Productivity Commission – Productivity Inquiry

Executive summary

The Productivity Commission should conduct a full review of the policy instruments, regulatory environment and market function of the entire health sector. Given CHA's Members' expertise, this submission includes productive recommendations to improve the contribution of the private health sector to the health of Australians.

A vibrant and effective private health sector provides health care to a significant portion of Australians directly, alleviates pressure on the public hospital system and improves overall efficiency. However, many of the policy instruments governing the health sector and particularly the private health sector are no longer fit for purpose. Regulation has not kept up with a changing health workforce and technology landscape, and there is insufficient coordination between primary and hospital care sectors primarily overseen by Commonwealth and State governments respectively.

A Productivity Commission review of the health sector should consider the most appropriate policy settings to allow for:

- Optimised patient outcomes in the private sector
- Value for money for the patient and for Commonwealth-funded private health insurance rebates
- Sustainability of access to care, including hospitals
- Reduced pressure on the public system.

This submission outlines a series of common-sense recommendations to meet these goals through considered adjustment of existing policy instruments. In keeping with the direction of the Productivity Commission's inquiry, the submission includes proposals to enhance the ability of the private hospital sector to offer innovative models of care that improve outcomes, reduce costs to patients and ease pressure on the private sector.

A holistic review of policy settings for private health care in Australia

Recommendation:

- **The Productivity Commission should conduct a broad review of the policy settings supporting health care. This will help to ensure a sustainable, efficient and high-quality private health care sector complimenting the public health system into the future.**

Over a period of decades, Australia has developed a substantial, high quality private health care sector. This sector provides a wide range of services including chronic care management, elective and non-elective surgery, palliative and rehabilitative care and mental health services. Not-for-profit Catholic hospitals alone account for around 30 per cent of private hospital care each year. However, 'building the plane while flying it' has resulted in a private health regulatory environment that does not offer adequate protections for consumers, sustainability assurances for hospitals, limits hospitals' ability to expand innovative new services and restricts interoperability with local public hospitals and primary care.

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The value proposition of private hospitals in financial terms alone is incredibly compelling. More than two out of every five hospital admissions in Australia are to a private hospital.[1] Two out of three elective surgeries in Australia from 2019–2021 were performed in private hospitals. In 2019–20, 71 per cent of the $17.1 billion spent on private hospitals (some $11.5 billion) was funded by non-government sources. For $5.6 billion, Australian governments saw two fifths of hospital admittances and two thirds of elective surgeries delivered, before accounting for any of the other enormous benefits provided by private hospitals. This is a bargain by any measure. For comparison, governments collectively spent some $60 billion on public hospital services.[2]

For patients, the value proposition is just as clear. Patients can choose to purchase high quality care via self-funding or insurance that is both accessible quickly and at a hospital and with a doctor of their choosing. This stands in contrast to ever-increasing wait times in public hospitals for elective surgery. Worryingly, this includes growing numbers of patients in the public system facing delays longer than their clinically recommended waiting period.[3] This can lead to the exacerbation of the original health concern and worse health outcomes.

And yet, as compelling as this value proposition is, the private hospital sector is experiencing immense financial hardship, with its long-term viability threatened. Private hospitals have suffered through the COVID-19 pandemic and governments' response to it, exacerbating structural and regulatory challenges already present in the sector. The most immediate financial challenges include:

- Health inflation
- Workforce shortages (and associated wage inflation)
- Pandemic-related costs such as personal protection equipment (PPE)
- The unsustainable viability agreements put in place during the pandemic to ensure private hospitals did not close immediately as a result of government restrictions
- Increasing and unfunded cost burdens resulting from government regulation such as the recent critical infrastructure bill
- Poorly designed prostheses reform currently anticipated to blow a $250m hole in private hospital budgets

Currently the Commonwealth Department of Health is conducting multiple reviews of various policy levers impacting private health care provision including:

- The Medicare Levy Surcharge
- Default and minimum benefits
- Risk equalisation
- Lifetime Health Cover Loading

While it is appropriate to regularly review all policy instruments that impact the availability of health services to Australian residents, adjusting any single instrument can have unintended consequences. Thus, the Productivity Commission is best placed to conduct an independent, whole-of-system review that can provide recommendations on how best to ensure a sustainable, efficient and high-quality private health care sector into the future.

