AHIA Submission to the Regulation Taskforce

November 2005

ABOUT THE AHIA

The Australian Health Insurance Association (AHIA) is the Australian Private Health Industry's peak representative body that represents 26 health funds throughout Australia and collectively covers more than 94% of the private health insurance industry. AHIA member funds today provide healthcare benefits for approximately 9.5 million Australians.

INTRODUCTION

Private health insurance is often referred to as the most heavily regulated industry in the Australian market place.

The National Health Act (NHA) is 52 years old and was crafted in a regulatory and healthcare environment completely different from the current one. In those 52 years, there have been numerous changes and amendments to the NHA and additional acts (Health Insurance Act, etc.) that are impacting on the PHI industry. As a result, the overall PHI legislative regime is extremely complex and now imposes increasingly burdensome and costly compliance requirements on the PHI industry. This NHA compliance exercise delivers limited value. A comprehensive review of the NHA to reflect a modern Australian Healthcare system would assist in addressing these issues. An AHIA industry survey estimates that each year $46 million administrative dollars are spent on compliance costs simply in order to abide by regulation.

Consideration should be given to reviewing the overall regulatory structure for private health insurance. Currently, multiple regulatory frameworks apply in terms of both the Department of Health and Ageing administering the National Health Act and Health Fund Rules, etc., and of PHIAC regulating the financial condition of Health Funds.

There are many components of the current regulatory regime that adversely affect industry competition and impose unnecessary barriers on private health funds achieving better health outcomes for their members. These barriers not only limit efficiency gains within the private health sector but also restrict potentially better health care for members. Ultimately this adds to overall costs that are reflected in higher premiums for members of PHI, as well higher outlays for the Federal Government via an increased private health insurance rebate.

This paper provides specific information on individual macro and micro regulatory constraints faced by health insurance organisations in delivering a product to meet the changing needs of today’s health system.

All matters covered in this paper should be read in conjunction with the AHIA submission to the House of Representatives Inquiry into Health Funding.

ITEMS FOR CONSIDERATION BY THE TASKFORCE

1. HEALTH INSURANCE ACT 1973

Part VII, Section 126 (1) of the HIA is shown below:

> ## *Part VII—Miscellaneous*
>
> ***126 Prohibition of certain medical insurance***
>
> *(1) A person shall not make a contract of insurance with another person that contains a provision purporting to make the first-mentioned person liable to make a payment in the event of the incurring by the other person of a liability to pay medical expenses in respect of the rendering in Australia of a professional service for which Medicare benefit is, or but for subsection 18(4) would be, payable. Penalty: $1,000.*

This clause effectively restricts any organisation paying for any health service for which there is a Medicare Benefits Schedule (MBS) item and payment rendered as a professional service.

Schedules 1 and 5A of the National Health Act detail the parameters under which health funds can pay for medical services, but health funds can only provide a benefit payment to members for a "professional service in respect of which a Medicare benefit is payable" under the current hospital table environment. Such benefit payments are made under *applicable benefit arrangements* under which health fund members are entitled to receive benefits for "all professional services rendered to a patient, while in a hospital or day hospital facility, being professional services for which a Medicare benefit is payable" (73AAf(bd)(ii))

This regulation means that funds can pay only for professional services rendered in the hospital setting. Such regulations encourage unnecessary hospital treatments, as funding mechanisms for both hospital and medical providers are triggered only at the point of a person being admitted to hospital.

The consequence of section 126, detailed above, makes it illegal for health funds to pay benefits towards treatments outside the hospital setting where an MBS item was charged. This means that even though such medical services may be more appropriate outside the hospital setting they cannot be covered by health insurance. Such procedures may indeed be safer and provide better outcomes for patients if provided outside the hospital setting. Section 126 of the National Health Act and related NHA provisions create perverse incentives for admission.

Hospitals are expensive components of the health insurance system and a number of studies have proven they can be a source of infection and injury to patients. It is unreasonable that patients are driven into the hospital setting for financial considerations. Widening the scope of the health insurance product to allow innovative approaches with providers will improve competitiveness and consumer choice. If the scope allowed for care as a true substitute to current hospital admissions, then there would be reduced pressure on health fund premiums and consequently reduced pressure on Federal Government outlays. These regulations have the effect of enshrining inefficiencies within the private health care sector.

2. REINSURANCE

Reinsurance is a system that redistributes benefit payments for high users of the health system (members over 65) and the chronically ill. This system ensures that high users of the system are not discriminated against because of their higher utilisation characteristics. This means that whole of industry is responsible for the most vulnerable in our community.

This is an admirable concept and one that is supported by industry. The current system however creates further perverse incentives in that only hospital treatments can be included in the reinsurance pool. For example, if a fund provides more appropriate treatment paths for its sicker members rather than being hospitalised it cannot submit these costs to the reinsurance pooling mechanism. The current reinsurance system therefore creates a disincentive to pay for more appropriate care. The current arrangements penalise funds that make an effort to manage their health care risks pro-actively.

The AHIA has an **industry agreed** model that would improve the current system rather than radically altering it. It widens the scope of the age groups to be included in the redistribution formula to reflect the shift in high cost treatments in today's society and enables health funds to pool costs associated with helping members avoid costly and potentially dangerous hospital treatments and access more appropriate substitutional care.

3. DEFAULT BENEFITS

Health funds contract with hospitals on behalf of their members. If contracts are not concluded then health funds have to pay default benefits to the institutions. This is regardless of whether the hospitals provide a diminished quality of service or do not provide similar patient outcomes as other comparable hospitals. Effectively hospitals are provided with an underwriting mechanism from default benefits, without any consideration of supply or demand within the health sector. This in itself must create more admissions than are actually necessary in the private health sector, which adds costs to members and the Federal Government via unwarranted utilisation and, very importantly, a lack of control over safety, quality and outcomes.

The current system of default benefits restricts competition and encourages inefficiencies, risking improved quality and safety of treatment with the hospital setting. For these reasons alone the AHIA would welcome the removal of the default benefits.

4. HOSPITAL LICENSING

Hospitals are effectively "rubber stamped" into the private health financing marketplace. State Governments quite readily approve hospitals via state licensing on the premise that they will relieve pressure from their public hospital system. Once this approval is received, the Federal Government provides the hospital/day surgery with a provider number. A provider number provides the hospital with an entitlement to health fund benefits. Health funds have no choice but to pay for services rendered within any private hospital via the default benefits system outlined above. The current practice of hospital licensing at both a State and Federal level is one which leads to inefficiencies within the private health sector.

Provider numbers are allocated without hospitals being required to demonstrate any commitment to common safety principles that would be expected in a hospital setting, yet the benefits they receive from health funds are mandated.

Licensing is sometimes inappropriate or the nature of services poorly defined (for example "sub-acute"). This can lead to disputes about the nature of service delivery and the level of coverage offered to members.

5. PORTABILITY

Portability regulations are intended to protect member's interests such that the members can move between health funds without losing entitlement to the equivalent levels of cover. Currently the regulations are being used by health providers to arbitrage the system for financial gain. Providers can encourage members to move between health funds in order to receive higher benefit entitlements. This costs the insured community and Government by way of increased premiums, although the patient receives the same level of treatment.

6. MEDICAL FEES /INFORMED FINANCIAL CONSENT

The number one complaint by consumers after receiving hospital treatment is out of pocket expenses – especially those costs that are not explained to the patient prior to surgery, i.e. if there is an absence of "informed financial consent".

Health funds can enter into agreements with providers to pay at certain levels above the medical benefits schedule, yet they can not compel the doctor to accept only that benefit – specialists are still free to charge at their own discretion. In the majority of cases in which patients receive gaps, the accounts have been raised by specialists whom the patients have not even met. It would be sensible for either the Specialist in charge to take responsibility for informing the patient of all costs associated with the procedure, or alternatively specialists involved in the procedure who do not meet the patient prior to surgery should not be permitted to charge a gap.

The Privacy Act prohibits funds providing information to consumers in regard to specialist's charging practices. Privacy Act exemptions should be enacted such that industry wide data on medical specialists charging practices can be provided to the public.

7. ANNUAL PREMIUM ADJUSTMENTS

The annual rate application process undertaken by Private Health Insurance funds is arduous, labour intensive and has no certainty for individual funds in forecasting future premium income. A number of the issues surrounding this process include:

- the length of the process required to prepare the application and achieve the rate increase (usually October through to April each year)
- uncertainty about the rate application approval until the last moment
- the risk that rejection of a rate application will have an adverse impact on the prudential circumstances of a fund
- no advance knowledge of the date of approval which affects the production and distribution of brochures, publications and letters
- the duplication of material and potential waste of resources resulting from this lack of certainty

A more transparent, timely and consistent process would address a number of these issues.

8. PRIVACY LEGISLATION

Even though this issue of Privacy was addressed earlier in this submission with regard to medical gaps, there is a far bigger issue in the sense that the private health industry is unable to collect and to make publicly available information in relation to hospital treatments by medical providers. (Collection is covered in point 14). Further laws related to defamation make it very difficult for health funds to publish provider identified information.

Without the ability to provide this information, industry is hampered in efforts to guarantee or improve patient safety and treatment outcomes. Such information would assist in the reduction of unnecessary hospitalisation or adverse events in the hospital setting.

9. LIFETIME HEALTH COVER

The current LHC cover provisions are complicated and burdensome on health fund systems. There is a multitude of dates that affect entitlement to the LHC scheme. This system should be simplified to enable better public understanding.

