AMA

AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T | 61 2 6270 5400
F | 61 2 6270 5499
E | ama@ama.com.au
W | www.ama.com.au
39 Brisbane Ave Barton ACT 2600
PO Box 6090 Kingston ACT 2604

SUBMISSION

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Private Health Insurance (PHI) Incentives and Hospital Default Benefits Studies

AMA submission to Department of Health and Aged Care consultation on PHI Incentives and Hospital Default Benefits Studies

Via email to PHIconsultation@health.gov.au

Introduction

The AMA appreciates the opportunity to respond to this consultation on the final reports of Finity Consulting (Finity) and Ernst and Young (EY), noting that much of the work done by consultants and the Department for this consultation was proposed by the AMA in 2020 in The AMA prescription for private health insurance.

This response follows the AMA's responses to the Department's consultations on Private health insurance default benefit arrangements and Risk equalisation in late 2022, and the release of The AMA repeat prescription for private health insurance in April 2023.

Australia's private health system is complex, the sum of many policy levers and a multiplicity of different funding approaches. It is also the product of a range of external factors, including the state of the public and primary health systems, the demographics of our population, the impact of the economy and the health choices each of us make, all of which are contributing to an ageing, chronically unwell population.

The impact of any one of these factors can be small or large and this can change as the other dynamics and the demographics of our Australian population also change. Historical data from the Australian Prudential Regulatory Authority shows clearly that pulling on individual policy levers at some times has had negligible effects (e.g., the introduction of the Medicare Levy Surcharge in 1997) and yet changing other levers at other times, caused a major shift (such as the introduction of Lifetime Health Cover in 2000).

None of these mechanisms stay static and each needs to be made and kept relevant. We need to ensure every part of the jigsaw puzzle that makes up our private health system is performing optimally and is fully integrated with all other aspects. Failure to do this over the past decade means that we have a private health system that does not optimise the

resources that go into it, that does not provide best practice service, and does not deliver the best health outcomes for the millions of Australians who use it every day.

It is critical that any changes to policy levers arising out of this/future consultations are carefully calibrated given that settings for each of the policy levers — the Medicare Levy Surcharge (MLS), Lifetime Health Cover (LHC), PHI premium rebate (PHI rebate), Risk Equalisation, and Default Benefits — have a powerful impact on the equity, efficiency and effectiveness of the others.

They also have a powerful impact on the viability of other foundational policy settings that were out of scope for this consultation, including community rating, a mixed public/private system, and the clinical autonomy of medical practitioners.

It is also critical that any changes made improve the value proposition of private health for patients. For Australians to take out private hospital insurance and maintain that coverage through their lives, they must see value in the product they are purchasing. PHI products must not only deliver value to consumers for the amount they pay but also be easy for consumers to understand.

Purchasing PHI is incredibly complex. The move to the Gold, Silver, Bronze and Basic categories improved the situation, but there are still a multitude of products offering an increasingly bewildering array of choices. The AMA believes more work needs to be done to make PHI products more transparent and easier to navigate for consumers and providers.

The need for a Private Health System Authority to oversee reforms

To accomplish all this, the AMA believes that there is an urgent need to reform current policy settings and regulatory arrangements to ensure they remain fit for purpose. Current regulatory arrangements were designed at a time when PHIs were mostly non-profit with strong membership, and when private hospitals had greater profit margins. While they are effective at protecting consumers by maintaining insurer solvency, managing consumer complaints and ensuring the safe delivery of healthcare, mechanisms to ensure that the private health system changes in line with government policy objectives are limited and ad hoc.

Furthermore, there are 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. As the last 20 years have demonstrated, the current approach, with a minimally resourced team within the Department and no ongoing mechanisms to bring the sector together is not adequate to ensure the timely, rigorous review and adjustment of policy and regulatory settings as required.

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. Further, the AMA experience is that where complaints require immediate action and intervention — be they relating to a consumer's need for pre-approval for a procedure, the behaviour of a fund, or issues between a fund and a health facility — there is a regulatory hole.

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.

The AMA is calling for the establishment of an independent authority to oversee the private healthcare system to fill gaps in the current regulatory framework, oversee the sector helping maintain a level playing field, collect and analyse data growing the evidence base for policy decisions and highlight system issues to government.
The AMA provisionally refers to this concept of an independent authority as a Private Health System Authority (PHSA).