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[1] https://www.healthdirect.gov.au/understanding-the-public-and-private-hospital-systems
[2] https://www.aihw.gov.au/reports/hospitals/australias-hospitals-at-a-glance/contents/spending-on-hospitals
[3] https://www.finder.com.au/private-vs-public-hospitals-wait-times-and-safety

Adequate consumer safety nets in health – where market failure is not an option

Recommendations:

- **Minimum default benefits should be extended to Type C procedures to allow for more efficient delivery in out of hospital settings**
- **Improve Second-Tier benefit settings to expand transparency, close loopholes and prevent unintended negative policy outcomes**

In reviewing the policy instruments underpinning private health, the Productivity Commission will inevitably need to consider the appropriate levels and applications of protections for consumers in the system. Some of the key protections for consumers include default and second tier benefits. A well-designed policy and regulatory platform for private health care ensures:

- Insured customers can continue to access the private hospital of their choice even where contract disputes (or no contract) exist between their insurer and that hospital
- Smaller private facilities are able to offer sustainable services, which are often vital to their communities and free up capacity in available local public health services
- Private hospitals have the funding certainty necessary to invest in innovative and efficient new care models.

Default benefits

Default benefit protections are essential components of the scaffolding supporting consumers access to private health care in Australia. When well targeted, they ensure that in the event a private health insurer is out of contract with a private hospital (perhaps as part of a negotiating position), an insured Australian can still access care at that facility. Otherwise, that person is likely to seek care at their local public facility, placing pressure on a strained public hospital system. Further, they may abandon their insurance product as poor value, further reducing private contributions to maintaining Australia's health care.

Well targeted minimum default benefits provide a capability for hospitals to continue to deliver care to insured patients. Simultaneously, a well targeted default benefit incentivises hospitals to contract with insurers by paying a typically reduced level of accommodation benefits to the hospital and increasing out of pocket costs, making the hospital less attractive over the long term. Without any default benefit consumer access and choice is substantially diminished, and insurer leverage in contract negotiations (particularly with smaller hospitals) unreasonably expanded.

Unfortunately a design oversight has led to the continued degradation of the minimum default benefit consumer protection due to failure to index the rates to health inflation. This impacts all hospitals with unfunded services relying on minimum benefits for their patients and places a higher burden on consumers. This is particularly impactful for consumers holding private insurance policies that restrict services such as palliative care, mental health and rehabilitation. Table 1 outlines the impact of the lack of indexation to health inflation on a number of health services.

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Table 1 - Impact of indexation on minimum default benefits 2012 - 2022

	2012	2022	% change (average 1.7% p.a)	If indexed at same rate as Premium increase - industry average (average 4.40% p.a)
Advanced Surgical				
1 to 14 days	$384	$453	18%	$588
>14 days	$266	$315	18%	$407
Surgical				
1 to 14 days	$356	$420	18%	$545
>14 days	$266	$315	18%	$407
Other				
1 to 14 days	$356	$364	**2%**	$545
>14 days	$266	$315	18%	$407
Mental Health				
1 to 42 days	$356	$420	18%	$545
43 to 65 days	$309	$364	18%	$473
>65 days	$266	$315	18%	$407
Rehabilitation				
1 to 49 days	$356	$420	18%	$545
50 to 65 days	$309	$364	18%	$473
>65 days	$266	$315	18%	$407

Minimum default benefits should be extended to Type C procedures, as most of these services (for example, transfusions) are not provided in non-hospital settings. In a public hospital, these services would be funded via a calculation under the Independent Hospital Pricing Authority (IHPA) administered Tier 2 Non-Admitted Services Classification. No such funding framework exists for private patients which places them at a severe disadvantage.

