AMA
Research & Reform

Discussion paper:
A whole of system approach to reforming private healthcare

The role of a Private Health System Authority

Discussion Paper

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Level 1, 39 Brisbane Avenue Barton ACT 2600
Telephone: 02 6270 5400
www.ama.com.au

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EXECUTIVE SUMMARY

Private healthcare is an essential pillar of our health system, working in partnership with the public sector to ensure Australians have access to safe, high-quality, and affordable private healthcare. While we have seen a modest increase in private health insurance uptake in the last year which can be attributed in part to the COVID-19 pandemic, the viability of the private sector is still in trouble. Over the last five years we have seen a significant shift in the demographics of the insured population, with those over the age of 60 set to become the largest insured population. As a result, private health insurers are under increased financial pressure and in need of mechanisms to reduce outlays while also driving innovation and filling gaps in service delivery. However, the only levers available to insurers to reduce outlays, drive innovation and fill gaps in service delivery are ones that may lead us down a United States-style managed care pathway, such as selective contracting and purchasing healthcare services to provide vertically integrated care.

The current regulatory arrangements were designed at a time when private health insurance 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 arrangements are effective at protecting the interests of consumers by maintaining insurer solvency, managing consumer complaints, and ensuring the safe delivery of healthcare. The mechanisms in place that ensure the private health system is changing in a lasting way as government policy intends are however limited and 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. 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. There are also no mechanisms overseeing the impact of broader health system reforms on the private sector, or mechanisms to ensure that the policy settings underpinning the private sector remain fit-for-purpose. These gaps in regulation ultimately impact the patient through unexpected out-of-pocket costs and make it challenging for patients to navigate an already complex system.

As COVID-19 restrictions continue to ease, our public sector will not have the capacity to address the rise in COVID-19 cases, in addition to the backlog of non-COVID-19 related care, and therefore the private sector will continue to play a crucial role in ensuring the care needs of patients are met. **A new approach to reform is therefore needed now more than ever**. As the government has largely exhausted the policy levers at its disposal, this reform must take a whole-of-system approach that recognises private healthcare as a public policy necessity, and an essential pillar of our healthcare system.

The AMA is calling for the establishment of an independent and well-resourced Private Health System Authority (the Authority) to fill the gaps in the current regulatory environment and oversee the private healthcare system. This ‘independent umpire’ would have the capacity, objectivity, and expertise to ensure the system evolves as government policy intends, balancing the interests of patients, day hospitals, private hospitals, private health insurers, medical device manufacturers, and doctors. It would also create a platform for all the players in the sector to come together and agree on the necessary once-in-a-generation reforms which are required to ensure the future viability of private healthcare in Australia.

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INTRODUCTION

Australia's healthcare system: a delicate balancing act

The private health system is an essential component of Australia's healthcare system, offering patients access to a wider range of services and reducing demand on the public sector. One of the unique strengths of the Australian healthcare system is the equilibrium that exists between the public and private sectors, which work in partnership to provide high-quality healthcare to Australians. The equilibrium relies on a strong private healthcare sector which complements the public sector to:

- Reduce demand on the public health system, by reducing public expenditure, wait times and demand for public hospital beds.
- Enable consumers to have more control over their healthcare, including selecting their preferred practitioner, accessing care more quickly (through reduced wait times for elective treatment), and having access to a wider range of services outside of the public sector.
- Encourage innovation and quality improvement in healthcare services.

Significant changes in either the public or private sector threaten this delicate balancing act, and therefore the sustainability of the Australian healthcare system.

The private health sector is at a tipping point

Explored in further detail in *AMA's Prescription for private health insurance* report, the proportion of the population with private health insurance hospital cover has continued to decline since 2015, with the exception of a modest (1.1%) increase between June 2020 and September 2021 which can be attributed to in part to the COVID-19 pandemic.[1] Notwithstanding this recent increase, those over 60 years of age are set to become the largest insured population in the foreseeable future. This shift in demographic composition (depicted in Figure 1) is placing insurers under increased financial pressure, resulting in insurers needing to identify ways to reduce their costs.

While some methods are positive, such as programs which improve the health of customers through promotion of preventative health strategies,[2] others are concerning such as:

- 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.[3]
- Increasing vertical integration between insurers and providers, which impacts patient choice and clinical independence.[4,5,6]
- Differing levels of co-payments, excesses and benefit payouts which creates confusion for consumers.[7]
- Implementing new models of care which may result in fractured care if not codesigned and delivered in consultation with medical practitioners.[8]
- Increasing formation of buying groups with substantial market power, reducing competition within the private health sector, and introducing aspects of managed care.[9]

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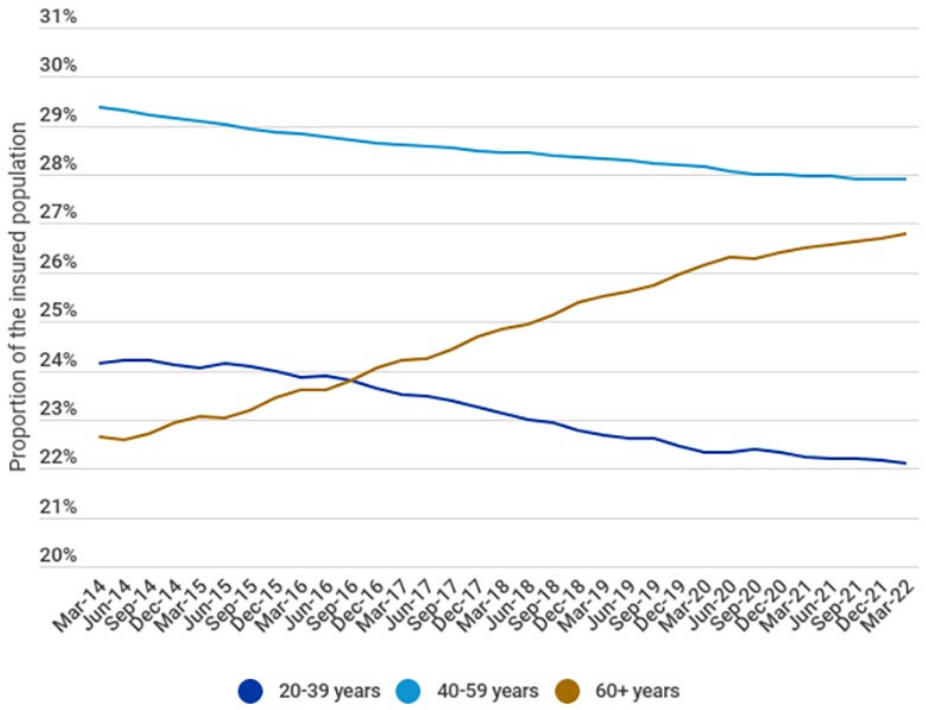
Figure 1: Demographics of the insured population[10]

