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POSITION STATEMENT

Principles for private health insurance to cover out-of-hospital care

2024

Introduction

This position statement outlines the Australian Medical Association position on fundamental principles for the establishment and delivery of private health insurer-funded out-of-hospital care.

In this document, out-of-hospital care refers to care that is generally initiated and delivered in a hospital by default, but could be delivered outside the hospital where appropriate, for clinically eligible patients. It may be likened to 'hospital substitution' care, whether delivered via 'hospital in the home' models or telemedicine, potentially with the aid of digital devices and applications that can send relevant data back to treating medical practitioners. However, out-of-hospital care excludes outpatient-style care, primary care and peri-operative management outside of prehabilitation and rehabilitation.

Funding arrangements for private healthcare fall under three categories: the federal government through Medicare Benefits Scheme, private health insurers and the patient via their payment of private health insurance premiums, and any out-of-pocket costs associated with the type and level of private health cover they hold.

Under current legislation, set out in the *Private Health Insurance Act 2007* and associated regulations, private health insurers cannot cover the cost of consultations or treatment provided by general practitioners or specialists outside of hospital when the patient is classified as a non-admitted patient.

This legislation is currently lagging behind emerging models of care in the out-of-hospital care space. Private health insurers (PHIs) are developing their own models of out-of-home care on their own terms to save money, often through vertically controlled services where they control healthcare providers, the services they can provide, and what they can charge, via contract or employment conditions.

These insurer-led models of out-of-hospital care are not available to all privately insured patients and carry the risk of US-style managed care, which jeopardises the principles of patient choice and clinical autonomy.

The lack of any standardised regulations, rules, or standards for the provision of out-of-hospital care within the private health system is also undermining the intent of 'gold, silver, bronze and basic'

reforms which sought to standardise policies and make it easier for prospective patients to choose between such policies.

The AMA believes it is crucial to establish such regulations, rules and standards to ensure true contestability of service and equity of access to out-of-home models of care in the private health system. We envision a private health system where irrespective of where they live in Australia, all patients with appropriate private health insurance cover can choose the best care option for them under the clinical guidance of their medical practitioner, funded by their insurer.

Benefits of out-of-hospital care

The AMA is very supportive of greater provision of out-of-hospital care and services in the private health system. A considerable amount of evidence, much of which is cited in the AMA report on out-of-hospital models of care in the private health system, suggests the use of well-designed out-of-hospital models of care in clinically appropriate cases can offer benefits for patients, hospitals, and the health system as a whole.

For patients, these benefits may include improved health outcomes, for example, through a reduced risk of hospital acquired infections. The capacity to enjoy the comforts of home during recovery, better manage any caring responsibilities, and potentially, work from home (if individually appropriate), can all help to reduce stress and anxiety for patients during treatment and recovery. Furthermore, patients who do not have to travel back and forth to hospital for treatment may benefit from the reduced time, potential discomfort and costs of travel, particularly those living in regional and rural areas who may live a significant distance away from the nearest hospital.

With respect to benefits for hospitals and the wider health system, out-of-hospital care is also an efficient way for the hospitals to manage bed flow, thereby reducing pressure and potential wait times for patients. It is also more cost-effective as in some cases it is cheaper to deliver care in the home, as overheads are far greater when a patient is admitted overnight. For the health system, improvements in the private system will relieve pressure on the public hospitals, reduce pressure on private health insurance premiums and offer better value for the taxpayer.

However, it is critical that out-of-hospital care in the private system is equitable and clinically led, as opposed to the current model where it is largely insurer-led and only available to patients with specific private health cover policies living in certain areas of Australia.

Principles that should define delivery of private out-of-hospital care

1. Patient choice and clinical autonomy must be protected

1.1 Regulation must be implemented to prevent insurers and hospitals from influencing whether a patient is selected for in-hospital or out-of-hospital care.

1.2 Consistent guidelines around private health insurance product categories must be developed for out-of-hospital programs to ensure private health insurance policies remain easily comparable.

1.3 Patients should not be diverted to an out-of-hospital program, or to lower intensity care, without agreement from their treating medical practitioner.

1.4 Substitutions to patient care should not be made unless directed by the treating medical practitioner. In particular, private insurers should not amend appointments or treatments or suggest alternative treatments without consultation with the treating medical practitioner.