Note – default benefits are discussed further under 'Out of hospital care'

Second tier benefits

Similarly to minimum default benefits, second tier benefits are an essential policy instrument providing protection to insured consumers. 2022 has seen very public breakdowns in contracts between major private hospital groups and specific private health insurers – highlighting the need for well-designed default and second tier benefit regulations. Smaller hospitals have long had a disproportionately higher dependence on second tier benefits, but the huge numbers of hospitals that now hold Second Tier status is indicative of the

continued importance of this safety net in maintaining the viability of private hospitals, and in minimising out of pocket costs to patients.

Second tier benefits are not a gravy boat for private hospitals. Typically second tier benefits are set at 85% of the average of a funds' charge for an equivalent treatment in an equivalent hospital. As such, large, well capitalised hospital groups are overwhelmingly incentivised to contract with private health funds rather than rely on second tier benefits. However, particularly for smaller hospitals which often cater to under-served communities, this benefit is vital.

While second tier benefits continue to be a critical component of the private health framework, there are areas what warrant review/improvement:

- Improved transparency for all parties – currently hospitals provide enormous transparency under second tier benefit arrangements via Hospital Casemix Protocol Data. Conversely, the methodology used by funds' to calculate benefits are not always transparent. For example, where a price exists on a pricing schedule it is included in the calculation, even if that service is not in use at a given facility. At a fund-level, these poorly-designed methodologies can have a significantly distorting impact.
- Where there are few analogous hospitals/services in a State, provisions should be made to calculate the second tier rate for a service at a national level.
- The binary second tier **or** contracted facility condition should be removed. Where a fund rejects the opportunity to contract with a second tier eligible hospital for a service, that service should default to the second tier rate.
- Making clear that *Band 1 same day accommodation* applies to full and half day rehabilitation and mental health equivalent benefits.
- Reviewing anecdotal evidence of unintended consequences in the current system. For example, services set up specifically to 'cherry-pick' high volume, high profit services under second tier arrangements to the detriment of the viability of local facilities providing broad-spectrum critical care.

Out of hospital care - the low hanging fruit

Recommendations:

- **Review and recommend changes to the Private Health Insurance Act 2007 and its corresponding Rules to enhance the capability of private health insurers and hospitals to form collaborative agreements to fund and delivery OOH care**
- **Recommend extending minimum default benefits to OOH services provided by or on behalf of hospitals to incentivise more efficient service delivery.**
- **Recommend appropriate and necessary care related to hospital admissions is covered by private health insurance policies for all high volume, evidence-based clinical pathways.**

Out of hospital care (OOH) models of care are an opportunity to address pressure on the health system and meet patient preferences for more flexible care. Compared to traditional inpatient care for medically stable patients, OOH care can often be more efficient and effective, with lower readmission rates, length of stay, and mortality, and increased patient satisfaction.[4]

[4] https://www.cha.org.au/wp-content/uploads/2021/03/6-CHA-Report-J170720.pdf

Despite the enormous opportunity for improved productivity and health outcomes, OOH care has been described as the 'missing sector'. This is the result of inadequate government attention and funding, particularly in the delivery of these services by private hospitals. As part of a Productivity Review of private health care, OOH care represents the 'low hanging fruit' for a structurally significant improvement in the capacity of the health care system to deliver high quality care to Australians at scale. The Review should examine:

- Limits to the capacity of OOH services to expand
- Barriers to allowing or encouraging private health insurers to fund OOH services attached to private hospitals
- Fragmentation of OOH services that damages the value proposition of private healthcare
- The unequal regulatory playing field between providers of OOH care.

The Catholic hospital sector has significant potential and desire to expand their OOH services and deliver more holistic models of care, particularly with respect to palliative care, mental health, Hospital-in-the-Home (HITH) including in the residential aged care setting, rehabilitation, chemotherapy, postnatal care, and renal dialysis.

This is an area in which all the key stakeholder groups in the sector (governments, patients, hospitals, insurers, device manufacturers etc) would benefit from a workable solution, and a new framework for the delivery of OOH care. However, such a shift in the industry landscape can only be conducted in the context of a broad Productivity Commission Review of the private healthcare, to ensure changes generate more, better care for Australians and a sustainable, viable private health sector.