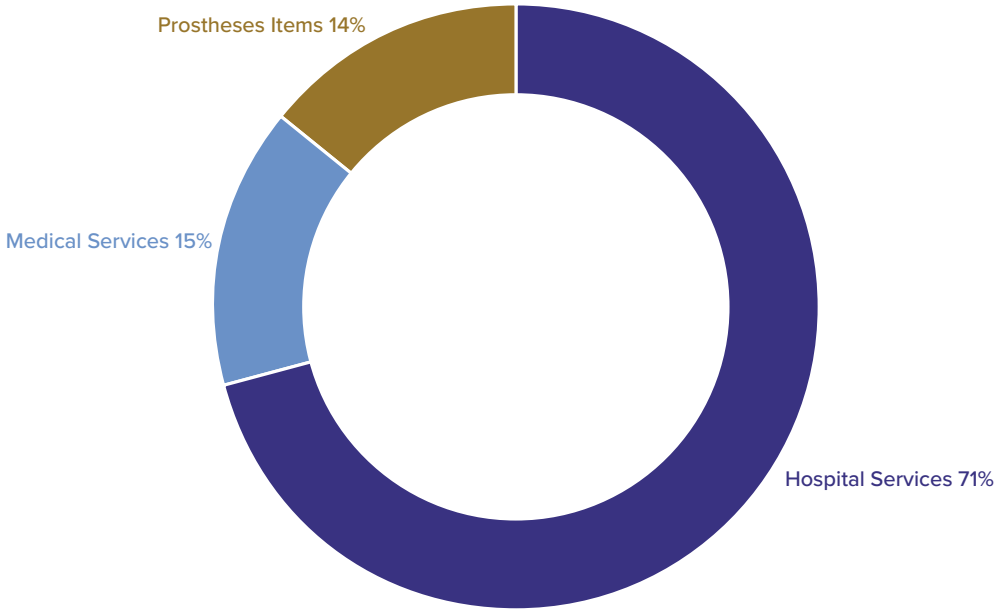


Due to the dramatic shift in the relative market share of for-profit insurers[11,12] (further discussed in AMA's *Private Health Insurance Report Card 2021*), these cost-saving initiatives are being increasingly utilised by insurers to reduce expenses and increase profits. Without these cost-saving initiatives, the only other way insurers can offset the shift in composition of members is to increase their premiums. The major driver of the rise in health insurance premiums is increases in benefit outlays, with hospital services making up the major component of outlays for hospital treatment (71%) (depicted in Figure 2).[13] The high costs of prostheses as well as recent increases in fund management expenses may also be contributing to the rise in premiums.[14,15]

With the cost of premiums being a predominant financial concern for Australian households,[16,17] consumers are weighing the benefits of private health insurance against the value of the public system, as well as other goods or services they could spend their money on.

The recent uptake in private health insurance combined with the reduction in claims, largely due to the COVID-19 pandemic limiting access to non-urgent health services, has resulted in short-term profits for insurers. In their annual report into the private health insurance industry, the Australian Competition and Consumer Commission noted that many insurers have been returning these profits to policyholders, primarily through premium credits or direct payments to policyholders.

Figure 2: Breakdown of benefit outlays for hospital treatments[18]



