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AMA Submission: Department of Health Consultation on the draft standard clinical definitions for private health insurance hospital treatment policies

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4 May 2018

Background

The AMA has always advocated that maintaining and improving the value of private health insurance for consumers is vital for the future of private health care in Australia. The Australian health system is best served by a dual system of public and private care. The AMA understands that purchasing private health insurance is a significant financial commitment for many consumers and achieving value for money is very important.

Private health insurance is one of the most complex forms of insurance and the current complexity of product offerings has led many consumers to report that they do not understand what they are covered for.

Noting that a fundamental aim of the Private Health Insurance Ministerial Advisory Committee's (PHMAC) work is to build consumer confidence in the private health system and the insurance that underpins it, the AMA has a number of issues with the consultation on draft clinical definitions.

Summary

As a key participant on the PHMAC, the AMA knows exactly how critical changes to clinical definitions are to the overall private health insurance reform. Therefore, the short timeframe and process for seeking stakeholder feedback for this consultation on clinical definitions is unacceptable.

PHMAC has now been operating for more than a year, yet allowing a timeframe less than three weeks has not permitted wide consultation to inform appropriate allocation of clinical services under the proposed private health insurance categories and definitions. The AMA looks forward to advice from the Department on how future feedback on benefit coverage combined with the standardisation of clinical definitions will be considered.

Given the short timeframe permitted, the AMA has reviewed the current mapping for clinical issues at a high level only.

The most positive aspect of the methodology underpinning the introduction of the health insurance tiers *Basic, Bronze, Silver* and *Gold* is consumer certainty that if a treatment is listed as 'insured' on a policy this will mean all hospital accommodation, theatre, intensive care, nursing, ward drugs, prostheses, and diagnostic services costs will be fully insured during an admitted episode in a contracted hospital, or insured at 2nd tier rates in a private non-contracted hospital (outside CHIP restricted services). This of itself will go a long way to assisting consumers understand their insurance benefit entitlements.

However, the AMA considers significantly more work needs to be done to refine the allocation of standardised terminology and Medicare Benefit Schedule (MBS) item numbers to treatment categories, and the coverage offered by some of the categories, as outlined below.

The submission is structured to highlight issues related to:

- Consultation
- Mapping changes
- Attachment A - Feedback example issues from members (General / Specific)
- Attachment B - MBS use in contemporary private practice
- Attachment C – Previous issue with MBS items and PHI allocation
- Attachment D – Example mapping of coverage levels (current vs proposed)
- Attachment E – The submission by the Australian Orthopaedic Association

Further, while the AMA is represented on PHMAC, the AMA does not endorse the clinical definitions in their current form and reserves its right to provide further feedback as necessary.

Consultation

The AMA is disappointed with the consultation process, and in particular, that the mapping has not been undertaken via wider consultation with key stakeholders directly involved with administration of, or reform to the MBS.

Firstly, it is concerning for the AMA to learn that relevant Department of Health (Department) areas, including Medicare Benefits Division or MBS Provider Integrity Benefits Division (Compliance), were not consulted on the mapping. These internal Divisions can provide practical advice on item development, utility and claiming patterns of medical services.

Secondly, it seems counterproductive that amidst a parallel MBS Review which looks at appropriate use of the MBS services and how items combine to form a clinical pathway, that there has not been demonstrated consultation with the MBS Review Taskforce or the relevant clinical sub-committees, in order to transfer this knowledge into the clinical

definitions design. To further highlight the AMA's approach to the MBS process and how the AMA sees the interaction with the PHMAC process, please see **Attachment B.**

Alignment of MBS item numbers with clinical definitions for the purpose of private health insurance benefit coverage must be informed by consultation with clinical experts familiar with the MBS and its application. The AMA understands that the current consultation process has been limited to a select list of invited groups, which is not publicly available.

The allocation of MBS items to clinical definitions ultimately determines the value proposition of private health insurance, when a patient is covered for a service, and when a benefit will be received. The clinical definitions for privately insured patients impacts clinical scope of practice. This can influence where a patient is treated, the level of medical services provided and whether there is a private health insurance benefit paid for the service.

AMA cautions that this oversight will result in unexpected or increased patient out of pocket costs, therefore undermining the purpose of the PHMAC reforms, whilst negatively impacting the longstanding work of the MBS Review.