Response to the Finity final report on the Review of Medicare Levy Surcharge (MLS), PHI rebate and Lifetime Health Cover (LHC)

Recommendation 1: Overall recommendation: We recommend establishing a process to regularly review and adapt PHI policy settings to allow settings to become more optimal over time, better meeting consumer preferences and efficiently supporting health system objectives.

For many years, the AMA has criticised current regulatory and policy settings, which, as the Department notes in its consultation paper, have not changed for 20 years.

Accordingly, the AMA supports this recommendation, with the caveat that the process of regular review and adaptation of PHI policy settings must be supported by ongoing data and evidence collection, rather than ad hoc contracts to consultants.

As discussed in detail in the AMA's 2022 Discussion paper: A whole of system approach to reforming private healthcare, the AMA believes that an adequately resourced, independent, consumer-focussed PHSA should be established to undertake this work. Such an Authority would be best placed to:

- implement the increased and ongoing data collection and analysis of the private health system that is sorely needed
- balance the claims of various stakeholders in the interests of consumers
- ensure that there is ongoing capacity to generate the appropriately evidence-based policy that will be essential to maintain a safe, efficient and fair private health system into the future.

Short-term recommendations (0-3 years):

Recommendation 2: Retain the MLS, PHI rebate, and LHC.

Finity's actuarial studies demonstrate that both the MLS and LHC are effective and working as originally intended and that the PHI premium rebate is still incentivising consumers to take out PHI policies.

For this reason, the AMA supports this recommendation, on the condition that the settings of these policy levers are optimised and then remain under review to ensure that they remain fair, retain their efficacy, and do not have perverse or unintended flow-on effects.

More detailed AMA suggestions on the optimisation of these policies are provided in response to more specific Finity recommendations below.

As discussed above, an independent Private Health System Authority should be established to undertake this ongoing work.

Recommendation 3: That MLS continue to strongly incentivise the highest percentile of earners to contribute to the Australian health system by buying PHI.

The AMA supports this recommendation.

Recommendation 4: Incentives for others with above average income: That MLS not be extended to those earning less than $90k, and that government consider removing some or all Tier 1 earners from MLS.

The AMA has long argued that because of inadequate (or zero) indexation of MLS income thresholds over many years, MLS settings have become unfair, because they have not matched changes in demographics and earnings.

For some cohorts, this has resulted in the perverse outcome that the MLS being applied to people at a lower income than originally intended, but the amount levied is less than the rate likely to be paid for a reasonable PHI product, due to increased premiums.

Finity's recommendation is in two parts – the first part being that the MLS should not be extended to those earning less than $90k (or $180k for families).[i]

As Finity's study was based on prevailing MLS rates/thresholds at the time the study was conducted, when the Base MLS Tier at which no MLS applied was for singles on $90k or less, and families on $180k or less,[ii] this recommendation essentially supports the status quo. As the ceiling of the Base Tier for the 2023–24 financial year is $93k (singles)/$186k (families), the AMA assumes that Finity's recommendation now applies to singles/families below this level of income.

The AMA supports this part of the recommendation.

With respect to the second part of the recommendation, which is less clearcut than the first part, the AMA offers conditional support, dependant on the findings of further actuarial analysis/modelling.

Finity itself notes that 'removing middle income earners (Tier 1) is an equity decision. This would improve choice for this group, but it would remove healthy people from the PHI pool (higher average premiums) and reduce government MLS revenue.' [iii]

The MLS is a particularly powerful policy lever. Given this, the AMA believes that liability for the MLS and the rates of MLS that apply must be carefully graded by income, in light of data on the likely impact of removing any or all the current Tier 1 income range on PHI membership, PHI premiums and community rating.

Accordingly, any decision to exempt all or part of the current Tier 1 income earners from the MLS must be informed by data on:

- the percentage of different age groups who earn different levels of income within current Tier 1 and 2 income ranges
- the proportion of these age/income groups that are already covered under either their own or family policies (as dependents)
- the level of insurance they have, i.e., 'junk' (basic) policies or above

- their propensity to drop or downgrade their cover if not subject to the MLS/subject to a higher rate of MLS.

Recommendation 5: Indexation: That MLS thresholds be annually indexed to reflect changes in earnings.

The AMA has previously highlighted the inequities that have arisen from the failure to appropriately index the MLS to reflect changes in earnings and supports this recommendation.

Recommendation 6: Incentives for the wealthy: That government investigate whether an equivalent of the MLS could be developed for high wealth households.