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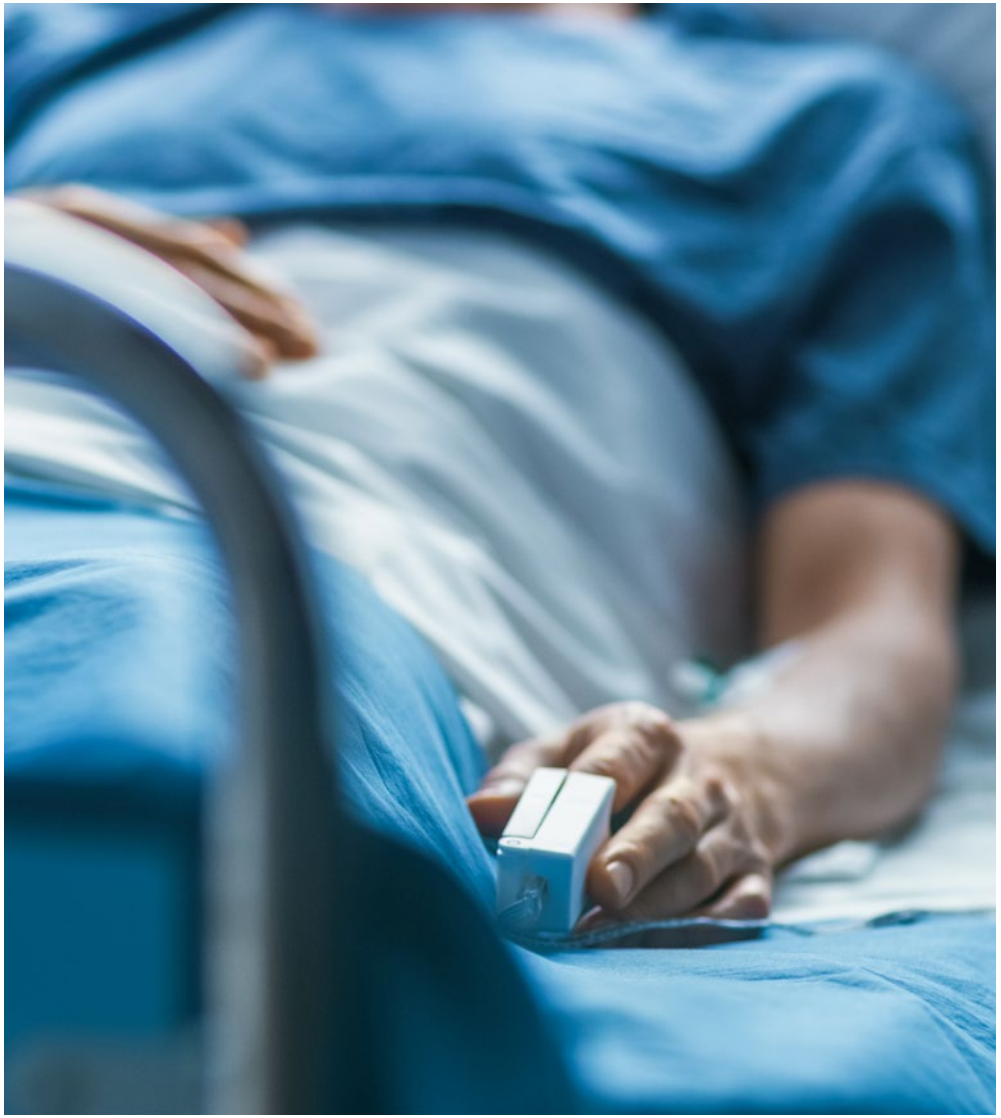

The private health sector has also played a key role during the COVID-19 pandemic, providing additional capacity to support the COVID-19 response.[19] As COVID-19 restrictions continue to ease, the healthcare system will be under significant pressure as it addresses the rise in COVID-19 cases in addition to the growing backlog of non-COVID-19 related care, some of which is likely to be more complex as it has been delayed for several months. As public hospitals will not have the capacity to scale up and meet this demand (further detailed in AMA's *Public hospitals: Cycle of crisis* report, the private sector will continue to play a crucial role in the COVID-19 response and ensuring the care needs of patients are met.

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HISTORY: PAST ATTEMPTS AT REFORM – THE SUCCESSES AND FAILURES

Several reform initiatives have attempted to improve the uptake of private health insurance and the viability of the private healthcare sector. Detailed below, these various attempts at reform have been piecemeal and limited in scope, and have therefore not addressed the underlying issues in the system.

Government policy levers

There are currently several government policy levers designed to encourage uptake and maintenance of private health insurance, including the Lifetime Health Cover (LHC) loading, Private Health Insurance Rebate, Age-Based Discount, and Medicare Levy Surcharge (MLS).[20] While these policy settings have in many ways been successful, they are increasingly becoming less effective as they have been unable to keep pace with changes in demographics, wages, disease patterns, consumer need, and technology (see AMA's Prescription for private health insurance report for further detail). Recognising the significant impact these policy settings have on private health insurance participation, several initiatives have been recently announced and/or introduced to ensure these settings remain fit-for-purpose, including:

- A review of the MLS policy settings and private health insurance premium rebate.[21]
- An actuarial study focused on LHC (as well as risk equalisation).[22]
- Increasing the maximum age of dependants for private health insurance policies from 24 to 31 years and removing the age limit for dependants with a disability.[23]

Private Health Ministerial Advisory Committee

Established in 2016, the Private Health Ministerial Advisory Committee (PHMAC) brought together key stakeholders in the private healthcare sector to provide advice to government on the development and implementation of reforms to private health insurance.[24] The establishment of PHMAC and its various working groups represented a significant attempt at targeted reforms to private health insurance in response to the problems facing the industry. Further detailed in AMA's *Private Health Insurance Report Card 2019*, the reforms introduced largely focused on simplifying private health insurance products and improving transparency and certainty through:

- The introduction of the Gold, Silver, Bronze and Basic classification system in April 2019, requiring insurers to classify all private hospital policies as either Gold, Silver, Bronze or Basic based on standard clinical definitions and a defined minimum set of services.[25]
- Allowing insurers to offer travel and accommodation benefits for people in regional and rural areas that need to travel for treatment.[26]
- Requiring insurers to allow people with hospital insurance that does not offer full cover for mental health treatment to upgrade their cover and access mental health services without a waiting period, on a once-off basis.[27]
- Increasing the maximum excess consumers can choose under their health insurance policies.[28]
- The introduction of age discounts in April 2019, allowing funds to offer a discount of 2 per cent for every year a consumer is under the age of 30, up to a maximum of 10 per cent for people 18-25 years of age.[29]

Several key reforms and intentions outlined in PHMAC's original Work Plan were never progressed.[30] For example, reforms to the current risk equalisation arrangements were not substantive in their design and implemented in full, despite risk equalisation being key to community rating[31] and the Risk Equalisation Working Group undertaking extensive modelling of several scenarios.[32] The Commonwealth Government subsequently announced in the 2020-21 Federal Budget that an independent actuarial study would be funded which focuses on risk equalisation (as well as LHC, as outlined above).[33]