As an example, there are several different LHC criteria applying to migrants:

- Migrants eligible for Medicare prior 01/10/1999
- Migrants eligible for Medicare between 01/10/1999 and 22/04/2004
- Migrants eligible for Medicare on or after 23/04/2004
- Migrants (citizens of New Zealand) who became eligible for Medicare prior to 01/10/1999, between 01/10/1999 and 22/04/2004 and after 23/04/2004

Such boundaries make it difficult for staff and members to comprehend when loading applies and when it doesn't, perhaps made more complex by a need to communicate with people whose first language is not English. It would be more appropriate to have one generic ruling for all migrants.

A second example of the complexity relates to the numerous criteria applying to Australian citizens and permanent residents overseas:

- Australian citizens and permanent residents who were overseas 01/01/2000 – 01/07/2000 inclusive
- Australian citizens and permanent residents who were overseas on 01/01/2000
- Australian citizens and permanent residents who were residing in another country on 01/07/2000 but were visiting Australia on 01/07/2000

Again it is difficult for health fund staff and members to comprehend when loadings apply and when they do not. It would therefore make be more appropriate to have one ruling.

10. FEDERAL GOVERNMENT 30% REBATE LEGISLATION

(i) Rebate forms have to be completed to apply for the rebate as a premium reduction on private health insurance premiums. The form must be stored for 5 years in either paper or electronic format. This is not only inconvenient for members but adds costs to premiums by having to store and scan forms.

A better solution would be for funds to accept verbal requests and send written confirmation to members in the form of a policy certificate and by paying the reduced premium members indicate their confirmation to accept the rebate as a premium reduction.

(ii) Tax statements must be issued annually to every member by 15 July each year. This is a real cost to funds. A better solution would be to only compel funds to send tax statements to members who have not applied to have the rebate as a premium reduction.

(iii) The rebate can be claimed as a cash payment from Medicare Australia. This imposes difficulties for funds in terms of reconciliation. Health fund systems could be more administratively efficient if the ability for persons to attain the PHI rebate via cash collection through Medicare offices were to be removed. This would not only save Medicare revenue, but would ensure the patient had the advantage of receiving the lowest possible premium at the point of purchase

(iv) Health funds are required to store the rebate history of all members to cater for the Savings Provision Entitlement. This is an unnecessary impost on health fund systems. One solution would be to allow funds only to store rebate history for members registered for rebate as a premium reduction.

*(*v) Before the current rebate scheme was in place, the Private Health Insurance Incentives Scheme existed. The detail about this scheme is still contained in the Health Insurance Act on the premise that a patient would possibly be better off financially under this scheme as opposed to the current rebate scheme. This redundant regulation, (enacted in 1997), should be removed to simplify health fund systems. There are real costs for health funds by having to manage two types of rebate and having to issue two types of tax statements (one for 30% and one for PHIIS). This rule should be removed.

(vi) The current Savings Provision Entitlement (SPE) for the 35/40% rebate is very confusing and complex. It is difficult for staff to understand the concept, let alone the members. It is also problematic when a person leaves one health fund and joins another. SPE entitlement should be reviewed and regulatory change made where appropriate.

(vii) Annual rate change letters mailed to members require funds to include in the letter the old rebate amount and the new rebate amount. This confuses members and also imposes an administrative burden. It would be more practical to state that the rebate amount has increased and quote the new amount.

11. PHIAC

Health Funds in recent times have moved to broaden their product offerings into areas such as financial services. Such organisations then also face alternative regulatory regimes, such as APRA, with different approaches, standards, terminology and sometimes competing regulatory requirements.

In reviewing the overall regulatory framework for Health Funds, consideration should be given to the establishment of a single regulator across the Health and General Insurance sector responsible for all regulatory supervision. To some extent, if PHIAC were to come under the auspices of APRA, a single regulatory regime would exist allowing for consistent approaches in the processes as well as providing PHIAC with a depth of knowledge and expertise from a regulatory perspective.

12. WAITING PERIODS

Waiting periods are prescribed under the Act, and are generally 12 months. It would protect existing members of health funds if variable waiting lists were to apply. For example waiting periods for knee and hip replacements, which are the result of many years of progressive joint disease, could be subject to longer waiting periods than other ailments. The existing PEA rules do not adequately protect the health funds from anti-selective behaviour.

13. ELECTRONIC EFFICIENCIES – HARD COPY REQUIREMENTS

In the age of electronic communications and storage, it is untenable that funds are required to produce “hard copy” Rebate forms or hard copy anything. Funds have moved to set these up on their websites so that they can be electronically attached to the member record. Regulators should acknowledge changed times. A health fund can still print the documentation and provide it to members as required.

A similar comment could be made in regard to the requirement for funds to have (hard copies of) Fund Rules, brochures etc in their Branch offices. These items can be downloaded from the website, or if members can't access the website, the funds can download and print off. This is still a much more cost effective option than being required to produce hard copy documents.

Publications such as the "Key Features Guide", "Insure/Not Sure", and the "Private Patients Hospital Charter" are of questionable benefit to members. The PHI Code of Conduct should render many of these superfluous. Funds get almost NO requests for these documents but they add to the cost of PHI. If funds need to have them at all, electronic copies should suffice.

Requirements for all products to be in one brochure is not only impractical for the end user but adds to the complexity of the product offerings.

14. HCP DATA

While the legislation says that a hospital should provide HCP data there is no effective penalty. The only sanction a fund has is to refuse to pay benefits. This would disadvantage patients. Further, such actions endanger hospital contracting arrangements which could destabilise patient access or threaten health fund/hospital relations.

Funds can collect data from hospitals if negotiated as part of hospital contracts (HPPAs), and this data can be analysed to improve safety and clinical outcomes at a fund level. However, if a fund does not have an agreement with a hospital then there is no requirement for the hospital to supply data.

An amendment could mandate that hospitals provide HCP data - whether in contract or otherwise - on a timely basis or incur financial penalties. Without industry wide data the private health system cannot make efficiency gains or improve hospital treatment quality and outcomes for patients.

15. ACUTE CARE ADVISORY COMMITTEE

If a patient stays in hospital for more than 35 days they are classified as a Nursing Home Type Patient which means the hospital attracts lower accommodation benefits as a lower level of care is required. This occurs unless the hospital provides the health fund with a 3B certificate to certify continuing acute care is required. Health funds must pay $2,000 to have ACAC review the 3B certificate every 35 days one is issued by the hospital.

Even if funds are successful in the ACAC review, they incur a $2,000 expense that must be passed on to contributors through premiums. The hospital receives no penalty even if ACAC overturns the certificate that was submitted to attract higher health fund payments. If health funds do not question 3B certificates then they may be paying significantly higher daily benefits than necessary. Either way, the health fund pays, which adds to contributor premiums, and hospitals can submit unwarranted certificates for financial gain without a disincentive.

Ideally hospitals should be required to reimburse health funds for every ACAC review found in favour of the health fund, or at a minimum the fee for an ACAC review should be shared between both parties.

16. NOTIFICATIONS OF HEALTH FUND REGISTRATIONS

Section 81(2) of the National Health Act states "*Whenever an organization is registered or the registration of an organization is cancelled, the Council shall publish in the Gazette a notice of the registration or cancellation, as the case may be*". The internet has become a more appropriate resource rather than the Gazette and as such, Section 81(2) should be removed.

Section 82 (6) reads "*A person shall not publish or display or cause to be published or displayed an advertisement or notice which indicates that an organization is an organization the rules of which provide for the payment of benefits for hospital treatment unless the advertisement or notice states:*

(a) in the case of an organization which is a registered health benefits organization - that the organization is a registered health benefits organization; or

(b) in any other case—that the organization is not a registered health benefits organization.

Penalty: $10,000 or imprisonment for 5 years, or both."

This section makes it an offence for a health fund to publish an advertisement that does not include the endorsement that the fund is registered. In reality, funds find it difficult or impossible to comply in media such as radio or television commercials and it adds to 'small print' in press.

The requirement may have had validity in the days when health insurance was conducted by unregistered operators. But Section 67 in 1985 has ensured there are other penalties for conducting PHI. An unregistered organisation that portrayed it can pay hospital benefits would be subject to action under the Trade Practices Act for misleading and deceptive conduct, or NHA Section 67. Therefore, this piece of legislation should be removed.

17. PREVENTATIVE HEALTH CARE

Poor diet, lack of exercise, etc., is a real issue and is emphasised daily by health professionals as THE health issue of the 2020s. It is also a very significant issue for young members who, by taking up membership, help to defray the health costs of the elderly. Fitness benefits, when provided, were a very significant retention factor for younger, healthy members and funds have now been forced to pay these benefits from "marketing" costs, rather than claims costs, to "get around" the regulations. This is quite absurd since the effect on contributions (and therefore the Rebate) is the same. Health funds at their discretion should be able to explore opportunities to offer preventative measures to high risk populations to improve health outcomes and minimise hospitalisations.

CONCLUSION

The AHIA welcomes any opportunity to expand further on any of the issues discussed in this submission or the attached AHIA Submission to the House of Representatives Inquiry into Health Care Funding.