1.5 A minimum guaranteed payment scheme must be implemented to ensure the private health insurer pays for any out-of-hospital service chosen by the treating medical practitioner and the patient (provided the patient has appropriate levels of cover), within reasonable cost limits.

2. Quality and safety standards

2.1 Patients who receive out-of-hospital care must be assured of equivalent or improved clinical outcomes to patients who receive treatment in hospital.

2.2 Robust quality and safety standards that are underpinned by clear clinical governance arrangements and meet the National Safety and Quality Health Standards must be implemented so out-of-hospital models do not result in suboptimal care.

2.3 Medical colleges and societies should be consulted in the development, approval, and review of out-of-hospital models of care for relevant procedures/episodes of care within their disciplines.

2.4 Treatment should be carried out by healthcare professionals who have appropriate qualifications and training, as determined and advised by the treating medical practitioner.

2.5 Medical practitioners are the only health professionals trained to autonomously assess patients, initiate clinically appropriate treatments, and where necessary, refer care for a condition to other appropriately qualified and experienced healthcare practitioners. Non-medical healthcare professionals to whom the treating medical practitioner refers patients for out-of-hospital care must understand and work within their individual their scope of practice and ensure they refer to other health professionals where clinically required.

2.6 Data capture, monitoring, and evaluation should be included in the design of all out-of-hospital programs, to ensure these models of care are achieving their intended goals of delivering safe, high-quality care, while also reducing healthcare costs and providing care that improves the patient and provider experience.

2.7 Learnings from monitoring and evaluation should be used to update protocols, frameworks, and guidelines to ensure they remain contemporary and best practice.

2.8 The impact of private out-of-hospital models of care on the public healthcare system — most particularly public hospital emergency departments — must be assessed to ensure these models of care are not burdening other parts of the health system.

3. Patient protection: managing patient deterioration/re-escalation of care

3.1 Out-of-hospital care models in the private health system must be designed so that if a patient's condition deteriorates, they know their options for care re-escalation, and who to contact for help. In this situation, patients should be stewarded back to their private hospital through their own out-of-hospital team wherever possible, to avoid unnecessary presentations to public emergency departments.

3.2 The AMA recommends implementation of an agreed, stepped clinical governance protocol so patients and their treating team know what to do when a patient deteriorates in an out-of-hospital setting or expresses a preference to transition to in-hospital care. Among other elements, such protocols should specify who is responsible for managing an adverse outcome and escalation of care.

3.3 The NSQHS Standards for Recognising and Responding to Acute Deterioration should be leveraged in the design of a stepped protocol. These will need to be adapted for an out-of-hospital setting.

3.4 Out-of-hospital programs must work together with public hospitals, other private hospitals that have private emergency departments, and ambulance services to ensure they are aware of the possibility of additional emergency department presentations and are informed of the relevant stepped protocol.

3.5 In the event of an unplanned re-admission or presentation to an emergency department, it is crucial that patient records can be accessed promptly by relevant medical practitioners and that handover back to the out-of-hospital care team is undertaken expediently.

3.6 In the event of an unplanned deterioration, patients receiving out-of-hospital care should not incur any out-of-pocket expenses that would have been otherwise avoided if had they deteriorated as an inpatient.

4. A clear and equitable funding mechanism

4.1 The AMA believes government must design a funding safety net for out-of-hospital models of care in the private health system. It must be a solution that provides surety of funding, provides clarity for medical practitioners and patients on who pays, protects patient access and choice, is equitable, and is accessible to all who have appropriate cover.

4.2 This funding safety-net must include a minimum required insurer payment amount for out-of-hospital care that establishes a pricing framework, creates a price signal for the market, and provides clarity and surety of funding for all stakeholders.

4.3 Critically, clear rules must be developed for private health insurance policy product design for out-of-hospital care. Without such rules, the complexity of private health insurance products will continue to increase, and the efforts of recent governments to create easily comparable policies across insurers through 'gold, silver, bronze, basic' insurance reforms will continue to be undermined.

4.4 To create a platform for the deliberate design of these reforms, the AMA is calling for the establishment of an independent and well-resourced authority — a Private Health System Authority — to bring together and balance the interests of all sector stakeholders to build a better system.

See also:

AMA report on out-of-hospital models of care in the private health system

AMA private health insurance report card 2023

The AMA prescription for private health insurance