The AMA has spoken with a number of Colleges, Associations and Societies (CAS) over the consultation period, and we are not confident that the relevant clinical leaders across the CAS have been consulted in an in-depth manner within the current timeframe. Likewise the short timeframe has meant AMA has not been able to consult with its wider membership.

Transparency is critical to any large reform process and the AMA would expect that the broader CAS is extensively consulted with. To highlight this, **Attachment C** describes a recent example where an MBS Review, having been led by the relevant clinicians was completed and accepted by Government and the profession, only to be undermined by inappropriate Private Health Insurance classification.

Mapping

In relation to the mapping of MBS item numbers, more clarity is needed as to which MBS items have been included, excluded or shifted under the specific draft clinical definitions**.** MBS item structure is complex and it would be helpful if the background papers give a clear indication of approach used to classify the MBS items, particularly for those stakeholders not familiar with PHMAC's prior work.

The AMA also considers a full and thorough mapping exercise is needed to compare the proposed coverage by product category/tier with the existing health insurance product offering. Mapping the current product offering against the proposed new *Gold, Silver, Bronze, Basic* categories will assist PHMAC in understanding where consumers will lose coverage of items which they currently have, and where they can expect to see an improvement in their level of coverage. As far as AMA can see, this mapping work has not yet been done.

Attachment D represents the findings of a quick 'desktop' search of a number of private health insurance policies and their associated levels of coverage, contrasted with the proposed new tiers of insurance. It is by no means complete, and carries a number of caveats as outlined, so is provided to PHMAC Secretariat for illustrative purposes.

What it does highlight is that for a number of policies, their equivalent in the new schemes will result in a reduction of policy coverage for a range of conditions.

The AMA is concerned that the current consultation exercise is being driven only by cost consideration, and does not yet draw on the rigorous approach in place to support an evidence-based MBS.

For example, the inclusion of a procedure in the MBS Schedule is subject to the rigorous requirements of the Medical Services Advisory Committee (MSAC) process to determine what procedures should be covered, for what purpose and the specialty qualified to use the item.

The AMA is also concerned that through this closed consultation, for those stakeholders who have not had a 'seat at the PHMAC table', the draft definitions list will appear arbitrary. Without more detail as to the methods for allocating item numbers in the current consultation draft, stakeholder groups are not well placed to respond in an informed way.

For the AMA, this is particularly important as the AMA defers feedback relating to speciality items and their application to the relevant CAS, as we have with the MBS Review.

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Enclosed attachments

- Attachment A - Feedback example issues from members (General / Specific)
- Attachment B - MBS use in contemporary private practice
- Attachment C - Previous issue with MBS items and PHI allocation
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Attachment A

The following feedback illustrates the need for clinician review of the proposed MBS mapping. The comments represent a small sample from AMA committee members, many whom are renowned specialists in their field and have experience with MBS reviews and insurance policies.

Feedback from Members:

General examples/issues and gaps with the current definitions list:

- What happens to the current suite of accident and emergency policies in the transition to a body system classification?
- It is unclear where a pulmonary embolism would sit – respiratory or vascular?
- It is unclear where non-surgical medical admissions will be identified (not related to a specific surgical procedure)? How will asthma be dealt with?
- It is unclear where malignant melanoma sits under the new categories – is it 'skin'? In which case is staging for melanoma (sentinel node etc) covered along with grafts and flaps to close the defect?
- It is unclear where abdominal and extremity surgery for malignant or potentially malignant conditions would sit e.g. sarcoma of a limb, retroperitoneal sarcoma, abdominal wall desmoid?
- It is unclear how patients with aggressive benign pathology (e.g. desmoids) will be treated if their tumour is not technically malignant (even though they are treated with chemotherapy, surgery, and radiation therapy)?
- It is unclear how coverage/exclusions will operate 'post hoc', on the basis on histology (given that in a number of cases the diagnosis is not made until after the procedure – e.g. laparotomy and bowel resection or laparoscopy and lymph node biopsy+/- small bowel resection)?
- What would happen in the case of trauma where there may be multiple health (and therefore body system) issues – what would be the approach to coverage?
- It is inappropriate that male reproductive services (e.g. testicular torsion, prostate surgery, male sterilisation) are covered under a bronze policy, but female reproductive services (e.g. ruptured ovarian cyst, hysterectomy for heavy menstrual bleeding, female sterilisation) require a silver level policy.
- What will occur to a woman admitted with suspicion of appendicitis who turns out to have an ovarian torsion? At what point of her operation does she become a public patient? Or worse still if the surgery is being conducted at a private hospital does she end up with a bill once the admission is reclassified?
- Cataract procedures are one of the most commonly required surgical interventions and should be covered by all categories – the proposed allocation restricts it to high levels.