AUSTRALIAN HEALTH INSURANCE ASSOCIATION
22 November 2005

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AHIA SUBMISSION

Attachment 2

House of Representatives Standing Committee on Health: Inquiry into Health Funding

Beyond the Hospital Gate:
A new province for Private Health Insurance

"There have been significant changes in clinical practice and in the organisation and delivery of health services that make it timely to consider how Medicare might now evolve. In addition the relative roles of the public and private sector in providing and funding health care have also shifted considerably over the last 20 years. When Medicare was introduced, patients admitted to hospitals usually had multi day stays and there was a strong focus on care provided in institutional settings. Now, many types of care, including dialysis and chemotherapy, are routinely provided on a same day basis and often in community based settings or in the patient's home. Models of care are now quite different. However funding arrangements remain largely unchanged and reflect historical practice rather than contemporary models of care and clinical practice…

"The Reference Group's work shows that historical organisational and funding arrangements had not evolved with changes in clinical practice and contemporary perceptions of roles and responsibilities. For this reason these arrangements do not encourage continuity of care, provision of multidisciplinary care or provision of care in the most clinically appropriate setting. In addition the current funding arrangements may actually prevent and distort access to best practice clinical care…"

(Report to the Australian Health Minister's Conference from Australian Health Care Agreement Reference Groups, September 2002)

RUSSELL SCHNEIDER
AUSTRALIAN HEALTH INSURANCE ASSOCIATION

EXECUTIVE SUMMARY AND RECOMMENDATIONS:

The Federal Government's incentive measures, particularly the Private Health Insurance rebate, have played a significant part in restoring the attractiveness of private health insurance by making it more affordable. Before the rebate the average direct cost of health insurance to members was heading towards four percent of average weekly earnings; today it has been reduced to 3 percent as a direct result of the rebate. As a result health insurance participation rates are relatively stable, and certainly much more so than before the incentive program was introduced.

While the incentives have helped achieve stability in membership, the health insurance product itself remains relatively unchanged from when Medicare was introduced almost a quarter of a century ago. In that time clinical practice has changed significantly, and much of the emphasis has changed from treatment in hospital to providing care which reduces or avoids hospitalisation. While medicine has changed with the times the regulations that apply to private health funding have been left in a time warp.

AHIA believes that health care costs can only be contained within a truly efficient health care system which avoids unnecessary errors, concentrates on those treatments that evidence confirms do work, and ensures treatment is provided in the most appropriate setting, backed by early intervention in lower cost environments.

If this is to be achieved in Australia a number of legislative and regulatory reforms are needed. The most important is to end the current rules which effectively confine health fund benefit payments for medical and medically related services to admitted in-patients of a hospital.

Removal of these limits would open the way for insurers to sponsor, encourage and fund a wide range of alternatives to hospitalisation which emphasise the provision of care in the most appropriate setting. This should result not only in lower costs but more importantly, better outcomes and a more attractive product better able to deal with the changing health needs of our society.

AHIA recommends this as the most important way of improving private health insurance in Australia. In addition propose a number of reforms intended to overcome existing deficiencies and make private health insurance even more attractive. The recommendations are as follows:

1. **Current legislative restrictions on health funds providing or paying for medical services outside the hospital setting should be removed. Health funds should be permitted to pay for medical or other health or health related services outside hospital at their discretion.**
2. The current definition of "hospital table" should be amended to allow funds to provide benefits for those services which either substituted for hospitalisation or reduced the length (and cost) of hospital stays. These could include, for example, home dialysis, hospital in the home, early discharge programs, home support. This would be of considerable importance in respect of the treatment costs of older people.

3. The new environment should be permissive rather than mandatory: i.e., insurers should be able to choose whether and which services they will fund rather than being forced to do so via government "default" benefits or other regulatory devices, as these would add to costs rather than reduce them. A permissive approach, on the other hand, would allow insurers to determine which services would be genuinely cost effective and direct their efforts to their provision.
4. Funds should be able to provide benefits for approved psychiatric same day programs, chemotherapy and other services delivered outside hospital.
5. An efficient health care system is a safe health care system. AHIA believes Parliament should support health fund initiatives aimed at using the contracting process to encourage better safety and quality assurance in the private sector.
6. The Government should take a significant step forward in showing its concern to promote quality in the private health sector by making compliance with the current 2nd tier quality criteria the minimum necessary for a private hospital to receive, or continue to receive,. a provider number.
7. The Commonwealth Department should immediately reconvene the Private Health Industry Quality and Safety Committee to develop new 2nd tier quality criteria to ensure hospitals which become entitled to higher non-contract benefits are of demonstrably higher quality than those eligible for the basic default.
8. As well as being required to meet higher quality and safety criteria, 2nd tier benefits should not be applied in respect of technology which may be available in a reasonably accessible contracted hospital.
9. To allow members to transfer between funds seamlessly (portability) the Government should adopt the necessary measures to restore the original concept of portability being a dollar entitlement to the member rather than a contract with a hospital.
10. A condition of the issue of a provider number should be that a hospital either publishes (and adheres to) a "rack rate" of charges for uninsured persons, or agrees that it will charge uninsured persons at least the average of its contracted rates
11. AHIA believes a standard product which ensured no uncertainty would be a very desirable outcome but notes that it can only be achieved if the Parliament is prepared to take action to ensure the fees and charges rendered by doctors, hospitals and other health care providers are similarly standardised.
12. A medical fee for treatment in hospital which has not been agreed in advance should not be legally enforceable.
13. More details of hospital and other provider performance, individually and comparatively should be published (as is the case with health funds via the PHIAC annual report). These would include both financial and clinical performance data
14. There needs to be far more evaluation of the actual clinical benefits of new technology, supported by the development, by expert clinicians, of appropriateness indicators which assist in determining which patients will benefit from its use.
15. Governments should ensure that purchasing arrangements for prostheses are designed to maximise competition with a view to encouraging developers of new technology to price them within the limits consumers can afford to pay
16. In addition Governments should look to greater evaluation and encouragement of those technologies which, in fact, decrease costs either by replacing more expensive and outdated treatments or reducing costs brought about by work force shortages.
17. AHIA will work with new prostheses purchasing arrangements but is concerned they may not contain costs, in which case it will seek appropriate changes.

18. The HIC should assist in encouraging greater awareness of Lifetime Health Cover by writing to all persons turning 30-31 to advise them of the existence of LHC and the impact on them should they postpone taking out PHI
19. The Australian Taxation Office should advise paymasters of the surcharge and provide them with details of appropriate PAYE deduction amounts. The system should also require paymasters to alert employees of their potential exposure to the levy prior to deducting the necessary PAYE amount. This would allow prospective surcharge payers to determine whether they wished to take out insurance or pay the surcharge before a tax obligation is incurred.
20. The Government should reduce the current disincentive FBT poses to employer subsidised health insurance to improve productivity and promote better health in the workforce. Action in this area should be seen not so much as a cost to Government but an investment in a healthier population, a more productive society, and a less expensive health insurance system than would otherwise be the case.
21. The 30 percent Private Health Insurance Rebate and the Seniors Rebate should be retained due to their significant benefits to the overall health care system.

Introduction

The Australian Health Insurance Association (AHIA) welcomes this opportunity to provide a submission to the Committee, and particularly welcomes the interest of the House in health financing and delivery questions. Given the need to provide appropriate and adequate health care to the Australian population this century AHIA believes it particularly important that Members of the House of Representatives look to the issues involved in the delivery and funding of health care in both the public and private sectors. As the industry Association representing 26 registered health benefits organisations which together cover 93 percent of the privately insured population and 95 percent of insured people aged more than 65, AHIA is anxious to promote reforms which make health insurance more attractive and our overall health system more efficient.

Private health care forms an integral part of Australia's health system, in both delivery and funding. Each year 2.3 million privately insured patients are admitted to hospital, and health funds pay more than $7.6 billion in benefits for private health treatment, including benefits for hospitalisation, medical services in hospital, prostheses, and allied health professional services. There are more than 300 private acute and psychiatric hospitals and almost 250 free standing day surgeries. In addition health funds pay several hundred million dollars in benefits for private patients in public hospitals.

The Federal Government's incentive measures, particularly the Private Health Insurance rebate, have played a significant part in restoring the attractiveness of private health insurance by making it more affordable. Before the rebate was introduced the average direct cost of health insurance to members was heading towards four percent of average weekly earnings: today it has been reduced to 3 percent as a direct result of the rebate. Health insurance participation rates are relatively stable, and certainly much more so than before the incentive program was introduced.

While the incentives have helped achieve stability in membership, the product itself remains relatively unchanged from when Medicare was introduced almost a quarter of a century ago. In that time clinical practice has changed significantly, and much of the emphasis has changed from treatment in hospital to providing more integrated care particularly that which reduces or avoids hospitalisation. While medicine has changed with the times the regulations that apply to private health funding have been left in a time warp.

AHIA is anxious to improve the attractiveness of the private health product - not just the private health *insurance* product. AHIA believes the community's preparedness to buy private health insurance is largely determined by its perception of the value of private health care. This means that all involved in the private health sector must strive to add value to private health care while ensuring it is accessible at prices people can afford to pay. The need for cost containment is as essential to the sustenance of a viable private health sector as it is to the maintenance of a viable private health insurance system.

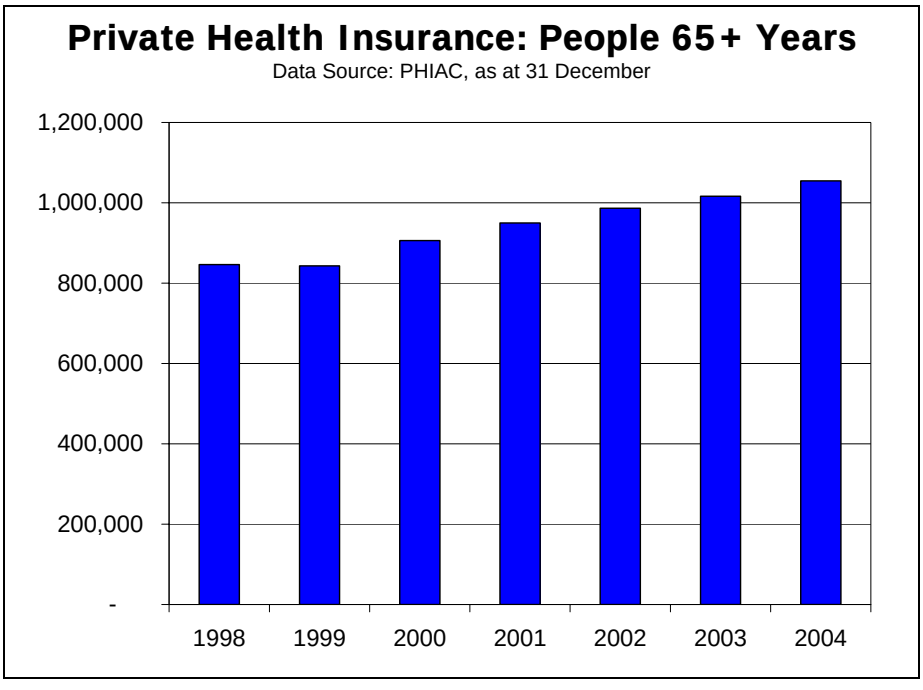
AHIA believes that health care costs can only be contained within a truly efficient and competitive health care system which avoids unnecessary errors, concentrates on those treatments that evidence confirms do work, and ensures treatment is provided in the most appropriate setting, backed by early intervention in lower cost environments.