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The limited recommendations made by the Improved Models of Care Working Group's with respect to mental health and rehabilitation models of care were also not entirely operationalised by the sector.[34] Further reforms announced as part of the 2020-21 Federal Budget to expand home and community-based mental health and rehabilitation care were not implemented in April 2020 as announced, and to date have not been progressed.[35] Furthermore, while several options for reforms to the contracting environment and the second-tier default benefit arrangements were presented by the Contracting and Default Benefits Working Group,[36] the only changes that were implemented were to the second-tier administrative processes.[37]

These shortfalls are indicative of why a ministerial committee is not the most appropriate or effective mechanism to drive reforms to the private healthcare sector, as there was no entity looking at the implications of reforms on the whole system. Additionally, due to the confidential nature of the committee, consultation with the broader sector was limited which meant that key stakeholders were unable to input into reforms or interact with each other, and were not brought along on the reform journey.

Transparency and informed financial consent

Following the 2017 Senate injury and report on the value and affordability of private health insurance and out-of-pocket medical costs[38] and the release of the Ministerial Advisory Committee on Out-of-Pocket Costs report in 2018,[39] the Commonwealth Government announced that it would launch a national strategy to tackle excessive out-of-pocket costs charged by medical specialists.[40] Since the announcement, several initiatives have been implemented including:

- The development of the Medical Cost Finder on the Department of Health's website which collects, validates, and publishes de-identified data on typical out-of-pocket costs of common specialist medical services.[41]
- Expansion of the Commonwealth Ombudsman's functions and enhancements to the PrivateHealth.gov.au website, which is managed by the Commonwealth Ombudsman and enables easier comparison of health insurance products.[42,43]
- Education activities to increase consumer understanding of how health insurance works and what out-of-pocket costs are.[44]

While these initiatives represent a significant step to ensuring patient choice and informed financial consent, they do not provide full transparency to the patient. As outlined in AMA's *Informed Financial Consent* guide, full transparency requires the patient to understand the amount charged by the doctor for their procedure, the amount covered by Medicare, and the benefit amount paid by the insurer depending on the type of policy they have.[45] The current website may be misleading for patients as it only provides a range of typical doctors' fees and does not specify the benefits paid under each insurance policy. Following two years of continuous scrutiny from the media and several peak bodies, as well as the poor implementation of the recent 1 July 2021 MBS changes, the Commonwealth Government agreed to work with the AMA to improve informed financial consent processes.[46]

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Certification for hospital admissions

Closely linked to informed financial consent are the challenges associated with certification requirements for consumers, healthcare providers, and private hospitals. The increased disputation and rejection of Type B and particularly Type C certificates[i] sometimes after lengthy delays, places the financial burden of outstanding claims on private hospitals. This is resulting in some providers requiring payment for admission in advance, leaving consumers out-of-pocket and needing to seek retrospective reimbursement from insurers.[47] It also creates an administrative burden on hospitals which may disincentivise medical practitioners and hospitals from admitting patients, resulting in patients not having access to the appropriate care.[48]

As there are currently no regulatory processes or mechanisms in place to determine the appropriateness of a certification disputation or rejection, some disputes remain unresolved for several years. Additionally, while it is agreed that medical practitioners should have clinical autonomy when determining the need for hospital treatment, the lack of regulatory processes and accountability measures means that the potential for inappropriate practices and disputes is increased. To address these issues, changes to the certification process were announced in the 2021-22 Federal Budget allowing the medical colleges to develop clinical guidelines about when it is acceptable medical practice for a procedure to be provided in hospital. It was also announced that the role of the Professional Services Review (PSR) Agency will be expanded to review inappropriate practices around certifications by medical practitioners and associated hospitals to ensure the integrity of the certification arrangements, although inappropriate practices by insurers regarding certifications is currently not included in the scope of these PSR reviews.[49,50] It should however be noted that the PSR is not an appropriate body for this work as the majority of disputes occur between the hospital and insurer as opposed to the medical practitioner.

Administration of the Prostheses List

The administration of the Prostheses List has been 'set and forget' for several years, which has resulted in disproportionately high costs of medical devices when compared to the public sector. Since its introduction in 1985, the Prostheses List has undergone several reviews[ii] and attempts at reform. More recently, in response to the recommendations by the Industry Working Group on Private Health Insurance Prostheses Reform in 2016,[51] the Prostheses List Advisory Committee (PLAC) became responsible for supporting and undertaking reform work (in addition to their primary role of providing recommendations and advice about the listing of medical devices and their benefits).[52] Subsequently in 2017, the Commonwealth Government entered into a strategic agreement with the Medical Technology Association of Australia (MTAA) in an effort to deliver reforms on the Prostheses List.[53] Further reforms were then announced in the 2021-22 Budget to better align the cost of prostheses with the public system and streamline application and assessment pathways.[54] Poor consultation with the sector and little consensus between key stakeholders on how reforms should be implemented has ultimately resulted in a piecemeal approach to reform which fails to address the underlying issues with the Prostheses List.

[i] Some procedures can be performed in the doctor's office while others require admission to hospital. Type B and C certificates allow for hospital accommodation benefits to be paid where a Type B or C procedure is unable to be performed safely unless it is delivered in a hospital setting (as Type B procedures are usually do not require an overnight stay, and Type C procedures usually do not require any hospital treatment).

[ii] Including the 2007 Doyle Review, 2009 Health Technology Assessment Review, 2016 Industry Working Group on Private Health Insurance Prostheses Reform, and 2017 Senate Inquiry into Price Regulation Associated with the Prostheses List Framework.