- It is unclear if at this stage a health fund can be compliant with providing a prerequisite service in any level of cover by having them offered as public hospital inpatient only. This is obviously not the intent anyone else wants.
- Haematology should be in the bronze package as haematological malignancies often affect the young (more likely to choose bronze).
- It is unclear if cover has been removed for the more common "medical" admissions? e.g. infective exacerbation of CAL, exacerbation of CCF. Do these now require silver level cover or higher?
- What is the process for review and adjustment of these categories? And how will these things develop as novel therapeutic approaches are developed?
- Ectopic pregnancy should be included with miscarriage and termination, and with all three early pregnancy issues included even if a woman chooses not to take out cover for pregnancy related services.
- Spinal operations are fundamentally different procedures to joint replacement surgery and should be considered separately.

Specific Issues

Ear Nose and Throat (ENT) – Grommets and Cancer

- The exclusion of tonsils, adenoids and grommets from the rest of the ENT codes is bizarre. As is the further advice to remove grommets. One recommendation would be to remove the T/A/G section and move it all into ENT surgery.
- Members believe MBS items 41608 and 41615 should remain within the ENT section. 41615 is used for other ENT procedures and is now used for emergency hearing loss in the acute setting to get steroids into the cochlea - definitely not an implant-requiring procedure (which is the gist of this whole section).
- 41608 is such a relatively cheap implant that it again fades into insignificance compared to the cochlear implants / bone-anchored hearing aids.
- There are concerns that many of the ENT codes for cancer covered in “bronze” will not be able to be performed because of the need of mucosal closure using codes from the plastic surgical section “silver”. This essentially excludes anyone having surgery for ENT cancer from being covered in “bronze” cover.

Skin Flaps - Illustrative example to consider the consequences of inappropriate classification

- Skin flaps are covered under the ‘plastics and reconstructive surgery’ category as services will be performed by a plastic surgeon, while skin excisions are covered under skin and skin lesions. There is therefore a gap between skin excisions and flap repair (which is not covered in the bronze category and only covered under plastic surgery).
- This procedure is as much the domain of ENT, General Surgeons and Dermatologists (and some GPs). Looking at MBS data will show the utilisation by all specialities. The

College of Dermatologists has AMC accreditation in their curriculum which clearly trains fellows in these defect repair approaches as a core training requirement.

- Furthermore, this is significantly discriminating against non-metropolitan patients as access to plastic surgery outside the capital cities can be limited. Therefore, these other specialities do all the work for skin.
- If the Department doesn't include these in skin items, then there is a significant threat of out of pocket costs because their admission for the skin excision maybe covered but the repair (a bigger item number) won't be. There are times when you don't know a flap/graft is required until you have completed the actual surgical excision. If the Department is truly wanting to improve the value of PHI then they need to reconsider how items are used group them accordingly.

Spinal Fusion

The AMA notes a significant oversight in the consideration of spinal fusion services. We refer to the Submission by the Australian Orthopaedic Association (at **Attachment E**) to illustrate specific clinical concerns. In terms of policy gaps for spinal fusion, the AMA provides the following comment:

- There seems to be an assumption that all spinal fusion surgery is for degenerative back pain and this is certainly not the case. Spinal fusion surgery is established as standard of care for trauma, tumour, adolescent deformity correction and where decompression of neural elements leads to spinal instability. These are indications where the surgery is non-discretionary. Prior to starting the MBS Review of Spinal Surgery item numbers, the Department paid a Consultant to do an independent review into the evidence base for spinal surgery (fusion and non-fusion) which found a satisfactory level of evidence existed for all categories of pathology. Restriction of such surgery options significantly compromises the quality of insurance products.
- Australians who have invested in *top hospital cover*, some for decades, have a legitimate right to expect the new Gold cover to include access to all the current MBS item numbers.
- Many PHI holders who have previously consulted spine surgeons may return months or years later with a deterioration in their condition so that spinal fusion is warranted only to find they have no PHI cover.
- Patients who have undergone spinal surgery in the past under their PHI and may require revision spinal fusion procedures in the future and will not be covered.
- The proposed residual procedures to continue under PHI, include non-elective procedures for trauma, tumour, and infection. In many cases, spinal fusion is an integral part of treating these conditions. Patients with PHI could present to private hospital emergency departments with a rapid loss of neurological function, only to be told that part of their surgical treatment cannot be performed under their PHI. Delay in transfers to the nearest public hospital could have catastrophic effect on the patient's ultimate outcome.