If this is to be achieved in Australia a number of legislative and regulatory reforms are needed. The most important is to end the current rules which effectively confine health fund benefit payments for medical and medically related services to admitted in-patients of a hospital.

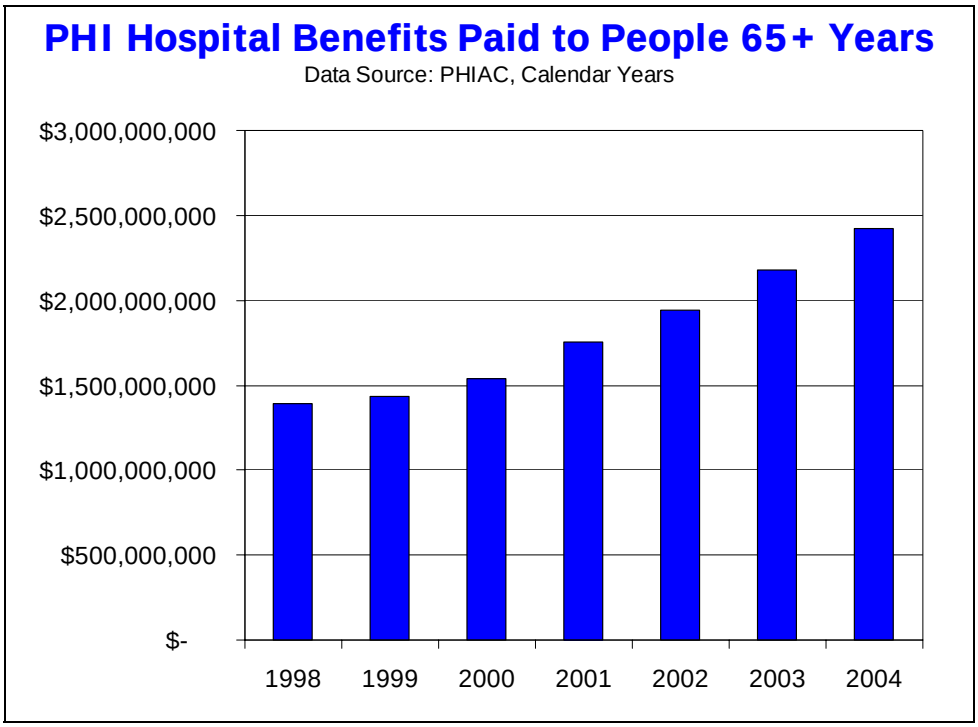
Removal of these limits would open the way for insurers to sponsor, encourage and fund a wide range of alternatives to hospitalisation which emphasise the provision of care in the most appropriate setting. This should result not only in lower costs but more importantly, better outcomes.

Private health insurance is an extremely important component of Australia's Medicare system. A strong, effective and affordable private health system relieves the financial and demand pressures on Medicare itself, ensuring that those Australians who wish to access private treatment are able to do so at prices they can afford, and are prepared, to pay. Each person who is privately insured is, by definition, one less likely to need public care. This is a very good reason for Governments to provide direct financial assistance to encourage individuals to be privately insured by recognising that their private insurance effectively reduces the financial pressure on a taxation funded health care system. The private health insurance rebate is a very effective way of assisting individuals, particularly those on lower incomes (many of whom are high users of health care services) to remain in the private rather than the public system. It therefore leverages private dollars into health care and allows the public (tax) dollar to be spread more widely.

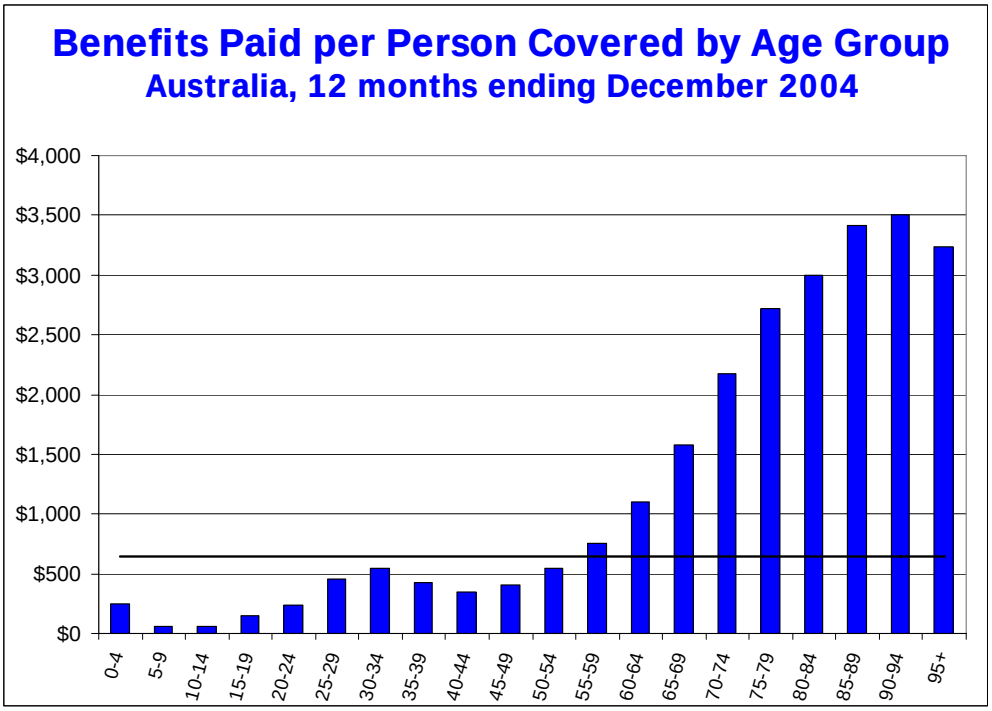
The Committee will be aware of the introduction of the Government's election promise to increase the PHI rebate for people over 65. These are mostly people on fixed incomes who face considerable difficulties retaining their private health insurance as prices rise as a result of unavoidable health care inflation. People within this age group are also the heaviest users of private health services. Although they represent only about 12 percent of the insured population they account for about 43 percent of hospital claims. However by virtue of being insured they also contribute significantly towards their own health costs. For this reason AHIA believes it is in the community's and economy's interests to encourage their retention of private cover.

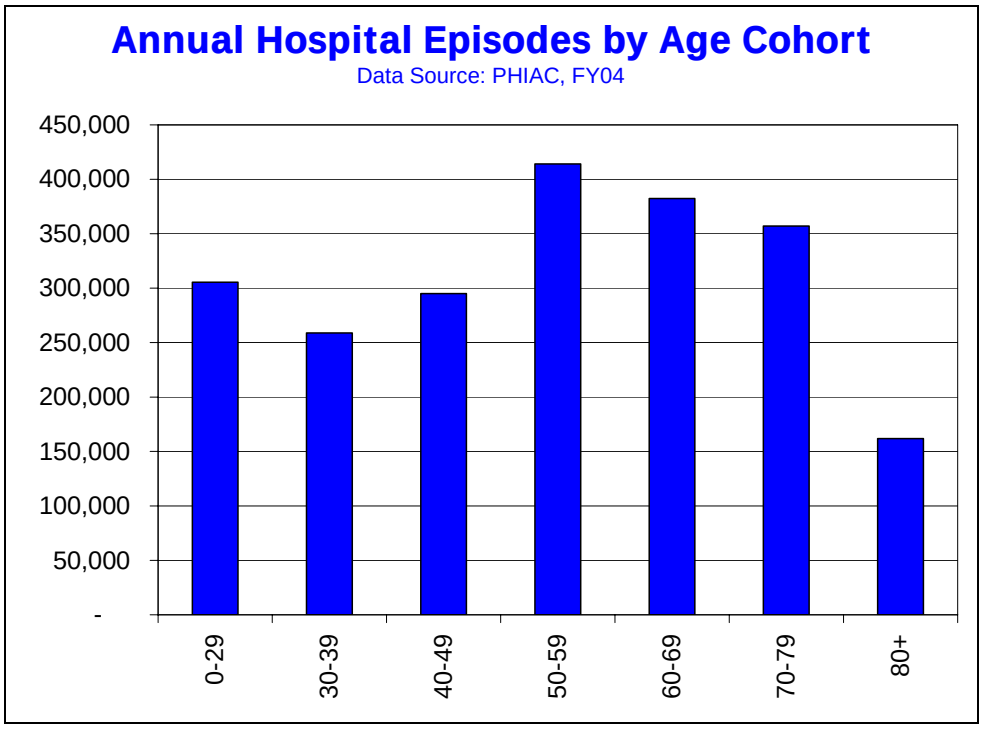


One of the most significant aspects of health insurance in Australia is community rating, which ensures all persons are entitled to the same level of cover without price discrimination based on their age, sex, state of health or potential health risk. As a result 42 percent of the over 65 population are privately insured. Because health treatments become more commonplace with age many other health systems do not provide cover for elderly persons, or charge prohibitive premiums. In Australia, by contrast, those most likely to use hospital services are able to retain private insurance. This has been further assisted by the Commonwealth's Seniors Rebate. This year health funds will pay more than $2.7 billion for hospital treatment of the over 65 population, and we estimate this will cover more than 800,000 episodes of care. For many of these people the existence of a private health insurance system is not merely an attraction, it is an essential.