Here, Finity notes that the MLS does not consider the net worth of households. They add that if high-wealth households are not technically high income earners in any given year, they are not subject to the MLS in that year, and, if they take up or continue with a PHI policy in that year, they will also receive the PHI rebate. In other words, PHI may be more affordable for this group than it would appear on the basis of income alone.

Therefore, they suggest that the Government consider the feasibility of establishing a wealth indicator that would make high wealth households liable for the MLS in years when they might not otherwise be liable based on income alone. They add that this would also allow for PHI rebates to retargeted away from this group, to preserve the equity of the system by ensuring that PHI rebate spending is targeted at those with less capacity to pay.

The AMA notes that Finity does not provide any data on the number of people this might apply to, even within the over 65 age group they were able to study for the purposes of this recommendation (because wealth indicators already exist for this group, in the form of assets tests applied to consider pension eligibility). Finity also notes that such a change 'may not be financially material as [it] only applies to a small proportion of insured individuals.'[iv]

Development of a wealth indicator would require considerable effort and government resources and may not deliver a strong impact compared to other initiatives proposed in this report.

Given these concerns, the AMA believes that this recommendation should be left on the table for consideration with input from all stakeholders as part of the next tranche of reforms.

Recommendation 7: Level of cover for MLS exemption: That those on the highest incomes (current tiers 2 and 3) be required to buy Silver-tier or higher hospital cover to avoid MLS.

Currently, there is no requirement for Australians who would otherwise have to pay the MLS (Tier 1, 2 and 3 income earners) to buy any level of cover beyond a 'basic' policy that may cost in the order of $1,000-1,500 while offering virtually no private cover beyond ambulance cover.

In addition to their recommendation that those on the highest incomes be required to buy Silver-Tier or higher hospital cover to avoid the MLS, Finity adds the caveat that if Tier 1 earners (singles earning between $93,001-108k/families on $186,001-$216k in 2023–24) remain subject to the MLS, they should not be required to buy Silver cover due to the high cost relative to their incomes.

The AMA believes that it is reasonable that incentive policies be directed towards meaningful insurance policies (rather than 'junk' policies that provide ambulance cover and little else) to help to preserve community rating.

On the other hand, the AMA is concerned that the recommended change would compromise the principle of consumer choice, by driving consumers to select a product purely based on its cost and their income, rather than being able to pick an insurance product appropriate to their needs. Consumer education is critical here, to ensure that consumer choice is well-informed with respect to what is offered by specific PHI policy products, and the waiting periods that apply.

In addition, it may be unfair to require high income earners living outside metropolitan centres to buy silver or gold policies if they are unlikely to be able to use those policies because there are no (or very limited) private hospital services within a reasonable travelling distance from their homes. This is a major reason why the proportion of PHI policy holders living outside metropolitan areas ranges from 7% in regional centres down to 0-1% in remote and very remote communities.[v]

Beyond this, the AMA is also concerned about the gender equity implications of requiring that high income earners buy silver or gold PHI policies. For example, a relatively young man in very good health may not need anything more than bronze cover. On the other hand, a woman of childbearing age (or a couple) on a similar income considering having a baby may need to purchase a gold (and hence much more expensive) policy to ensure that they have obstetric cover in the event it is needed.

For this reason, the AMA strongly advocates that reproductive health services should be universally accessible close to home for people seeking those services in both the public and private health systems. Pregnancy care in particular should be accessible through other categories of private health insurance cover, such as silver and bronze, given the patchy availability of obstetrics care through the public system, particularly in non-metropolitan public hospitals.

In light of these considerations, the AMA believes that if Government wishes to implement a requirement for high income earners to buy a certain category of PHI policy to avoid potential MLS liabilities, the minimum requirement would be better set at purchase of bronze-category policy (rather than silver or gold).

Recommendation 8: MLS rate: For those on the highest incomes (current tiers 2 and 3), we recommend that the MLS be set at 2% of income.

This recommendation represents a simplification of current arrangements, where different MLS rates apply to Tier 2 (1.25%) and Tier 3 earners (1.5%).

Finity notes that implementing a 2% MLS charge would retain the "policy stick" value of the MLS to incentivise high earners to take out PHI by ensuring that the penalty for not doing so would exceed the cost of buying Silver-tier hospital cover. It adds that the level of the surcharge should be reviewed periodically to ensure that it remains a strong incentive to the highest earners to contribute to the health funding system.

With respect to Tier 1 earners, Finity suggests that if the Government decides to keep them subject to the MLS, the MLS could also be increased to 2% for this group, unless a higher surcharge is considered unfair.