Some of the productive changes a review should consider include:

- The Commonwealth Government amending the Private Health Insurance Act 2007 and its corresponding Rules to enhance the capability of private health insurers and hospitals to form collaborative agreements to fund and delivery OOH care.
- Extending minimum default benefits to OOH services provided by or on behalf of hospitals.
- A mechanism combining Medicare Benefits Schedule rebates and fund benefits (such as that used for admitted patient care). This should include specific MBS items for OOH care and episode-of-care based payments.

Out of hospital care has the potential to fundamentally improve the capability and efficiency of the private health system. However, economies of scale can only be achieved with the funding certainty for hospitals to invest broadly and deeply into these services.

Digital health – technology and care

In its 7 April 2022 update, the Productivity Commission noted leveraging new technologies and innovation as a focal point for its inquiry. Health care is on the cusp of a significant expansion of the use of virtual health care to manage chronic disease, post-surgical care and mental health care – in addition to other care categories for which digital applications will be found as the technology and supporting infrastructure become more widely available. A recent Canadian report notes that "Care is care: whether virtual or

physical",[5] highlighting the shift in application of virtual technologies from a fringe opportunity to a significant driver of improved outcomes and efficiency.

There is consensus that under current funding settings, contemporary, multi-setting, multi-channel care models are disincentivised in favour of traditional, institutional, bricks and mortar models. Decision makers need sufficient certainty to make fundamental changes in their service delivery models. One critical component of this is the updating of funding models to support best practice, evidence based, patient centric, out of hospital care models.

To this end, the Productivity Commission should consider measures to improve funding certainty and support private care providers to innovate and deliver improved care outcomes at cheaper cost and at scale. These measures should include:

- Removing the hospital/non-hospital distinction from all private health insurance hospital policies.
    - For virtual and out of hospital care this could entail significant savings, improved access for patients and improved outcomes where non-traditional care is a clinically appropriate model. Insurers and hospitals could develop revenue sharing models to ensure that savings accrued fairly to providers and funders.
- Appropriate and necessary care related to hospital admissions is covered by private health insurance policies for all high volume, evidence-based clinical pathways.
    - Certain types of care are poorly served by the current insurance funding model, where funding only follows 'admitted' care.
    - Inclusion of out of hospital and virtual care would remove illogical out of pockets, increase the value of insurance to patients and improve continuity of care.
    - This need not increase total health outlays – funding models such as bundles could be explored, as could value capture where it is demonstrated that private care is alleviating pressure that would otherwise be placed on the public system.

Building a health workforce to support Australia's needs into the future

Recommendations:

- **Review health workforce planning coordination and capacity and, if lacking, recommend the restoration of Health Workforce Australia.**
- **Explore avenues to incentivise greater participation in the health workforce.**

The health sector is not immune to the workforce challenges facing most major sectors of the economy. The health care sector faces a structural deficit of available workforce, exacerbated by acute needs in the aged care and disability sectors. No central agency has sufficient oversight of current or future workforce needs in Australia's hospital sector. Different state and territory governments announce workforce development initiatives without a clear idea of where additional health care workers will come from, or cognisance of other jurisdictions and the private sector drawing from the same pool of potential workers for their own workforce plans.

[5] https://www.canada.ca/content/dam/hc-sc/documents/corporate/transparency_229055456/health-agreements/bilateral-agreement-pan-canadian-virtual-care-priorities-covid-19/template-wf-report-eng.pdf

This lack of data on current and future workforce needs need not have occurred. The Council of Australian Governments established Health Workforce Australia (HWA) in 2008 to act as the national agency to address health workforce reform including understanding the skills and volume of workers needed, and where in the country they will need to be distributed. This included developing national workforce projections for doctors, nurses and midwives through to 2025. This was in part in response to the Productivity Commission's own report on health workforce in 2005.

In 2014 the Commonwealth Government abolished HWA, citing two reasons:

- The perception that HWA was additional, wasteful bureaucracy
- Alleged confusion about the division of roles between HWA and the Department of Health

Ostensibly HWA's functions were rolled into the Department of Health. It is now evident given the sector's current workforce crisis that HWA's role was not successfully filled by the Department of Health.