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THE CURRENT REGULATORY LANDSCAPE AND ITS CHALLENGES

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: [55,56,57]

- **Australian Government Department of Health (the Department):** responsible for administering private health insurance under the *Private Health Insurance Act 2007*, developing policy in relation to private health insurance, and has the power to act as a regulator. Additionally, the Minister for Health and Aged Care is responsible for reviewing and approving new private health insurance premiums under the *Private Health Insurance Act 2007*.
- **Australian Prudential Regulation Authority (APRA):** the prudential regulator for private health insurance, responsible for ensuring that insurers have the ability to pay all policyholder obligations in accordance with the *Private Health Insurance (Prudential Supervision) Act 2015*. APRA is also responsible for collecting claim data and information from insurers to perform its role in overseeing the high-cost claims pool.
- **Commonwealth Ombudsman:** responsible for protecting the interests of private health insurance consumers through resolving complaints, providing advice to the government and industry about private health insurance, and managing PrivateHealth.gov.au.
- **Australian Competition and Consumer Commission (ACCC):** responsible for dealing with competition and consumer issues in the private health insurance industry, enforcing and encouraging compliance with the *Competition and Consumer Act 201*0 and Australian Consumer Law.
- **Australian Commission on Safety and Quality in Health Care (ACSQHC):** responsible for leading and coordinating national improvements in healthcare safety and quality.

Private hospitals and day hospitals also operate under a myriad of Commonwealth and State and Territory arrangements, as well as regulations which intersect with several aspects of Commonwealth legislation, for example where disputes arise between private hospitals and insurers regarding payments for services.

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Gaps and challenges in regulation and oversight

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 is changing in a lasting way as government policy intends are however limited and *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. These considerations in the past have included the challenges with avoiding conflicts of interest that arise from owning a healthcare service and negotiating insurer contracts, as well as limitations on private health insurers accessing My Health Record data or obtaining licences for medical equipment such as Magnetic Resonance Imaging (MRI).

As depicted in Figure 3, there are also 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.
- The impact that changes in the broader healthcare sector have on the sustainability of the private sector.
- The policy settings underpinning private health insurance and the Prostheses List and whether they remain fit-for-purpose.
- The mechanisms in place to protect consumers and provide them with informed financial consent, and whether they remain effective.

Illustrated in Figure 4 and the related examples, these gaps in regulation ultimately impact the patient through unexpected out-of-pocket costs and make it challenging to navigate an already complex system.

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Figure 3: The regulatory environment of the private healthcare sector

The Department of Health and Minister for Health and Aged Care

- Development of private health insurance policy
- Reviewing and approving changes to private health insurance premiums

Australian Commission on Safety and Quality in Health Care

- Leading and coordinating national improvements in healthcare safety and quality

Commonwealth Ombudsman

- Protecting the interests of private health insurance consumers through resolving complaints
- Management of PrivateHealth.gov.au

Gap in the regulation, guidance, and oversight of:

- Changing behaviours of insurers
- Implementation of whole-of-system reforms
- Impact of broader sector changes on the private sector
- Policy settings
- Mechanisms to protect consumers

Australian Prudential Regulation Authority

- Prudential regulator for private health insurance

Australian Competition and Consumer Commission

- Consumer and competition issues in the private health industry

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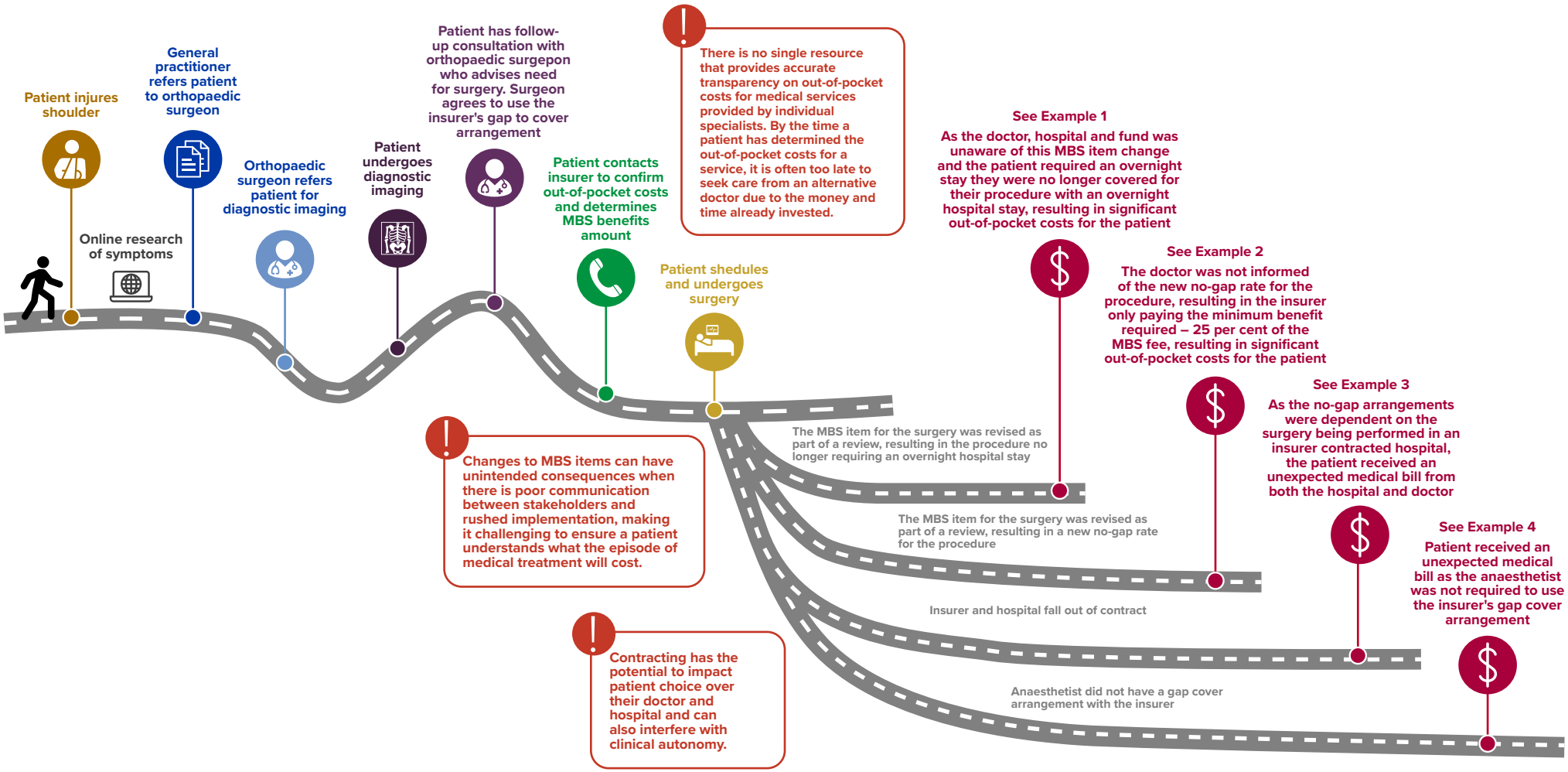
Figure 4: Overview of the patient journey through the private health system and where issues may arise due to gaps in regulation