At the same time AHIA is conscious of the need to minimise increases in the cost to Government of the rebate beyond those which are absolutely necessary. As people aged more than 65 (in fact, utilisation increases steeply from age 55) represent a high cost group every action possible must be taken to ensure cost containment applies in the private health system. All health funds constantly endeavour to minimise unnecessary outlays while still encouraging a safe hospital environment for their members. However these attempts are often frustrated or limited by the legislative and regulatory environment.


Benefits Paid per Person Covered by Age Group
Australia, 12 months ending December 2004
$4,000
$3,500
$3,000
$2,500
$2,000
$1,500
$1,000
$500
$0
0-4
5-9
10-14
15-19
20-24
25-29
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65-69
70-74
75-79
80-84
85-89
90-94
95+


Annual Hospital Episodes by Age Cohort
Data Source: PHIAC, FY04
450,000
400,000
350,000
300,000
250,000
200,000
150,000
100,000
50,000
-
0-29
30-39
40-49
50-59
60-69
70-79
80+

Value For Money

AHIA believes it is essential, if a large private sector is to remain a part of the Australian health care scene, that the private insurance dollar be spent in the most effective way possible, and that all involved, whether policy makers, providers, or patients, are aware of the desirability of cost containment within the health care system. We believe this can best be achieved by placing emphasis on ensuring patients receive the most appropriate care possible - the right care in the right setting by the right provider and at the right price.

While acknowledging the bona fide right and need for care providers to achieve realistic incomes, the income of providers should be secondary to the provision of the most appropriate care, based, wherever possible, on evidence. Perverse financial incentives should not encourage less than appropriate care. Treatments that evidence establishes do not achieve any real benefit consume dollars which could, and should, be otherwise used to either hold premiums down or provide more treatments which do achieve real and tangible benefits for patients. Benefits should increasingly be directed towards encouraging those treatments, and those providers, who achieve optimal outcomes rather than simply rewarding processes. To do this, however, requires some cultural change on the part of providers and consumers and, to a large extent, policy makers.

Consumer Benefit: A Better Health System

The outcome is, however, to the clear benefit of the consumer. There is already considerable evidence to suggest that a safer health system, in both public and private sectors, is not only better for consumers but also leads to lower health care costs. Far too many scarce health resources are today provided for avoidable re-admissions, avoidable infections and other forms of "iatrogenic injury." Each avoidable re admission to hospital represents a cost, not merely in social terms to the patient and their family, but a very real cost to taxpayers and health fund contributors. Our health care system, and those who pay for it, need very positive support measures to encourage and reward safety and quality. Unfortunately whenever such measures are proposed they are opposed on the basis that they may compromise the freedom of providers who hide behind the slogan "US style health care."

Cost Drivers

AHIA and its member funds are well aware of the concern Members of Parliament and their constituents have about the increasing cost of private health insurance. So too are all health fund managers. It should be recognised that health fund managers face an exquisite dilemma for they are torn between three different and quite opposing interests:

- Members who rarely claim, who have taken "insurance" literally, wishing to protect themselves from unlikely but potentially catastrophic financial consequences.
- Members of less than optimal health status who do expect (or, in fact do) claim and receive a very clear and tangible benefit from being insured.
- Care providers - doctors, hospitals, allied health professionals - all of whom rely on a large privately insured clientele to allow them to maximise their income.

Each of these groups wish to see what is a fundamental oxymoron: a health insurance system which offers low premiums and high benefits. Unfortunately this is unachievable within our current health system, or, perhaps, any health system. The cost of health insurance is primarily driven by the cost

of delivery. Increases in the cost of health insurance simply reflect increases in the cost of providing care for the insured population. It should also be noted that treatment in a hospital is generally the most expensive setting, and today health funds are effectively prevented from reimbursing medical costs incurred in less expensive environments. This is clearly inefficient from both a cost and appropriateness point of view.

It is, however, important to understand what is currently driving costs within the private sector, and to pose the question what, if any, of these drivers the Parliament wishes to curtail.

In the last 12 months, average costs rose by:

- 23 percent for treatment for prostate cancer - to about $6,100
- 9 percent for a hernia procedure - to about $2,500
- 16 percent for a heart "stent" operation – to about $14,500
- 8 percent for a total knee replacement – to about $16,400
- 8 percent for a hysterectomy – to about $4,300
- 45 percent for surgery for liver or pancreatic cancer – to about $6,200
- 16 percent for the fracture of a hip, femur of pelvis - to about $7,600

In broad terms health costs - in both the public and private sectors - are driven by a combination of factors: the age of the population, technology, utilisation of services, disease patterns, workforce costs (itself influenced by the size and shape of the workforce), capital equipment and a return on investment. In addition community expectations - fuelled by a media anxious to highlight alleged "wonder cures" on the horizon, or even here and now - create an environment where demand for services is limited only by supply, and often capable of being encouraged by supply. Information asymmetry compounds this problem.

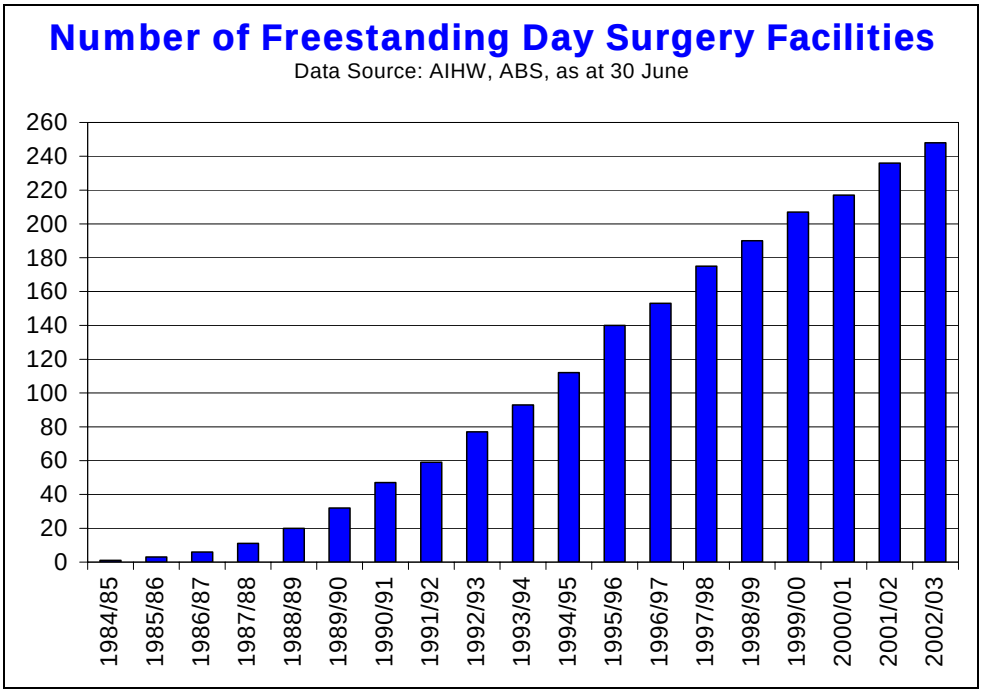
Funds can influence some costs, but not others. In some cases this inability to curb costs is caused by regulation, but in others it is simply a reflection of the fact that demand for health services throughout the world grows as fast, and sometimes faster, than supply…flowing through into prices. Funds can control, or more accurately influence (at least to some extent):

- Unit price, i.e., average accommodation and theatre benefits (but this capacity is restrained by default benefits, provider demands, and the possibility that if the hospital refuses to accept fund benefit offers contributors may face co-payments leading them to transfer to other funds).
- Average Length of Stay (by developing benefit structures such as episodic payments, step-down periods, encouraging day surgery) but have no capacity to prevent hospitals back-filling beds with new patients. (see graphs below showing utilisation of day surgery and overnight accommodation).
- Individual medical "gap" benefits by capping the amount they will pay above the MBS schedule (but this risks transferring some cost to the patient unless the doctor will accept the benefit in full payment).
- Administration costs (which have been proportionately reducing over recent years, and which are influenced in varying degrees by regulatory requirements. It should also be noted that in many cases fund initiatives aimed at supporting members to avoid hospitalisation and improve their health status have to be included as "administration").