In the absence of the accurate picture on the scale of the workforce challenge facing the sector that HWA could have provided, CHA commissioned research to identify the current vacancy rate for key health care roles nationally. That research, conducted by CHA and Notre Dame University, indicated a national health workforce shortage of over 82,000 staff, including over 11% of enrolled nurse and 6% of registered nurse positions vacant. Even that large deficit does not reflect the true scale of the challenge facing health care, as it does not account for nurse requirements in aged care, and is current as of 2022 – future workforce needs are likely to increase.

In order to address the crisis in Australia's health care workforce, the Productivity Commission should consider the following recommendations:

1. Restore national leadership to health workforce planning through the re-establishment of HWA. HWA would bring together critical workforce research, planning and development functions under one roof at a national level. It would collaborate with states, territories and the private sector to understand workforce needs, coordinate appropriate levels of training, and provide recommendations to the Commonwealth government where further skilled immigration is appropriate.
    a. HWA would also help maximise the use of our current workforce by collating and disseminating successful improvements to scope of practice, use of digital technologies to improve workforce productivity and other models of care.
2. Ensure the skilled migration list is up to date and targeted to the geographical areas of greatest need
3. Improve international recruitment, including reducing the administrative burden and costs.
    a. It can take approximately nine months for a nurse to obtain a permanent residency visa in Australia versus three weeks in the United Kingdom.
    b. CHA's members have noted that Australian Health Practitioner Regulation Authority registration can take up to two months, when it is required before lodging visa paperwork.
    c. Members are paying 10-12% of the total remuneration of a prospective staff to recruitment agencies, when this work could be better coordinated by governments. This is in addition to high costs faced by applicants themselves.

4. Explore other options to increase the domestic workforce in the near term. This could include but is not limited too:
    a. Loosening work-related income impacts on the aged care pension to encourage retired nurses back to the workforce
    b. Reduce income tax rates for health care workers nearing the retirement age
    c. Offer targeted measures to improve childcare access for health care workers, whose shifts often are not accommodated by childcare based around a 9-5 work day.

Working well, working together

Recommendations:

- **Recommend inclusion of specific primary care targets to ameliorate pressure on public and private hospitals in the National Health Reform Agreement.**
- **Recommend a requirement that the LHN CEO and Chair be appointed ex-officio to the PHN Board and vice versa.**

A well-functioning health system requires integration and coordination between its various elements. Where that coordination does not occur, workforce planning can fail to meet the needs of the health system, services can fail to meet the needs of their community (or alternatively, unnecessary duplication can occur), and health funding is not distributed efficiently. This 'fragmented' care represents part of the extraordinary cost and access issues that plague the United States of America's health care system.[6]

In Australia, this coordination needs to occur at multiple levels. Hospital and acute care is funded predominantly by states and territories (via hospitals they control), where primary care is funded primarily by the Commonwealth Government (via Medicare through general practitioners and allied health professionals). Public health awareness campaigns are varyingly funded by both tiers of government.

Across both hospital and primary care private providers offer care through a mix of public, insurer and user (patient) funding.

In previous sections the need for cohesive workforce planning through the reconstitution of HWA was outlined. However, the Productivity Commission should explore other means of encouraging further coordination between different elements of the health system. Positive improvements would include:

- Inclusion of specific targets and/or responsibilities in the National Health Reform Agreement (NHRA) for the Commonwealth to provide primary care services to ameliorate pressure on hospitals.
- Inclusion of defined targets in the NHRA for placement of patients in public and private hospitals into Commonwealth funded aged and disability packages.
- Reforms to the governance of Local Hospital Networks (LHNs) and Primary Health Networks (PHNs). The most immediate change should be the requirement that the LHN CEO and Chair be appointed ex-officio to the PHN Board and vice versa.

[6] https://www.health.harvard.edu/blog/is-our-healthcare-system-broken-202107132542#:~:text=Despite%20spending%20far%20more%20on,relatively%20low%20in%20the%20US.

- A risk-sharing regime should be adopted across public hospitals for Medicare ineligible patients to share the burden of patients across public hospitals in a more equitable manner.