The AMA is open to the idea of the highest (Tier 2 and 3) earners who do not take out PHI policies being subject to a maximum 2% surcharge, subject to a periodic review of flow-on effects.

Recommendation 9: PHI rebate optimisation short-term options:

- **That the PHI Rebate is removed for MLS Tier 2 earners.**
- **That the PHI Rebate for seniors is increased**
- **That older Australians of pension age (currently 67) receive a higher percentage PHI Rebate than younger Australians subject to buying Silver or Gold hospital cover policies.**

With respect to the first part of this recommendation, removal of the PHI rebate for MLS Tier 2 earners, the AMA notes that in 2023–24, Tier 2 earners are singles earning above $108k and up to $144K, and families earning above $216k up to $288k.

The intent of these recommendations appears to be to remove the PHI rebate subsidy from relatively high income earners to better subsidise PHI policy purchases for older Australians on considerably lower (Base Tier or Tier 1) incomes, subject to them buying Silver or Gold tier policies that have fewer exclusions on the kinds of treatments often needed by this age group. At a broader level, the intent is to preserve the viability of community rating whilst also reducing pressure on the public hospital system.

Whilst these suggestions may have merit, the AMA believes that they need further exploration and development by a Private Health Systems Authority, or at least an advisory body, before being given further consideration by government.

<u>Medium-term recommendations (3-6 years)</u>

Recommendation 11: That the Government implement a wealth indicator if this is found appropriate in the investigation recommended at Recommendation 6.

See the AMA response to Recommendation 6.

Recommendation 12: Pricing regulation: That the Department consider what changes should be made to pricing regulation given any changes made to incentive policies.

The AMA believes that a business case needs to be made as to why further resources should be invested here rather than in more concrete recommendations that can currently be applied.

The lack of evidence and detail behind this recommendation highlights the need for an independent, well-resourced and ongoing Private Health System Authority that can continuously examine the data to determine whether this particular recommendation is appropriate, along with other PHI policy settings.

Recommendation 13: Superior PHI product: That PHI policies evolve to better meet consumer needs.

The AMA strongly supports this recommendation, which it considers to be urgent, for a variety of reasons.

One is an emerging trend amongst PHIs to drop their gold policy offerings, or to price them at levels that act as a major deterrent to consumers taking them up. This has a critical impact on the availability and delivery of higher cost care, such as obstetrics and mental health care.

Changes are required to the structure of PHI policy products to support innovation and increased efficiency. The AMA has repeatedly called for greater use of hospital in the home (HITH), and programs delivering more home-based and community-based care. These need to be developed as part of a deliberate and deliverable overall effort to design a better system.

Careful, complex work involving all stakeholders needs to be done to design a system that supports the best programs that are patient centred, cost effective, clinically best practice, medical practitioner led, and insurer funded.

As the Department does not currently have the evidence base or resources required to undertake this work at the level required, the AMA believes that this work should be undertaken by an independent, adequately resourced and patient-focussed Private Health Systems Authority that has the skills and capacity to undertake the work, and a mandate to bring all stakeholders together to find an appropriate way forward.

Recommendation 14: Ensure policies remain optimised and integrated: That the effectiveness of the incentive policies is regularly reviewed.

The AMA strongly supports this recommendation, having argued through a succession of research reports that PHI settings cannot be 'set and forget.'

The range of policy levers operating in the private health system must be considered holistically, and regularly reviewed in the light of changes in a wide range of variables including but not limited to demography, income, PHI membership rates amongst various age and income groups, the availability of private and public hospital services across Australia, changes in health technology, treatments and modes of health delivery, and changes in health fund behaviour, PHI policy offerings and pricing.

Beyond this tranche of reforms, there is a strong need for the development of an ongoing mechanism that increases the collection of relevant data, improves the evidence base and can provide the ongoing, high quality analysis required to underpin timely future policy changes.

As already mentioned, the AMA does not believe the Department of Health and Aged Care has the resources nor independence to achieve this outcome and believes that an independent Private Health Systems Authority should be established to undertake this work on an ongoing basis.

Recommendation 15: Communication: Once the policy settings have been determined, we recommend the Department develop a communication plan to maximise the effectiveness of the policies.

The AMA strongly supports this recommendation, along with Finity's view that there should be regular reviews of the effectiveness of both government and insurer communication activities related to PHI.