- A spine surgeon needs to be in a position intra-operatively to perform the surgery required at that time to treat the condition found in theatre. Until the access is obtained, there is no certainty that further, more complex procedures, may be required and may not be covered by the patient's PHI.
- Modern spine surgeons practising evidence based medicine will be ethically compromised in their practice: do they offer a discectomy or laminectomy that might temporarily relieve symptoms but is not best practice? If they offer less than best practice and there is a poor clinical result they are at risk of litigation and complaints by dissatisfied patients.
- Removing spinal fusion from PHI will inevitably result in many patients self-funding their surgery and thereby increasing the overall *out of pocket* burden under their PHI.

Attachment B

Background - MBS items and their use in contemporary private practice

The MBS Reviews have shown how considered and wide-ranging input from relevant CAS is essential when dealing with how the MBS supports and facilitates patient care in private clinical practice.

In this submission, the AMA outlines some of the issues seen with MBS items – in the context of the MBS Review, private health insurance and Medicare compliance – to highlight how these reforms are likely to suffer similar issues, if the consultation process is not improved before these standard definitions are implemented.

The AMA's support for the MBS reviews, and the PHMAC process, has always been contingent on both processes being clinician-led and having direct and early involvement of the specialist CAS. With regard to the MBS Review, the AMA has called for the review to be fully transparent from decision making through to implementation and be underpinned by a scientific approach. Where the reviews have worked well, it has largely been because there was a strong understanding of how MBS items are used in clinical private practice to best treat patients for their particular condition. Likewise, the allocation of MBS items to a 'clinical definition' should be equally sound, and work in a co-ordinated manner with the MBS review.

The AMA's position has always been to defer recommendations relating to specialty items to the relevant CAS groups, and comment on the broader policy issues and intervene where necessary.

In the AMA's latest submission to the MBS Review Chair, the AMA highlighted a number clear deficiencies and significant variations in the process adopted by the MBS Review. These were evidenced by a number of controversial recommendations within, for example, the cardiac services report, which the Cardiac Society believed to have lacked scientific support and therefore endorsement from the relevant CAS groups which the recommendations impacted.

A number of recommendations also introduced arbitrary and inconsistent restrictions threatening patient care.

The AMA therefore strongly recommends the PHMAC Secretariat work closely with the MBS Review team and the Medicare Compliance team, who have a strong understanding of the MBS items across the health system.

The AMA argues strongly that where a decision is made in contradiction to the advice of the medical profession, there should be clear evidence and data to support such a decision.

Attachment C

Previous issues with MBS items and Private Health Insurance eligibility

The MBS Skin Services review continues to demonstrate the important relationship between Medicare and Private Health Insurance eligibility.

The AMA worked closely with the Department in 2016 and 2017 on changes to MBS Skin items, and subsequent Private Health Insurance eligibility and banding.

A review of the MBS Skin items was undertaken to streamline the items, encourage appropriate clinical practice, but also generate savings to the Government. The work was led collaboratively by clinical leaders from the specialty.

However, when the items were allocated to Private Health Insurance 'banding', it was done without clinical involvement. The result was that key procedures, which the MBS items had been designed to cover, were no longer covered by private health insurance benefits.

This led to some of the most vulnerable patients no longer receiving insurance benefits for treatment, in a hospital setting, despite it being clinically necessary. Furthermore, a lack of understanding of how private health insurance benefits were to be applied to the items meant that a patient would be told they were covered for the removal of a skin lesion, only if, after the removal and testing of the sample, it was identified as malignant. Finally, the rushed implementation meant that when patients received informed financial consent and were told they were covered under their insurance, only to find out after the fact that they were not covered, due to the change in rules.

Ultimately this led to 18 months of work to fix the issue, with the AMA leading work for the Department to define further which conditions, under the broader MBS items in question, should be eligible for private health insurance coverage. This work is only now being finalised, as issues continue to persist.