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Example 1: Review of MBS skin items resulting in changes to private health insurance eligibility

Overview

A review of the MBS skin items was undertaken in 2016 with a view to encourage appropriate clinical practice, streamline the items, and generate savings for the government. The MBS Review work was led by the Department and involved clinical leaders from each specialty.

Assignment of these MBS items to procedure types (i.e. Type A, B or C private health insurance bands) was performed without the involvement of relevant medical practitioners, which resulted in these procedures no longer being covered by insurers when delivered in a hospital setting. As these changes were introduced with limited notice, informed financial consent was unable to be obtained and many of these procedures had to be cancelled or rescheduled. Additionally, some patients discovered after the procedure that they would not receive an insurance benefit for the treatment when their insurer rejected their claim. Defining which conditions should be eligible for private health insurance coverage took eight months to resolve, and required extensive consultation across the sector and the release of a Private Health Insurance Circular (PHI 37/17).

Relevance

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. This example demonstrates the challenges which arise when changes to one component of the sector (in this case the MBS) have unintended consequences on the private healthcare sector due to poor communication between stakeholders and rushed implementation.

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Example 2: Poor fee derivation on MBS spinal surgery item changes

Overview

The spinal surgery changes released by the Department in mid-October 2019 for a short notice 1 November commencement involved deleting over 70 items and replacing them with around 60 items[58]. This required a whole MBS restructure with new MBS items, requiring insurers to generate a new fee that they would pay for the new items. Insurers however were not provided with information on how the old MBS items mapped to the new MBS items, or any of the underlying assumptions, justification, or method used to create the new items. This resulted in insurers relying on cruder methods to develop fees, such as employing a blanket ratio or making an 'educated guess'.

Insurers were therefore unable to reflect an accurate or consistent payment compared to what they paid under the previous item structure, even when the same procedure or service was being provided. This resulted in reduced rebates as well as increased variability in rebates between insurers. Some insurers were also unable to deliver a revised funding table by 1 November 2019, which meant that doctors could not ensure informed financial consent or charge at 'no-gap' rates as new benefit rates did not yet exist. This resulted in insurers only paying the minimum benefit required – 25 per cent of the MBS fee.

Relevance

This issue resulted in either significant out-of-pocket costs for patients or significant cash flow issues for healthcare providers as they waited before submitting invoices, as well as a delay in procedures until insurers updated their schedules.

While the methodology behind creating the new MBS items was subsequently provided to insurers, some insurers have taken this opportunity to not revise their rebates based on the methodology and maintain a lower benefit level and increate their savings. The Department has not sought to rectify this issue, possibly due to its conflict of interest as both policy maker and regulator.

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Example 3: Conditions of no-gap and known-gap programs

Overview

With the intention of improving transparency for consumers, some insurers have specified that members can only receive no-gap or known-gap rates if their treatment is performed in a facility that has a contract with the insurer. Where services are not performed in a contracted facility or in a public hospital as an elective pre-booked procedure, the insurers would only pay the 25 per cent of the MBS rate, which is the minimum amount they are required to pay, regardless of whether the medical practitioner had agreed to the insurer's no-gap or known-gap scheme.

Relevance

While the intention is to improve transparency for consumers, this type of condition ultimately creates more confusion for consumers and results in patients losing choice over their doctor and hospital, and can result in unexpected out-of-pocket costs for the patient even where a practitioner charges the no-gap rate. To ensure no unexpected out-of-pocket costs, patients need to confirm whether their preferred doctor has admitting rights with a contracted facility, as well as whether their doctor has a no-gap or known-gap arrangement with the insurer.

Example 4: Selective contracting and no-gap programs

Overview

Insurers are increasingly entering into contracts with medical practitioners and healthcare providers to provide patients with reduced or no-gap services. For example, HCF's Swaddle program offers no out-of-pocket costs for the patient, including standard antenatal appointments, pregnancy management, and delivery fees.[59] Contracted obstetricians receive a higher fee and are only able to refer to or involve other medical practitioners and healthcare providers who have agreed to participate in the no-gap Swaddle arrangement.[60]

Insurers are also looking for ways to negotiate and manage contracts with healthcare providers more efficiently, which is evident in the recent authorisation to allow Honeysuckle Health (which is joint owned by nib and Cigna, a managed care corporation in the United States) to form a buying group to collectively negotiate and manage contracts with healthcare providers on behalf of private health insurers.[61]

Relevance

These contracting arrangements are largely unregulated, and therefore there is no one monitoring the potential flow on risks of selective contracting. For example, while offering participating obstetricians a higher fee is not necessarily an issue, those clinicians who do not participate may be disadvantaged or excluded. In addition, selective contracting arrangements aim to deliver lower insurance premiums for consumers, however there is a risk that they may devalue care by limiting patient choice and interfering with clinical autonomy.