During informal discussions with the AMA, Finity noted that it has heard from the Australian Taxation Office that taxpayers are often surprised when they suddenly find themselves subject to the MLS following a change to income.

Likewise, the AMA is aware that in relation to pregnancy cover, consumers are often unaware that there is a waiting period for such care under their cover, or when they go to change up their level of cover in light of an unplanned pregnancy.

The AMA shares Finity's view that government must play the key role in communicating any changes effectively, that insurers can also do more to assist people making choices about PHI products, and that opportunities to enhance the frequency and effectiveness of communication about PHI should be investigated and tested.

It is also critical that this information is available in the wide range of languages spoken in Australia.

Longer-term recommendations (6+ years)

Recommendation 16: That government continue to regularly explore changes that better integrate the Australian health system, and in particular consider PHI policy levers in addition to the PHI rebate, MLS and LHC.

Finity suggests that such consideration might encompass:

- Health financing, including state/federal cost shifting incentives
- New care treatments, such as coordinated care
- The potential for a standard benefits package and the role of co-payments and excesses
- Community rating (since this is central to the need for mandates and subsidies)
- Information management in healthcare.

The AMA supports the view that there must be ongoing investigations of potential means of better integrating the Australian health system, including consideration of other potential policy levers beyond the PHI rebate, MLS and LHC.

With respect to health financing, the AMA believes that it is critical that governments do more to encourage the establishment of private specialist services and private health facilities in non-metropolitan areas, because without these, there is no incentive for consumers living in those areas to participate in PHI.

The AMA also supports two additional innovations in health financing — namely, government-supported voluntary personal health saving accounts, and the mandating of minimum private health insurance returns to consumers, as discussed below.

Health savings accounts

Although Australians enjoy a generally high-quality health system at a relatively modest overall cost to the community, the cost of providing healthcare will continue to rise, driven by an ageing population and rising rates of chronic disease. New technologies bring welcome treatments for diseases that were previously considered untreatable but meeting the

healthcare expectations of the Australian population places pressure on government outlays and private health insurers.

The AMA believes there are better options for managing rising health cost pressures than rationing patient access to timely treatment or leaving patients to choose between out-of-pocket costs they may not be able to afford or delaying the health treatments they need.

Health Savings Accounts are a viable solution to support Australia's mix of public and privately funded health care delivery. They encourage people to make provision for their future health costs, especially younger working cohorts on early career salaries who are struggling with cost-of-living pressures and leaving private health insurance as a result.

Correctly designed, Health Savings Accounts have the potential to:

- restore the perceived value of private health care, including private health insurance
- particularly help younger cohorts maintain private health insurance throughout the rise and fall of living costs in each life stage or in periods of financial hardship where they might otherwise discontinue premium payments
- support the health insurance system to remain viable in the longer term
- improve equity of healthcare access for public hospital patients by reversing the shift in patient demand away from private to public hospitals
- assist health care providers maintain access for all Australians to a high quality, affordable health system now and in the future.

To that end, the AMA believes that the Australian Government should incentivise (but not mandate) Australians to open a Health Savings Account with the support of a progressive Commonwealth tax policy that rewards people equally, regardless of income level.

Health Savings Accounts should operate in a very similar fashion to contributory superannuation accounts. Superannuation funds are well placed to manage the earnings of consumers' Health Savings Accounts, and act as a highly efficient 'clearing house' for all eligible health service payments.

Superannuation fund managers are also well placed to apply a strong prudential framework to Health Savings Accounts and provide account holders with transparent annual reports.

Further details of this proposal are provided in the AMA 2021 position statement on health savings accounts.

Mandated minimum private health insurance returns

Australians need to know they are getting value from their PHI premiums. The AMA believes that relevant legislation should require all PHIs to return 90 per cent of premium dollars paid to the health consumer.