This example effectively demonstrates the technical issues which can arise when allocating MBS items to private health insurance eligibility, and the problems that can arise when this work is truncated. Following 18 months of extensive consultation, at the request of the Department, the relevant Colleges, Societies, Day Hospitals and the AMA have produced a list of 'approved reasons' as to why these items should be covered under private health insurance, so as to assist the Department in directing insurers to pay – as they are required to under the legislation. The Department has indicated insurers are still rejecting valid claims, despite appropriate certification documentation being submitted, citing the private health insurance classification relating to the items. The AMA is very keen to ensure that similar issues do not arise in the future.

Attachment D

Mapping

The AMA also considers a full and thorough mapping exercise is needed to compare the proposed coverage by product category/tier with the existing health insurance product offering. The Tables below demonstrate how such a mapping exercise could be conducted. The AMA has done a quick 'desktop' search of a number of private health insurance policies and their associated levels of coverage, contrasted with the proposed new tiers of insurance.

The aim of high level exercise was to illustrate that for a number of policies, their equivalent in the new schemes will result in a reduction of policy coverage for a range of conditions. To further assist, we have highlighted just two definitions – cataract and spinal, to show where the new categories require a significantly higher level of coverage for eligibility. The highlights do not represent all changes – but the colour coding does allow insights into other areas. It is important to note the caveats regarding this data, outlined further below.

Mapping of existing and proposed coverage levels (highlighted)

Green - Proposed categorisation (Department Health April 2018)

X – not covered in proposed categorisation

+ - covered in proposed categorisation

Red - Actual categorisation in current policies (research based on overarching tables and does not specify levels of coverage i.e., includes default coverage in non-contracted hospitals)

X – not covered in existing categorisation

+ - covered in existing categorisation

Medibank	Basic		Bronze		Silver		Gold	
Tonsil and Adenoid Removal	X	X	+	+	+	+	+	+
Repair of Hernia	X	+	+	+	+	+	+	+
Cataracts	X	X	X	X	X	X	+	+
Rehabilitation	+	+	+	+	+	+	+	+
Palliative Care	+	+	+	+	+	+	+	+
Psychiatric	+	+	+	+	+	+	+	+
Spinal Fusion/Back surgery	X	X	X	+	X	+	+	+

Medibank currently provides coverage for spinal surgery from their Bronze level equivalent policies, under the proposed coverage this would only occur at the Gold level.

BUPA	Basic		Bronze		Silver		Gold	
Tonsil and Adenoid Removal	X	+	+	+	+	+	+	+
Appendicitis	X	+	+	+	+	+	+	+
Cataracts	X	X	X	+	X	+	+	+
Rehabilitation	+	+	+	+	+	+	+	+
Palliative Care	+	+	+	+	+	+	+	+
Psychiatric	+	+	+	+	+	+	+	+
Spinal Fusion/Back surgery	Not specified							

BUPA currently provides restricted coverage for cataract surgery from their Bronze level equivalent policies, under the proposed coverage this would only occur at the Gold level (note this is due to change as of 1/7/18).

HCF	Basic		Bronze		Silver		Gold	
Tonsil and Adenoid Removal	X	+	+	+	+	+	+	+
Repair of Hernia	X	+	+	+	+	+	+	+
Cataracts	X	X	X	X	X	+	+	+
Rehabilitation	+	+	+	+	+	+	+	+
Psychiatric	+	+	+	+	+	+	+	+
Spinal Fusion/Back surgery	X	X	X	+	X	+	+	+

HCF currently provides coverage for spinal surgery from their Bronze level equivalent policies, under the proposed coverage this would only occur at the Gold level.

nib	Basic		Bronze		Silver		Gold	
Tonsil and Adenoid Removal	X	+	+	+	+	+	+	+
Repair of Hernia	X	+	+	+	+	+	+	+
Cataracts	X	+	X	X	X	X	+	+
Rehabilitation	+	+	+	+	+	+	+	+
Palliative Care	+	+	+	+	+	+	+	+
Psychiatric	+	+	+	+	+	+	+	+
Spinal Fusion/Back surgery	X	X	X	X	X	+	+	+

HIF	Basic		Bronze		Silver		Gold	
Tonsil and Adenoid Removal	X	+	+	+	+	+	+	+
Repair of Hernia	X	X	+	+	+	+	+	+
Cataracts	X	X	X	X	X	+	+	+
Rehabilitation	+	+	+	+	+	+	+	+
Palliative Care	+	+	+	+	+	+	+	+

Psychiatric	+	+	+	+	+	+	+	+
Spinal Fusion/Back surgery	x	x	x	+	x	+	+	+

HIF currently provides coverage for spinal surgery from their Bronze level equivalent policies, under the proposed coverage this would only occur at the Gold level.

