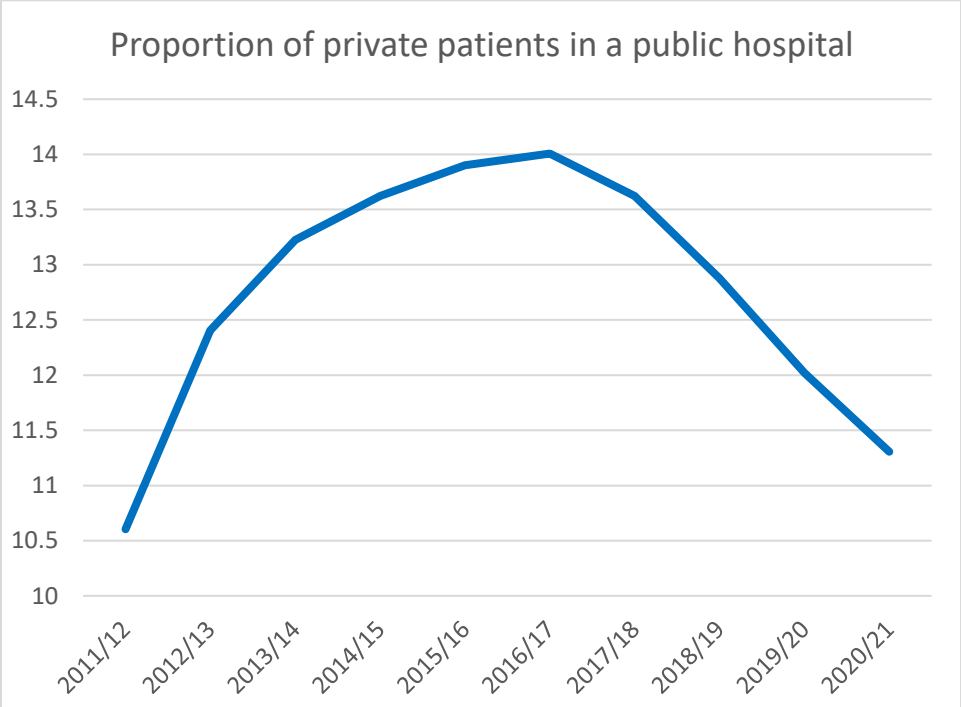
Integration and Adaptability within the Healthcare System

Question 30. *Please comment on whether and how default benefit arrangements impact the public health system considering: a. its role in the funding of private patients in public hospitals b. the extent by which it supports patients to access private healthcare services rather than public healthcare services.*

Default benefit arrangements are the key drive of behaviour in the public sector. The following charts show that for private patients in public hospitals the work of Health Ministers and then IHPA through the *2018 Heads of Agreement between the Commonwealth and the States and Territories on public hospital funding and health reform* have been the real reasons driving the changed behaviour graphed below.

Parties to the 2018 Heads of Agreement, agreed on the need to examine the underlying drivers of growth of private patients in public hospitals. Parties have also agreed on the importance of developing reform initiatives to improve practices that support patient choice and access to public hospital services by all patients on the basis of clinical need. IHPA was mandated to update its Pricing Guidelines to emphasise that the principles underpinning the national funding model should not lead to perverse incentives, financial or otherwise, that encourage public hospitals to prioritise admitting private patients.





Information for these figures comes from AIHW admitted patient data[8]

The provision of private services not only support the public system as a substitute for public services but also as a complement for the workforce. Many doctors work in both the public and private systems. Second-tier default benefits ensure a doctor has the ability to treat a patient at

[8] https://www.aihw.gov.au/reports-data/myhospitals

the local hospital even when there is no contract between the patient's insurer and that hospital. Interfering with second-tier default benefits would not only place private patients at risk of losing their local doctor of choice but may also reduce doctors' scope to practice in the public system.

Operational Considerations

Question 31. Please detail any ambiguities or other consequences that arise from the legislation in its current state that have not been described above.