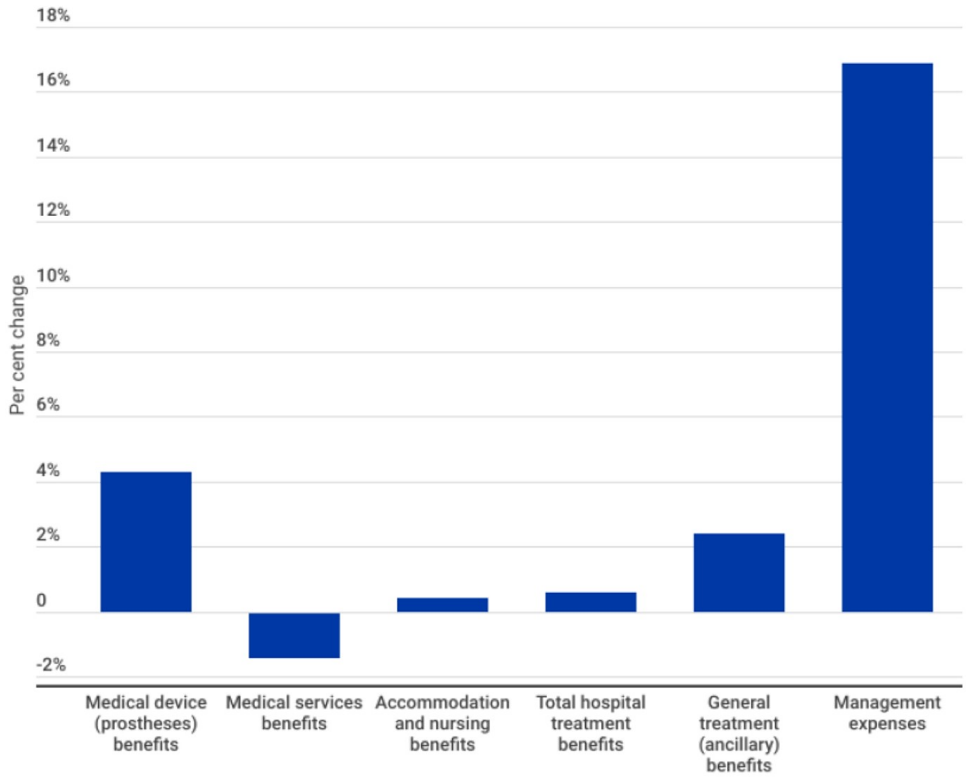
We have now had over two years of increasing hospital treatment insurance membership (rising from 44.2 per cent in June 2020 to 45.1 per cent in December 2022).[vi]

At the start of the pandemic insurers promised not to make profits on the back of COVID-19. The AMA acknowledges that many insurers have returned funds back to their members, but their expenditure on management expenses and profit margins still remain generously high.

Management expenses reported by PHIs vary considerably, with an industry average of 10 per cent, but some spending over 15 per cent.[vii]

As shown at Figure 1, increased management expenses reported by PHIs have been a significant contributor to increases in PHI premiums over the last few years.

Figure 1: Cost components to increases in PHI premiums over three years to June 2022



We call for the money that patients pay in PHI premiums to come back to them in the form of healthcare delivery, not increased profits for insurers. The AMA believes that government should mandate a minimum amount that every insurer is required to return to patient care in the form of claims benefits.[viii]

Finity LHC final report

The AMA recognises that Finity did not recommend an increase to the age at which LHC applies in the short, medium or long-term, although their testing seems to have been focussed on the impacts of raising the age to 40.

Finity's argument against raising the age at which LHC applies to 40 was based on modelling that found it would have an insignificant impact on levels of PHI membership and would likely lead to a small increase in policy premiums to offset higher expected average claim costs (due to the older average membership).

However, the AMA recommends that the age at which LHC applies should remain under regular review into the future to ensure that does not become a barrier to taking out PHI.

Consideration should perhaps be given to an increase to age 35, given relatively low wage growth for 24-35 year olds, and the fact that many people are studying longer and starting well-paid careers later in life, at a time that they are also starting to repay HECS-HELP student contribution debts, saving to buy a house, and raising children.

If such a change was considered, it would also make sense to align the ages to which youth PHI premium discounts apply to match this, and to raise the dependent age on family policies, given that the proportion of Australians living with their parents beyond the age of 25 has increased over time.[ix]

The AMA believes that any changes to LHC need to deliver on the following key principles:

1. Attract new, younger people into the PHI pool
2. Deter (or compensate adequately) for late entrants
3. Deter 'hit and runs' — that is people who take out PHI only to use it for costly health issues and then surrender their coverage following their treatment
4. Not to discourage use of health insurance by the elderly/unwell, especially for those that have been in PHI for considerable periods of time
5. To support, not be an impediment to, appropriate innovation in health care.

Further innovations in care: extending PHI coverage to hospital substitution care

The AMA welcomed the Government's announcement in the 2020–21 budget that it would be working on expanding home and community based mental health and rehabilitation care as a good start to creating a more modern, innovative private health system.