Australian Unity	**Basic**		**Bronze**		**Silver**		**Gold**	
Tonsil and Adenoid Removal	x	+	+	+	+	+	+	+
Appendicitis	x	+	+	+	+	+	+	+
Cataracts	x	x	x	x	x	x	+	+
Rehabilitation	+	+	+	+	+	+	+	+
Palliative Care	+	+	+	+	+	+	+	+
Psychiatric	+	+	+	+	+	+	+	+
Spinal Fusion/Back surgery	x	x	x	+	x	+	x	+

Note: There are 3 major levels of cover for each service in all health funds; Included, Excluded and Restricted or Minimum Benefits (MB). Restricted Levels of cover mean a larger out of pocket expense - as members are only covered partially for particular service/s (often MBS rates), the amount of cover will depend on the hospital. Restricted cover mean that members may only have cover if procedure is performed in a public hospital. Due to the limits of the time available to provide this response the level of cover (including any restrictions or other caveats on payment) provided by each insurer has not been fully determined. This exercise is meant to demonstrate that the proposed Hospital Product Design work may result in the removal of areas of coverage (such as Cataracts at the Silver Level and Spinal Fusions at Silver and Bronze Levels) in future products.

To further highlight the point, the following table on page 14 was provided to the AMA by an Ophthalmologist member identifying the changes in coverage for cataract surgery.

Again, the table is provided to the PHMAC Secretariat for illustrative purposes – actual coverage levels, as per the caveats in the insurer's documentation, needs to be confirmed with each insurer and facility. It is designed to show specific policies, as opposed the tables above which attempt a broader classification based around insurer.

Levels of Cataract Cover for a Range of Health Funds 2018

Hospital Product Design – (DoH) 2018	Basic	Bronze	Silver	Gold	
HCF	BASIC HOSPITAL	MID HOSPITAL	MID PLUS HOSPITAL	PREMIUM HOSPITAL	
	Excludes Cataract Surgery	Excludes Cataract Surgery	Major Eye Surgery including Cataract	Major Eye Surgery including Cataract	
NIB	BASIC HOSPITAL	STANDARD HOSPITAL	ADVANTAGE HOSPITAL	TOP HOSPITAL	
	Excludes Cataract Surgery	Excludes Cataract Surgery	Major Eye Surgery including Cataract	Major Eye Surgery including Cataract	
CBHS (Part of AHSA Group)	BASIC HOSPITAL	LIMITED HOSPITAL	ACTIVE HOSPITAL	COMPREHENSIVE HOSPITAL	
	Restricted Benefit	Restricted Benefit	Major Eye Surgery including Cataract	Major Eye Surgery including Cataract	
Hunter Health Insurance	Thrifty Hospital	Bronze Hospital	Silver Hospital - No Excess	Gold Hospital	
	Excludes Cataract Surgery	Excludes Cataract Surgery	Cataract and eye lens procedures	Cataract and eye lens procedures	
Doctors Health Fund		Smart Starter	Prime Choice	Top Cover	
		Excludes Cataract Surgery	Cataract and glaucoma treatment	Cataract and glaucoma treatment	

Attachment E

AUSTRALIAN ORTHOPAEDIC ASSOCIATION

3 May 2018

Ms Eliisa Fok
Senior Policy Adviser, Medical Practice
Australian Medical Association

By email: efok@ama.com.au

Dear Ms Fok,

Re: Clinical Definitions for PHI

Thank you for the opportunity to contribute feedback regarding the Department's consultation on clinical definitions for private health insurance.

Our first response must be to protest the very limited amount of time they have allowed for this stage of the consultation. While we have gathered some feedback and prepared a limited response, we feel that, as these issues have the potential to have significant and wide-ranging impact on the delivery of healthcare for the Australian public, the relevant deadlines seem unlikely to allow the considered responses required. With this in mind, we look forward to the Department's advice on how further feedback can best be delivered.

In addition to the issues raised below, I would also refer the Department to the Spine Society of Australia's (SSA) submission and the attached correspondence from Australian Knee Society President Bruce Caldwell.

Our primary concerns relate to the splitting of different services relevant to the same patient or condition between different levels of cover, leading to economic influences on decisions of patient care that should only be guided by concern for patient outcomes. Two examples are provided below; further detailed examples focusing on specific issues relating to the classification and placement of spinal fusion are available in the accompanying SSA submission.