The current regulatory arrangements across the whole private health sector were designed at a time when PHI was in a relatively healthy position with strong membership, when most insurers operated on a not-for-profit basis, and when private hospitals had a greater profit margin.

The current regulatory and legislative framework is proficient at protecting the interests of consumers by maintaining insurer solvency and managing consumer complaints, as well as ensuring the safe delivery of care in private and day hospitals.

The mechanisms in place that ensure the private health system evolves in a sustainable way to meet government policy objectives are limited and at best, ad hoc. There are also limited whole-of-system mechanisms to ensure the needs of patients, day hospitals, private hospitals, private health insurers, medical device manufacturers and doctors are considered and balanced.

In particular, the current regulatory and legislative framework does not prevent behaviours which may be leading us down a managed care pathway. For example, the current constraints on private health insurers owning majority shares of healthcare services and providing vertically integrated care are largely practical and commercial considerations made by the sector, as opposed to a legislative mandate from government.

The AMA believes there are significant gaps in the regulation, guidance, and oversight of:

- Contracting arrangements between insurers and healthcare providers,
- Insurers developing and delivering healthcare programs for fund members, which may occur in isolation of a patient's usual treating practitioners,
- Insurers delivering health services in the community that substitute for hospital care,
- The implementation of whole-of-system reforms required to secure the long-term sustainability of the private healthcare sector, and
- The impact that changes in the broader healthcare sector have on the sustainability of the private sector.[9]

Any changes to the legislative arrangements for default benefits need to consider the potential to shift the current balance and negatively impact on clinical independence and patient choice and health outcomes.

[9] https://www.ama.com.au/form/whole-of-system-approach

Question 32. Option for Change | In calculating the average charge for the equivalent episode of hospital treatment for second-tier default benefits, what are your thoughts on taking a volume-weighted approach?

A volume weighted approach is a reasonable option, provided the hospitals in the sample weights are comparable. That is, regional hospitals would have a different cost base to major metropolitan hospitals. Larger hospitals can share fixed costs across more episodes or specialty types of care. Provided the volume measure accounts for size and geography, a move to a volume measure would be fairer and would not provide an incentive to remove contract arrangements given the reduced benefit which would apply to comparable hospitals.

Question 33. Option for Change | What are your views on the current second-tier benefit hospital categories? Are there definitional issues created by these definitions - such as potential interpretations for 'rehabilitation care' in the definition of hospital category (b), and how the categories should apply to 'campuses' that are in different locations to a main facility?

Question 34. Option for Change | What changes would you make to these categories?

Question 35. Option for Change | Please provide details on the administrative costs associated with operationalising minimum and second-tier default benefits, highlighting any areas which are potentially inefficient.

Question 36. Option for Change | What options are available to improve administrative efficiency? Please consider: a. prescribed contract templates - applicable regardless of whether default benefit arrangements apply b. standardised terms and conditions, including in relation to quality and safety (see Section 3.3)

The AMA defers to the private hospital and PHI sectors to answer these questions.

Potential Future Options

Question 37. Option for Change | What specific changes would you like to see made to default benefit arrangements and what would be the benefits of these changes in relation to the assessment criteria?

Question 38. Option for Change | What are the other key considerations associated with these potential changes to default benefit arrangements, including: a. the impacts for consumers b. financial and non-financial cost considerations related to implementation and ongoing administration?

The AMA is not involved in contract negotiations between hospitals and insurers but would make the following observations: Each insurer and each hospital has whole teams of people working on contract renegotiations (including impact of default benefits). The current high levels of complexity, mistrust, and lack of transparency impact negatively on the amount of

work undertaken every time a contract is renegotiated. The AMA believes there must be a better way than the current adversarial, brinksmanship approach, but new options are not going to arise from the current style of consultation on this topic. We would like to see increased transparency and independence in price setting and contracting arrangements.

The AMA would advocate for an independent, expert authority to be developed in this area, one that would increase the evidence base, consider issues over time and work up better arrangements for the future. Short of an authority, the AMA supports the establishment of an advisory body comprised of key stakeholders in the private health sector to commence this work.

23 SEPTEMBER 2022

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