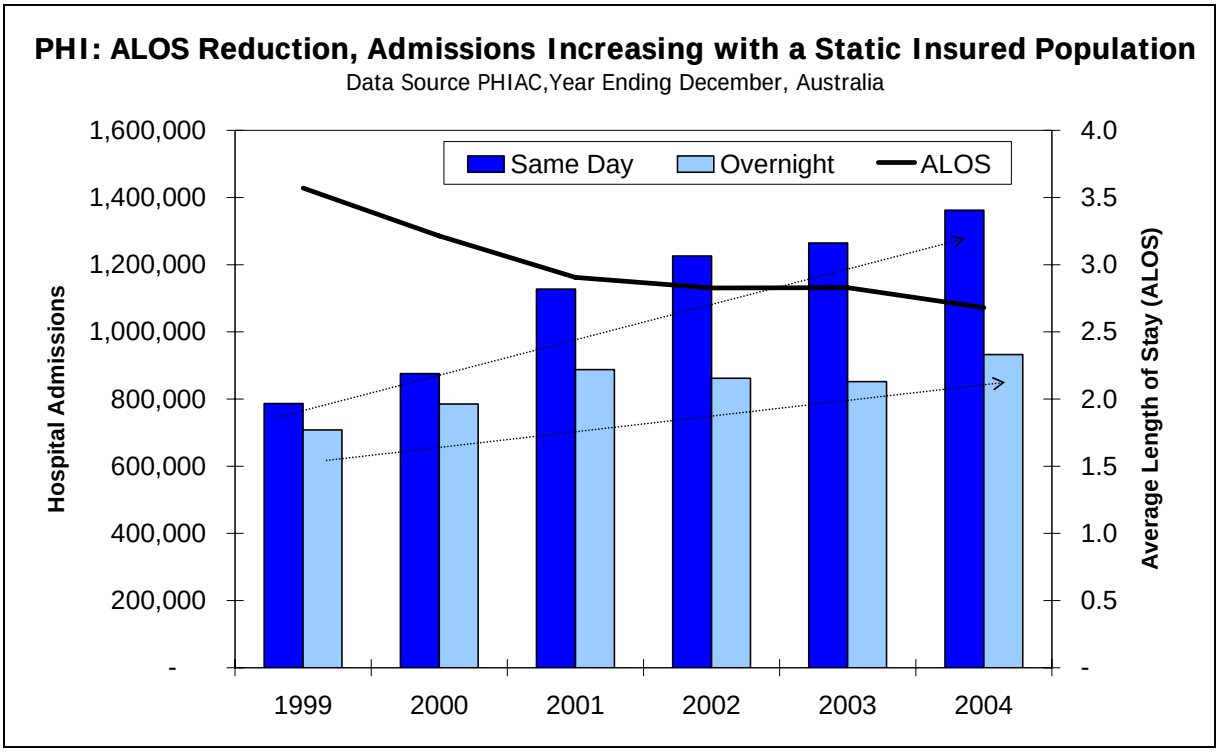
However funds cannot control (and in most cases are unable to influence)

- Utilisation: Funds are required to pay benefits for all members once they are admitted as in-patients to a (State) licensed hospital issued with a (Commonwealth) provider number
- This payment must be made even if the patient is not receiving professional attention
- Place of admission (determined by the doctor)
- Post discharge arrangements (although funds, despite regulatory barriers, are now experimenting with post discharge assistance and support)
- Appropriateness of care
- Individual length of stay
- Prostheses costs, introduction of new technology.
- Medical charges
- Uneconomic proliferation of facilities and services.

Funds have no capacity to determine the above pressures on their benefit payments, and therefore the price that has to be charged consumers. Support for prevention and other treatments which may avoid or minimise hospitalisation are severely inhibited by legislative and regulatory limitations, even though these activities could reduce overall outlays and result in better patient care. Although there has been a dramatic expansion in day surgery facilities in the last 20 years, we have not seen a corresponding reduction in overnight stays.



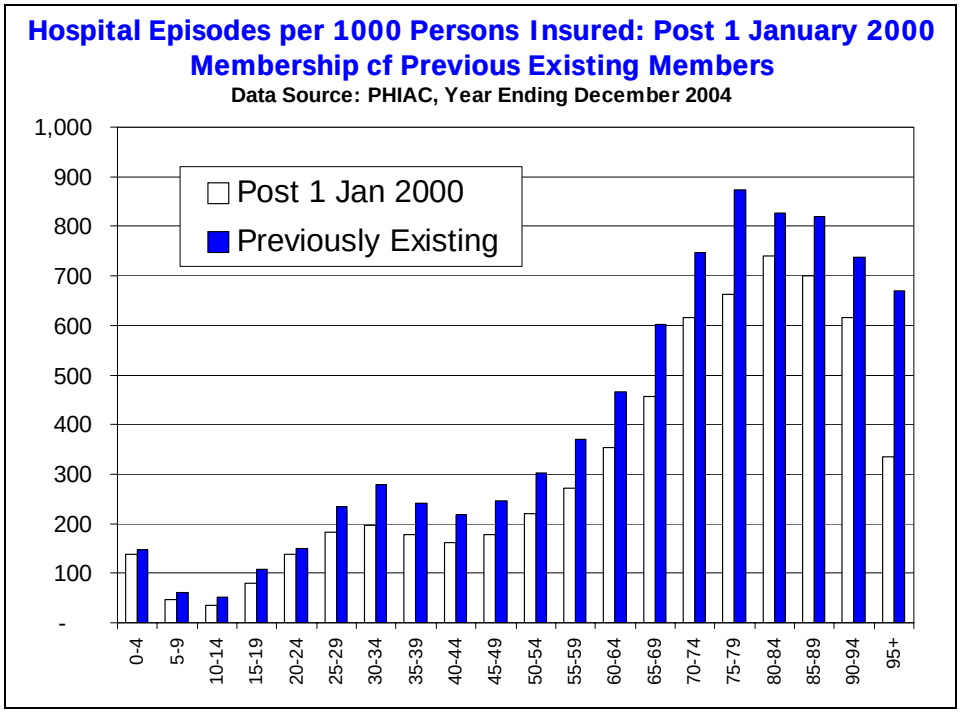
Although some procedures have moved from the overnight hospital to the same day setting (often in the same hospital) many seem to have moved from doctor's rooms to day surgeries as a result of perverse regulatory financial incentives And overnight stays have remained high.

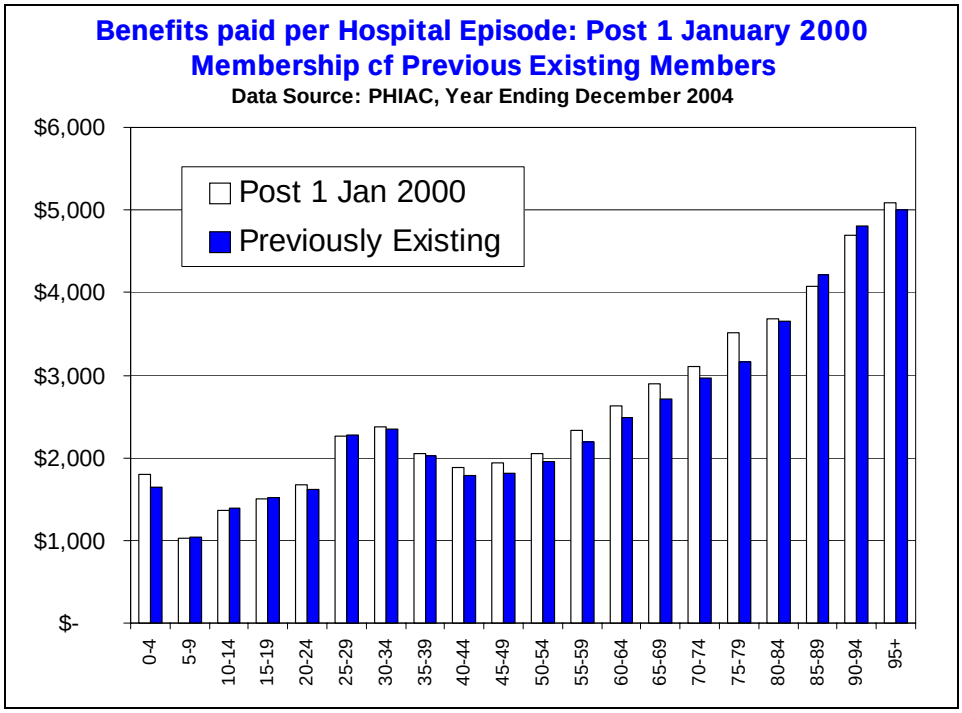


Risk profile

For many years it has been assumed that the cost of health insurance can be reduced simply by increasing the numbers of persons covered. This is only partly true. More realistically, increasing the insured population is more likely to reduce the rate of growth of premiums, provided they are spread around a better risk pool. For this reason the most important question the actual profile of the insured community, their risk status and their use of health care services…and the cost of those services. Any form of insurance tends to encounter adverse selection, as those who are most likely to be insured are invariably those who are concerned about the possible need to make a claim. For an increase in the numbers insured to reduce prices it is essential not only that those insured are of a lower risk status - and therefore use fewer services - than the currently insured population, but also to increase the numbers very, very significantly.

The combination of the 30% rebate and Lifetime Health Cover policies increased the insured population. An analysis of members that joined after the introduction of the policies compared with members that were already participating shows that the number of hospital treatments per person insured was lower for those that joined after 1 January 2000 than that of the previous membership base (see graph below) . However the second graph below shows the benefits paid per hospital treatment to be higher for those that joined after 1 January 2000 in 14 of the 19 age cohorts depicted suggesting this group underwent more complex hospital treatments. Had they not taken out insurance they would have undoubtedly added to demand on the public sector, or found themselves on waiting lists To argue that Government policies have not reduced pressure in the public hospital system is erroneous.