That work has not proceeded, and this is a lost opportunity for the Australian health system and for our patients. We are calling on Government to not abandon this area of health reform because it might look difficult but to embrace the opportunities and do the work to make these essential reforms happen.

Health care is changing and becoming more mobile through improvements in medical technology and IT. Innovation in our health systems is what will drive future improvements in patient outcomes and contribute to making our system more sustainable in the long term. The AMA strongly supports the development of HITH and similar programs delivering more home-based and community care.

Across Australia, programs that support palliative care, chemotherapy, mental health and rehabilitation as day visits or even in patients' homes are being delivered by private hospitals and private health insurers. Quality programs that shift treatment to home and community settings, that integrate care into patients' lives and usual care teams have the potential to reduce costs and improve health care outcomes when clinically appropriate. As a sector we need to come together and work out how to support the quality programs and ensure they are provided accessibly to patients that will benefit from them.

The AMA believes that any move to expand the role of private health insurers should be carefully planned and negotiated with the profession to ensure that the outcome is in the best interest of patients and does not compromise the clinical independence of the profession or interfere with the doctor/patient relationship.

This expansion needs to be supported by evidence and underpinned by appropriate safeguards and regulation. The system as it is currently configured does not provide the ability of the sector to come together and work to improve patient centred innovation.

Clinical quality and safety must not be compromised through the development of innovative models of out-of-hospital care. Depending on how they are designed and implemented,

models that shift treatment to home and community settings have the potential to reduce the quality, safety and outcomes of that care. Clinicians need to know that the programs they are referring their patients to are evidence based and delivering a high standard of care.

Accreditation of such programs cannot be left to the provider or to insurers, as they are not always impartial. To support continuing innovation and reform the AMA calls for the establishment of an independent, patient-focussed and appropriately resourced Private Health System Authority to bring together all the players in the sector to build a better system. The authority should have the capacity, objectivity, and expertise to ensure that robust mechanisms are in place to balance the interests of all sector stakeholders in the delivery of innovative, patient-centric, clinician led care.

Currently, growth of hospital-substitution type care is currently being driven by larger, vertically integrated, for-profit insurers, rather than non-profit insurers, private hospitals and other health provider organisations, partly because there is no guaranteed funding for the latter. At present, there is no public policy principle that would require PHIs to fund patients who want hospital substitution care run by a hospital or other provider that cannot get a contract from insurers for such services. Instead, insurers are able to direct patients to hospital-substitution services run by their own health service provider companies.

Growth of quality hospital substitution-type care, and patient choice of options for such care will also only be supported if legislative changes are introduced to provide funding certainty by extending provision of default benefits to appropriately accredited hospital substitution programs run by hospitals or other providers. Without this, only proprietary hospital-substitution programs run by the larger, vertically-integrated insurers will proliferate — an outcome that would severely restrict patient choice, and lead to further concentration of the market power of the largest health funds. This is discussed further in the next section.

EY Default Benefits Final Report

As noted in the AMA's 2022 submission to the Department's consultation on private health insurance default benefit arrangements, the AMA believes that the primary objective for the second-tier default benefit arrangements must be as an essential safety net for consumers attending non-contracted hospitals. 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 (five years) and their outlays were continuously increasing. Through the pandemic participation rates have now climbed for eight successive quarters (two years) and outlays have decreased due to the impact of lockdowns and workforce shortages. Private hospitals have now faced three 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 — by providing a reasonable safety net price, they prevent insurers from taking

undue advantage and trying to achieve greater levels of cost control at the expense of patient outcomes.

EY Recommendation 1: in the short-term, implement the following:

1.A. Use of a volume-weighted approach for determining contract averages

The AMA supports this recommendation as a means of reducing gaming and misuse of the current approach to determine contract averages.

As noted in the AMA's 2022 submission on default benefit arrangements, volume-weighting 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.

1.B. Introduce a cap on hospital out-of-pocket costs that can be charged when associated with default benefits

The AMA believes that private hospitals are best placed to comment on the likely outcomes of this recommendation. The AMA would not support this proposal if it led to hospitals reducing the provision of services which risk higher out-of-pocket costs (these are often more complex procedures.)

1.C. Introduce standardised operational expectations for all hospitals

Here, EY mentions options such as mandating use of national digital health infrastructure, participation in national clinical registers, and improving the quality, timeliness and consistency of data reporting.

The AMA believes that these are reasonable requirements that will help to integrate the health system as a whole, and better inform policy development and review.