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These examples demonstrate the consequences of having no independent mechanism to provide whole-of-system guidance and intervention when required. The current regulatory arrangements were designed at a time when private health insurance 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. With the private healthcare sector facing increasing pressures, it is evident that these arrangements are no longer fit-for-purpose, and the only levers available to insurers to reduce outlays, drive innovation and fill gaps in service delivery are ones that have the potential to lead Australia down a managed care pathway, or at least a pathway for insurers to be healthcare delivery providers with a significant conflict of interest. A mechanism is therefore required to ensure the long-term sustainability of the private healthcare system as an enabler of patient choice, improved access, innovation, and clinical autonomy regardless of what the private healthcare landscape may look like in the future.

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An independent authority for Australia's private healthcare system

Urgent reform of the private sector is needed. This reform must go beyond the current piecemeal approach which simply tweaks the existing policy settings and take a whole-of-system approach that recognises private healthcare as a public policy necessity, and an essential pillar of our healthcare system.

The AMA is calling for the establishment of an independent and well-resourced Private Health System Authority (the Authority) to oversee the private healthcare system and the reforms that are required to ensure its long-term sustainability. The Authority would ensure a cohesive and holistic regulatory model by relieving the Department of its conflicted role as a regulator and policy maker, and incorporating new functions to fill the gaps in the current regulatory environment, as well as supporting the regulatory and advisory functions currently performed by the ACCC, the Commonwealth Ombudsman, and ACSQHC (as depicted in Figure 5).

Recognising APRA is best placed to perform its current prudential role given it performs these functions effectively at a relatively low cost, it is proposed that the Authority would procure APRA to uphold the prudential standards they administer. The settings for capital requirements however will be determined by the Authority, recognising the different risk profile of private health insurance compared with general insurance, due to built-in features of the system such as community rating risk sharing through the high-costs claims pool. It is also proposed that the Authority 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. As this function is not currently performed by APRA (as its focus is on prudential regulation), the Authority will need to build the skills to undertake this critical function.

Under the *Private Health Insurance Act 2007*, all changes to private health insurance premiums must be reviewed and approved by the Minister for Health and Aged Care.[62] The Authority however will be better placed to review and approve these changes due to its whole-of-system oversight, independence, and expertise, and therefore it is proposed that the Authority also assume this function.

As an 'independent umpire', the Authority will have the capacity, objectivity, and expertise to create a solid platform for all players in the sector to work together on the necessary once-in-a-generation reforms. This will ensure a whole-of-system approach is evidence-based and incorporates implementation planning, providing protection to patients while also balancing the interests of hospitals, insurers, medical device manufacturers, and doctors.

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Figure 5: The role of the Private Health System Authority in the regulatory environment

The Department of Health and Minister for Health and Aged Care

- Development of private health insurance policy
- Reviewing and approving changes to private health insurance premiums

Private Health System Authority

- Overseeing the behaviours of all players in the sector, and highlighting system issues to government
- Implementation of whole-of-system reforms
- Performing continuous review of policy settings
- Reviewing and approving changes to private health insurance premiums
- Responsible for the prudential regulation of private health insurers

Australian Commission on Safety and Quality in Health Care

- Leading and coordinating national improvements in healthcare safety and quality

Australian Prudential Regulation Authority

- Procured by the Private Health System Authority to undertake prudential functions

Commonwealth Ombudsman

- Protecting the interests of private health insurance consumers through resolving complaints
- Management of PrivateHealth.gov.au

Australian Competition and Consumer Commission

- Consumer and competition issues in the private health industry

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Figure 6 provides an overview of the envisaged short-term priorities and long-term enduring functions of the Authority, as well as the functions which would be out-of-scope. In the short-term, the Authority would be focussed on addressing some of the immediate challenges affecting the sustainability of the private sector and supporting the existing reform initiatives currently underway, including the reviews of the private health insurance policy settings and the expansion of home and community-based mental health and rehabilitation care. The Authority would also be responsible for the development of mechanisms which safeguard access to care and clinical autonomy in new and innovative settings to ensure these reforms do not negatively impact consumers. These mechanisms would be similar to the policy principle of second-tier default benefits that protects the patient during contractual conflicts between industry, and ensures choice of healthcare services and medical practitioner. As part of its long-term enduring functions, the Authority would be responsible for overseeing the behaviours of all stakeholders in the sector and highlighting system issues to government, including behaviours which risk managed care, as well as ensuring a whole-of-system approach to changes and reforms. It would also be responsible for overseeing the evolution of programs and care models to ensure the interests of all stakeholders are considered.