Given the ageing of Australia's population it is unlikely that the pool of uninsured younger, healthy persons will be of sufficient numbers to allow a dramatic reduction in the cost of insurance even if all were to be insured. Certainly any increase in the numbers of better risks is beneficial, (and AHIA suggests some ways this could be done later in this submission) but this is a palliative to the problem of increasing cost, not a cure. It should definitely not obscure the need for maximum efficiency in the delivery of health care services. Only within a truly efficient health care system which avoids unnecessary errors, concentrates on those treatments that evidence confirms do work,

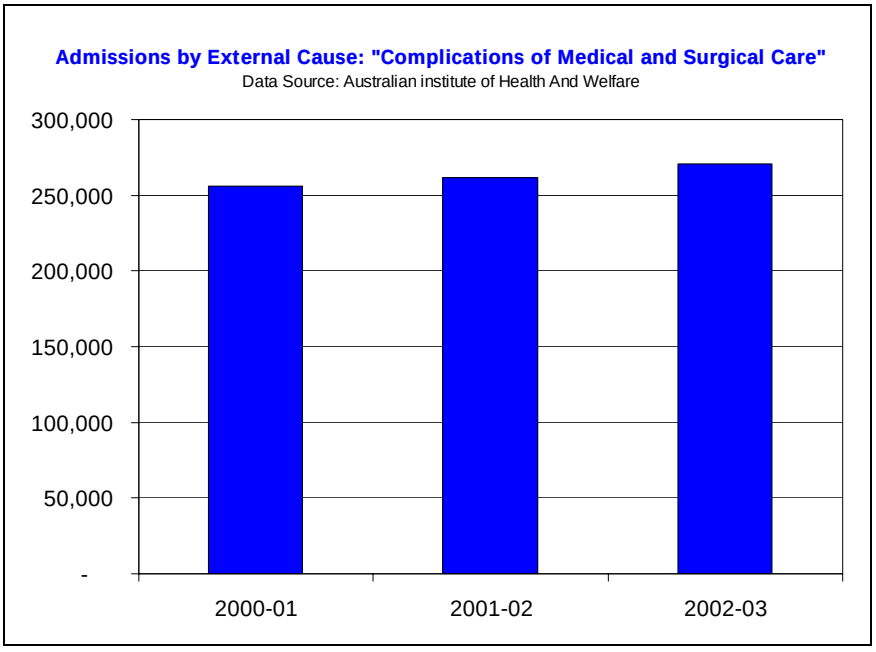
and ensures treatment is provided in the most appropriate setting, backed by early intervention in lower cost environments, can health care costs be effectively contained within boundaries that society can afford to pay in both the public and private sectors.

Quality and Safety are significant issues in the cost of health care, in both the public and the private sectors. So called “Iatrogenic Injury” not only inflicts unnecessary the pain and suffering imposed on those individual patients who are injured by health care: it also imposes very substantial costs on society in a number of ways: reduced productivity from those who may be forced out of the workforce; higher costs to society in providing services to the injured; and unnecessarily higher costs on payment systems, whether tax funded or privately insured.

For example, the Australian Quality and Safety Council (*National Strategy to Address health care Associated Infections 2003*) reported that there could be as many as 150,000 health care associated infections contributing to 7,000 deaths each year. It said that the total costs associated with bloodstream infections may have been as high as $686 million in 2001.This was money that could well have been spent on providing more treatments, or reduced the total cost of the nation’s health care budget. To put it another way, $686 million in 2001 was equivalent to 330,000 hospital episodes of care!

Infection is only one aspect of avoidable costs in our (or any) health care system. Avoidable complications, falls, inappropriate discharge arrangements and wrong diagnoses all add to the cost of health care. In the public system this may lead to bottlenecks and queueing because scarce public resources are devoted to treating illnesses caused by health care itself; in the private system health insurance premiums are higher than should be the case.

The Australian Institute of Health and Welfare (2004) reports the external cause of 270,818 hospital admissions in 2002-03 to be complications of medical and surgical care (187,845 in public hospitals and 82,973 in private hospitals). Assuming theses readmissions translated into the same average complexity of treatment as current procedures, removal of these admissions from the hospital systems would reduce total health care expenditure by around $650 million a year.



AHIA believes these questions need to be addressed, and one way is to support health fund initiatives aimed at using the contracting process to encourage better safety and quality assurance in the private sector. While no one can today adequately assess the cost of avoidable injuries, infections, and other inappropriate treatment it could well amount to 10 percent of total premium costs in the private sector, and, similarly, over 10 percent of public sector health budgets. There is, therefore a very clear and present imperative for all concerned to be pressing for a safer health system in both the public and private sectors.

This is not merely AHIA's view. A recent editorial (March 2005) in the Medical Journal of Australia (*The Safety of Australian Healthcare:10 years after QAHCS*) referred to a report it published on the Quality in Australian Health Care Study (QAHCS) which expressed concern about adverse events in Australia's hospitals. That study found up to 16 percent of hospitalised patients would suffer an adverse event, 50 percent of which were preventable and 10 percent of which would result in permanent disability or death. The editorial said:

> *"Ten years on can we confidently state that healthcare is safer for patients? Unfortunately the answer is no. There is insufficient information at a state or national level to determine whether any or all of the efforts over the past 10 years have increased safety in our hospitals. It is regrettable that we have not measured the frequency of adverse events in Australia in a way that allows us to assess how we have fared since 1995; how we compare with other countries….the absence of recent system wide data on patient safety seriously hinders our ability to manage the problem and make improvements. Its absence makes a mockery of the tenets of continuous quality improvement. We need a thorough understanding of the strengths and weaknesses of data derived from medical record audits, voluntary reporting systems, clinical indicators, and existing large data sets if we are to seriously tackle the size and nature of the problem, and determine whether a particular intervention or program has been successful in improving safety."* AHIA agrees.

Individual health funds are progressively including quality and safety requirements in their contracts, and in the interests of an improved health care system in the private sector we believe these efforts should be particularly supported by legislators. The Commonwealth can also play a role in ensuring on going quality improvement in the private sector by using its power to issue provider numbers to hospitals. Several years ago the Department convened an industry based committee - the Private Health Industry Quality and Safety Committee - to devise quality criteria as a pre-requisite for private hospitals seeking to qualify for 2nd tier benefits from those funds with which they did not have a contract. These criteria are attached (Appendix C).

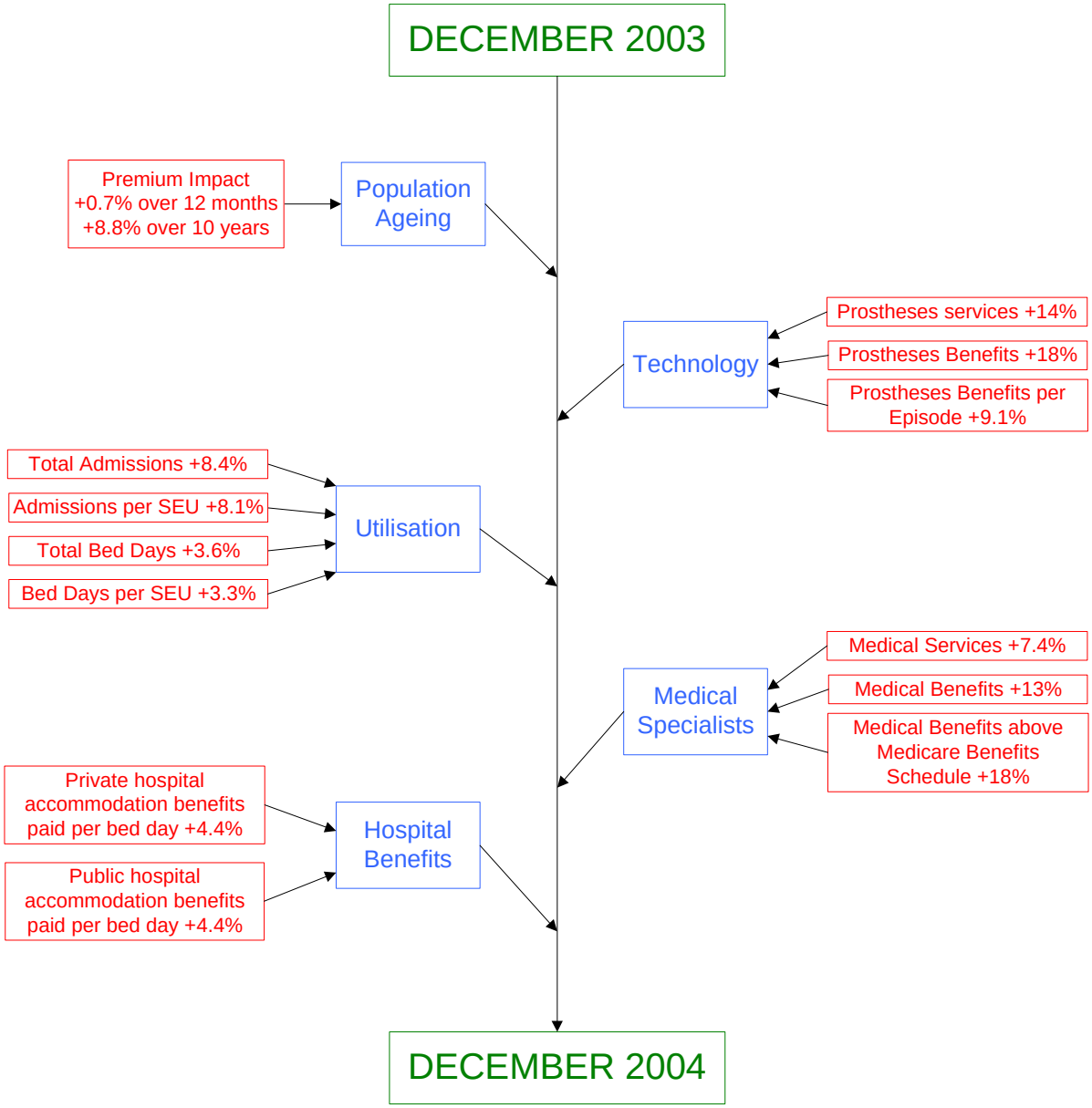
The quality criteria derived was the result of a consensus approach involving clinicians, health fund representatives and hospital operators. As a consequence the criteria were as good as could be achieved at the time. Several years later AHIA believes this criteria is no longer sufficient for a hospital to receive higher benefits than the basic default. ***AHIA therefore recommends that the Government take a significant step forward in showing its concern to promote quality in the private health sector by making compliance with the current 2nd tier quality criteria the minimum necessary for a private hospital to receive, or continue to receive, a provider number. The Commonwealth Department should immediately reconvene the PHIQSC to develop new 2nd tier quality criteria to ensure hospitals which become entitled to higher non-contract benefits are of demonstrably higher quality than those eligible for the basic default.***

Health Fund Cost Drivers

The following flowchart illustrates a variety of elements that impact health fund benefit outlays and ultimately health fund premiums met by the consumer. These cost drivers are easily identified but in most cases are unable to be addressed by industry due to the current regulatory framework.