Further refinement and development of such expectations could be undertaken in the process of developing market guidelines for insurers, hospitals and regulators, as recommended by EY at **2.C.** below.

Again, the AMA believes that an independent, objective and well-resourced Private Health Systems Authority would be best placed to bring the sector together to reach agreement on, and implement, such expectations.

EY Recommendation 2: In the longer term, implement the following:

2.A. Move towards an independently set funding model to determine default rates

The AMA agrees that this is an idea worth considering and exploring further.

Given that recent work on the Prostheses List reforms has highlighted the inadequacy of private hospital data collection and analysis, improving data collected on the private health sector should be the first step in this process.

2.B. Move to a single tier of default benefits for private hospitals

The AMA is concerned about the lack of detail provided by EY on this recommendation and the flow on implications across the health system such as the impact on the use of private health insurance in public hospitals and the potentially reduced viability of private hospitals and day facilities where they cannot obtain contracts with insurers.

The AMA also wants to see default benefits extended to out-of-hospital care such as HITH, post-stroke and other forms of rehabilitation care, and other clinically appropriate hospital-substitution care, and it is not clear if this recommendation will block this, at least in the short-term.

In discussions, EY has suggested to the AMA that the main aim of this recommendation is to reduce complexity, rather than reduce 2nd Tier default rates. EY has also suggested that once better data are available, independent rates are set, and changes are in place to support contracting for HITH and other types of hospital-substitution care, it would be possible to set default rates for this kind of care.

Accordingly, the AMA lends cautious support to further exploration and development of this proposal, on the condition that any such changes must not affect private hospital viability, must not inadvertently impact the use of private insurance in public hospitals, and must support the growth of HITH and other types of hospital-substitution care.

2.C. Develop market guidelines for insurers, hospitals and regulators

Noting the current lack of such guidelines or oversight of compliance with same, the AMA supports this recommendation, and believes that a Private Health Systems Authority should be established to undertake this work.

Conclusion

Governments have demonstrated that private health is complex and sometimes beyond their expertise to drive forward. To tackle these hard problems, and to make the breakthroughs our private health system and our patients need, the AMA believes we need an independent, impartial, patient-centred expert authority to drive the difficult reforms.

We are about to embark on a journey that is likely to lead to greater quantum of change to the work that is done in our private hospitals than we have seen before. Telehealth, remote monitoring, and remote delivery are likely to cause explosive growth in service provision done outside traditional hospital settings. This transition is not about to happen — it has started. But our governments and our workforce are not keeping pace with these changes.

Good, innovative health care needs best practice regulation, accreditation and funding systems in place to ensure that patient safety and outcomes are paramount. To allow unregulated, unchecked growth of health services provided to patients is likely to allow some of the worst behaviours of health providers and health funders to proliferate. The failure of governments across Australia to understand and take appropriate measures in our cosmetic surgery industry has shown us what happens when regulation fails patients. This cannot be the path we take for hospital substitution and out-of-hospital care services.

The AMA believes that now is not the time for timid reform of our health care system. To deliver holistic, evidence-based reforms that centre on and improve experiences and

outcomes for patients we need to work together in a planned and coordinated manner. We need to purposefully and deliberately design what our future health care system will look like.

Failure to do so will condemn us to repeat mistakes of the past and our patients, our workforce and our governments cannot afford for this to happen.

As a sector we need to address many underlying issues to make private health sustainable into the future. Further reform and engagement with all players is still crucial to deliver an adaptable, future-ready private health system, and the AMA stands ready to ready to continue leading the medical profession in that effort, as demonstrated at our Private Health Summit in June 2022.

Contact

president@ama.com.au

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[i] For families, the family income threshold is increased by $1,500 for each MLS dependent child after the first child

[ii] See preceding endnote

[iii] p.71

[iv] p.25

[v] Finity Consulting, Review of MLS, PHI Rebate and LHC, 2023, p.103.

[vi] APRA. Private health insurance annual cover survey December 2022 (released July 2023).

[vii] https://www.apra.gov.au/operations-of-private-health-insurers-annual-report

[viii] By this, the AMA means a mandated proportion of premiums paid returned in the form of overall claim benefits paid out, not a mandated proportion of individual premiums paid going back to each individual insured.

[ix] The Household, Income and Labour Dynamics in Australia Survey: Selected Findings from Waves 1 to 19, pp.9-10, https://melbourneinstitute.unimelb.edu.au/__data/assets/pdf_file/0009/3963249/HILDA-Statistical-Report-2021.pdf