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Figure 6: Short-term priorities and long-term enduring functions of the Private Health System Authority

Proposed short-term prioirities

- ✓ Develop a code of conduct / principles for cost-effective community care
- ✓ Identify opportunities to build consumer confidence in private health insurance (e.g. implementing mandatory minimum payout ratios)
- ✓ Improve the viability of private obstetrics
- ✓ Support and build on existing reform work currently underway (e.g. reviews of private health insurance policy settings and expansion of mental health and rehabilitation models of care)
- ✓ Responsibility of the Medical Costs Finder website and deliver on outstanding improvements
- ✓ Monitor current reform of the Prostheses List

Proposed long-term enduring functions

- ✓ Support and oversee whole-of-system reforms to improve the sustainability of the private healthcare sector, including developing the evidence-base for reform
- ✓ Prudential regulation of private health insurers
- ✓ Support the development and implementation of a future medical device and technology funding mechanism
- ✓ Perform continuous reviews of private health insurance policy settings and recommend adjustments
- ✓ Oversee the listing of medical devices and their benefits on the Prostheses List
- ✓ Review and approve increases to private health insurance premiums
- ✓ Oversee the behaviours of all players in the sector, highlighting system issues to government
- ✓ Support the procedure banding process as a member of the National Procedure Banding Committee, and review inappropriate practices with respect to certification arrangements
- ✓ Engagement with the Department of Health's compliance function regarding compliance activities, including MBS/private patients in public hospitals

Proposed out-of-scope functions

- ✓ Development and communication of private health insurance policy (Department of Health)
- ✓ Conducting MBS reviews and managing MBS items (Department of Health)
- ✓ Consumer and competition issues (ACCC)
- ✓ Leading and coordinating national improvements in healthcare safety and quality (ACSQHC)
- ✓ Establishing the price for prostheses (Independent Hospital Pricing Authority)
- ✓ Functions currently performed by Professional Services Reviews (excluding review of inappropriate practices with respect to certification arrangements), Medical Board of Australia, and Australian Health Practitioner Regulation Agency
- ✓ Protecting the interests of private health insurance consumers and management of PrivateHealth.gov.au (Commonwealth Ombudsman)

CONCLUSION

The current trajectory of the private healthcare sector is unsustainable. Without significant intervention, the balance between the public and private sector will continue to be threatened, which will ultimately lead to patients not being able to access the care that they need when they need it. As COVID-19 restrictions continue to ease, our public sector will not have the capacity to address the rise in COVID-19 cases in addition to the backlog of non-COVID-19 related care, and therefore the private sector will continue to play a crucial role in ensuring the care needs of patients are met. A new approach to reform is therefore needed now more than ever.

Filling the gaps in the current regulatory environment, the Private Health System Authority would have the capacity, objectivity, and expertise to ensure that the system evolves as government policy intends, balancing the interests of patients, day hospitals, private hospitals, private health insurers, medical device manufacturers and doctors. The Authority would create a solid platform for all the players in the sector to move away from the current combative debates and work together on the whole-of-system reforms required to ensure the sustainability of the sector into the future. While it will not be easy, the AMA stands ready to support the sector to safeguard this essential pillar of our healthcare system.

APPENDICES

Appendix A: Cost estimate of establishing the Private Health System Authority

- Estimated annual cost: $28 million in 2022-23
- Cost over four years to 2025-26: $119 million
- Establishment cost: $10 million (2022-23 only)

Based on data from:

- Australian Prudential Regulation Authority (2020). *Annual Report 19/20*.[63]

To estimate the cost of an authority which does not currently exist, the cost of APRA's prudential regulation of private health insurers was used as a benchmark. APRA's role to regulate banks as well as private health insurers implies their costs must be split across all their responsibilities. Private health insurers have significantly lower annual policy revenue than banks have in deposits (APRA annual report). Using this regulated asset base for comparison would imply that costs to regulate insurers would be lower than they are in reality. To account for this discrepancy, the number of regulated entities is used as a point of comparison.

At present, APRA reports that its total operating expenditure for the 12 months to 30 June 2020 was $196.2 million. Using the number of private health insurers it prudentially regulates (37 during 2019-20) and comparing that to the total number of entities it regulates (2,273), we could apportion the cost to a sensible approximation of $3.2 million per year. Relative to the size of the industries that APRA supervises, the cost per $1,000 of assets supervised was 2.6 cents in 2019/20.[64]

Using this crude metric, the proportion of APRA's 2019-20 expenditure ($196 million) dedicated to insurers is $25 billion out of total regulated funds of $7,684 billion. This equates to a small budget expenditure of approximately $650,000 (approximately only 4.5 FTE staff). It is likely APRA incurs a larger direct cost to prudentially regulate insurers than this crude calculation implies.

Comparing the implied cost by using the ratio per dollar of assets ($0.65 mil) to the implied ratio per entity ($3.2 mil) gives an approximate regulation cost per dollar of revenue in private health insurance funds to be five times that of the 2.6 cents per dollar of bank deposit. Restating the $3.2 million as a share of premium revenue is approximately 12.8 cents per $1,000 of premium revenue for the prudential regulation alone. While this calculation is crude, it can be used as an indicative cost benchmark for the expanded set of functions envisioned for the Private Health System Authority.

This role currently performed by APRA is an indicative efficient cost for an expanded set of roles envisioned for the proposed authority, and therefore additional funds are required to fulfil these extra functions. The total annual cost of the proposed authority is estimated to be $28 million in 2022-23 ($119 million over four years to 2025-6) based on an expanded set of roles approximated to cost up to 100 cents per $1,000 or 0.1% of premium revenue.

The ongoing cost of the Authority would need to incorporate any purchase agreement for services from APRA on a cost-recovery basis. There may be other future establishment costs to expand oversight of how insurers use patient data and information, and how data can be used to improve patient treatment and outcomes. The Authority would have a key role to play in ensuring patients are not disadvantaged through misuse of health data and information.

The government could choose to recover the ongoing cost of the authority through charges to insurers. The 0.1 per cent of revenue taken by private health insurers ($25m per year in 2019-20). This would likely see the cost passed on to consumers through higher premiums in the order of 0.1 per cent.

An additional $10 million is estimated to be required to establish the new authority and consult with stakeholders regarding its ongoing roles and responsibilities. If cost recovery was undertaken, this $10 million would be the only net cost to government.

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Level 1, 39 Brisbane Avenue Barton ACT 2600
Telephone: 02 6270 5400
www.ama.com.au