Where such a split occurs between several possible treatments in response to a diagnosis, and some of those treatments are covered by the patient's class of treatment but others are not, the pressure will be applied at the point of decision. It will inevitably be the case under this system that instances will arise where treating practitioners will be forced to choose between the treatment with the best evidence base and outcomes, and that which the patient can afford and receive quickly.

Example:

> *An elderly patient with long term silver-class private health insurance has to attend a casualty department after experiencing severe pain and restricted function around her right hip. The surgeon investigates*

and determines that she has a fractured neck of femur. There are two possible treatments to consider; the first, a reconstructive plates-and-screws procedure; the second, a hip replacement. Based on a thorough review of the patient's case, the surgeon knows that in this instance a hip replacement is the best-supported option. However, as joint replacements are only supported by gold-class insurance, that option requires transfer to a public hospital. The patient and her family are distressed as her health insurance does not cover an extremely common problem. There is no option but to transfer to a public hospital for further treatment. This involves a delay in treatment by surgeon not of the patient's choosing. This would involve a delay and this in turn may compromise surgical outcomes for the patient.

We trust that everyone agrees that putting patients and their treating practitioners in such a position would be unconscionable. In addition to subjecting treatment decisions to influences other than the best supported evidence for patient outcomes, the distress involved for patients and their families would inevitably lead to an increase in negative publicity around private health insurance, placing further stress on the already fragile public perception of its value proposition and also increasing the demand on public health resources

Where a service class-split occurs within a sequence of treatments, the first stages of investigation and treatment may be covered for a particular patient, but later developments may lead to a need for treatments that are not included in their coverage, necessitating a transfer to a public hospital.

Example (see SSA submission for further detail):

A patient is admitted to a private hospital for investigation and treatment of disseminated malignancy, which is covered by his class of insurance. In hospital, paraparesis develops, requiring decompression and stabilisation. However, spinal fusion is not covered in his class of insurance. As a result, he must be transferred to a public hospital in order to afford treatment. The delay in treatment results in a greatly reduced outcome, prolonged suffering and a greater chance of complications for the patient.

Again, this is a situation we assume all parties would wish to avoid.

While these examples refer to specific aspects of the draft documentation provided, the issue of cross-class service splits would seem inherent in the nature of the proposed system – that it uses services as its foundation predisposes it to such problems. The current structure will lead to treatment driven by item numbers, not by the best available evidence for the best possible patient outcomes.

If the system was instead structured around the pathology or situation requiring treatment, this issue could be resolved. Patients with a particular

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condition or disease for which their level of insurance provides coverage would be able to work with their consultant to decide the best treatment plan based on the best evidence available, without the intrusion of economic factors that do not align with the patient's best interests.

Such a revision would also better align the system with the project's stated aims of consumer understanding, consistency and certainty; consumer understanding, as customers reviewing private health insurance would seem more inclined to understand problems and conditions they might encounter than the specific variations of treatment for those conditions; and consistency and certainty about coverage, as situations where some possible treatments for a particular diagnosis are covered by some levels of cover but others are not, provide neither.

A further note on behalf of the Australian Orthopaedic Foot and Ankle Society: we note the inclusion of references to "podiatric surgery provided by an accredited podiatric surgeon" and must echo previous sentiment evident in Attachment B. There are no current options for valid accreditation of a 'podiatric surgeon' in Australia, as we have previously explained in related submissions to government bodies. Despite the Department's decision that 'podiatric surgery's inclusion in the *Private Health Insurance Act 2007* determines its inclusion in this system, the lack of any attributed item numbers would seem to reinforce the anomalous nature of its presence. We remain concerned that, without at least acknowledgement of this fact, there is a risk to consumer understanding in the suggested alignment of surgery performed by operating podiatrists with that of the services of properly trained and accredited specialist surgeons.

Again, I must reiterate that the timeframe given to this important phase of consultation is alarmingly brief. Matters that have the potential to so greatly affect outcomes for Australian patients must be reviewed with appropriate consideration and consultation, and the voices of Australian practitioners – the people most intimately acquainted with the delivery of the services in question, and the circumstances in which they are delivered – can provide a vital perspective.

Further feedback will be forthcoming, and we look forward to engaging in more considered and productive consultation moving forward.

Yours sincerely,

Lawrence Malisano
President