Private Health Insurance Cost Drivers

Calendar Year 2003 c.f. Calendar Year 2004, AHIA



The combined cost drivers resulted in health funds paying an average 9.3% more in hospital benefits in the calendar year 2004 compared with 2003.

Flow Chart Components in Detail

(a) Effects of an Ageing Population on Health Insurance Premiums

In 1993, in a document titled *Health Insurance: Working with Medicare*, the Australian Health Insurance Association highlighted the importance of recognizing the ageing of the population and the associated health care funding issues that would become known. Recently much work has been done to highlight the issue, but not much to address the reality of aging.

An ageing population by itself will put upward pressure on health insurance benefit outlays and therefore premiums. The tables and graphs below are based on extensive AHIA modeling.

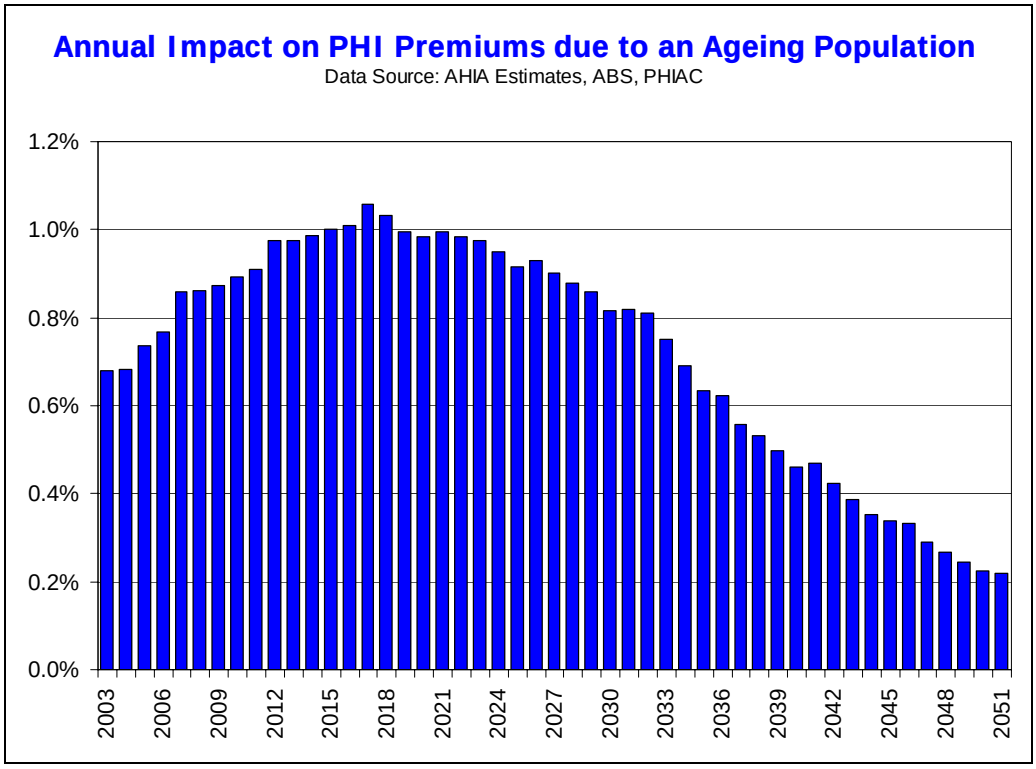
If the proportions insured by age group/sex remains constant, private health insurance benefits paid per person would, on average throughout Australia, increase by 0.7% over the next 12 month period. Over the next ten years premiums would be expected to rise in total by 8.6% purely due to an ageing population.

The table below shows the effects on premiums by State.

TABLE 1: Effects on PHI Premiums due to an Ageing population

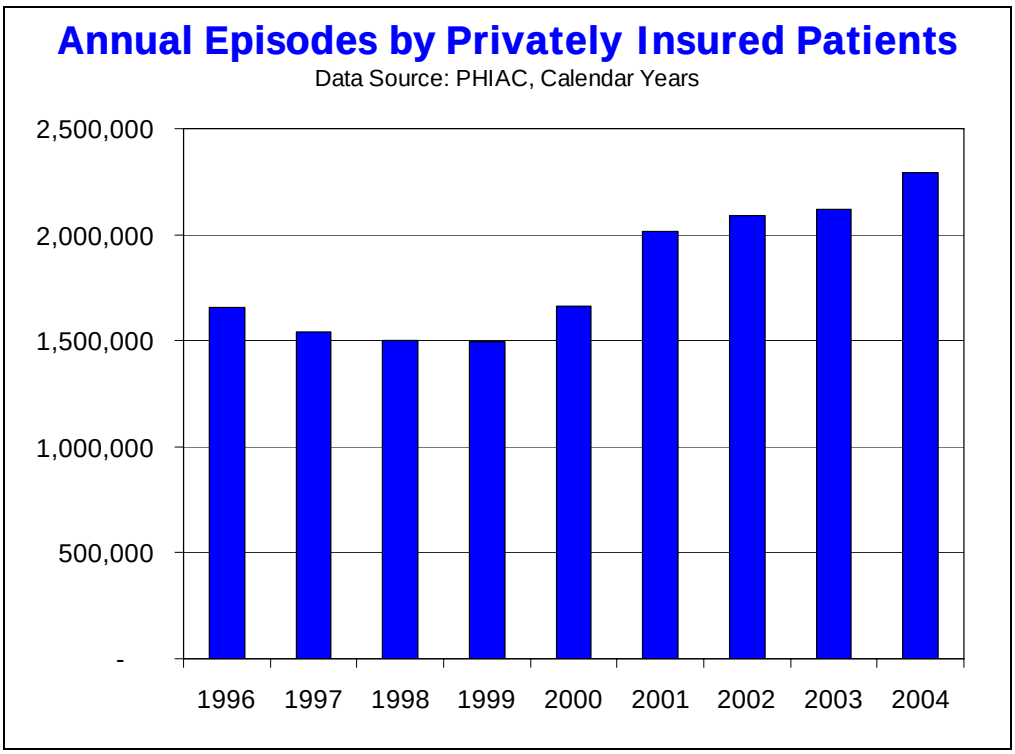
State	12 months	10 years	Annual Average (10 years)
NSW/ACT	0.7%	8.2%	0.8%
VIC	0.8%	9.6%	1.0%
QLD	0.5%	7.4%	0.7%
SA	0.8%	10.2%	1.0%
WA	0.7%	8.5%	0.9%
TAS	0.9%	10.6%	1.1%
NT	0.8%	8.8%	0.9%
AUST	0.7%	8.6%	0.9%

As the following graph shows the effect of ageing itself will put continual upward pressure on drawing rates until about 15 years from now when the upward pressure will turn around. There will still be an impact on premiums after this time - a smaller upward impact.



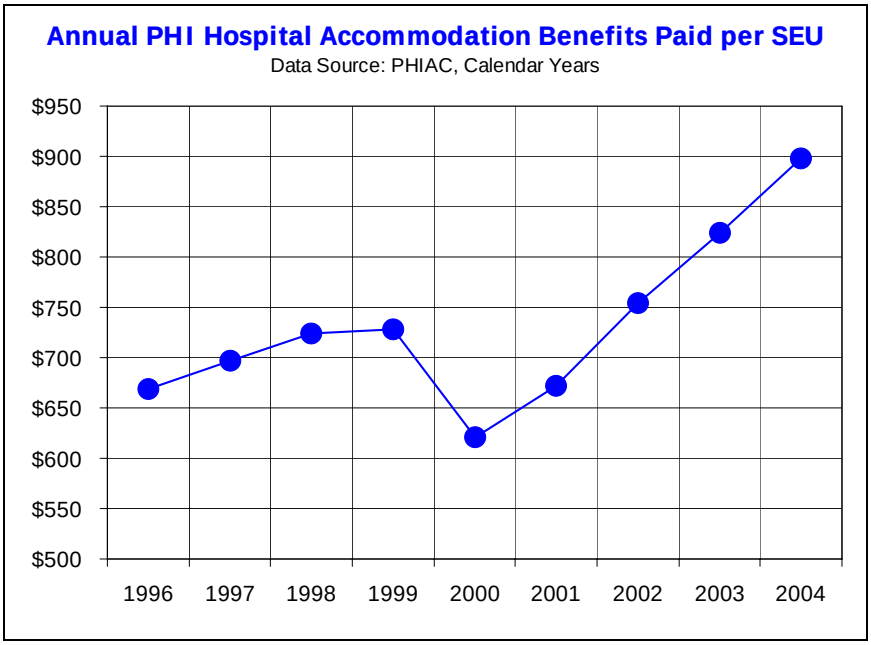
(b) Utilisation

The number of privately insured episodes has increased dramatically over the past 12 months. From year ending December 2003 to year ending December 2004 hospital admissions have increased by 8.4% even though the number of people with privately health insurance remained relatively static. In the calendar years 2002 and 2003 annual episodes remained reasonably flat at around 2.1 million episodes. For the calendar year 2004 the number of episodes increased by 177,000 to 2.3 million.



(c) Hospital Accommodation Benefits

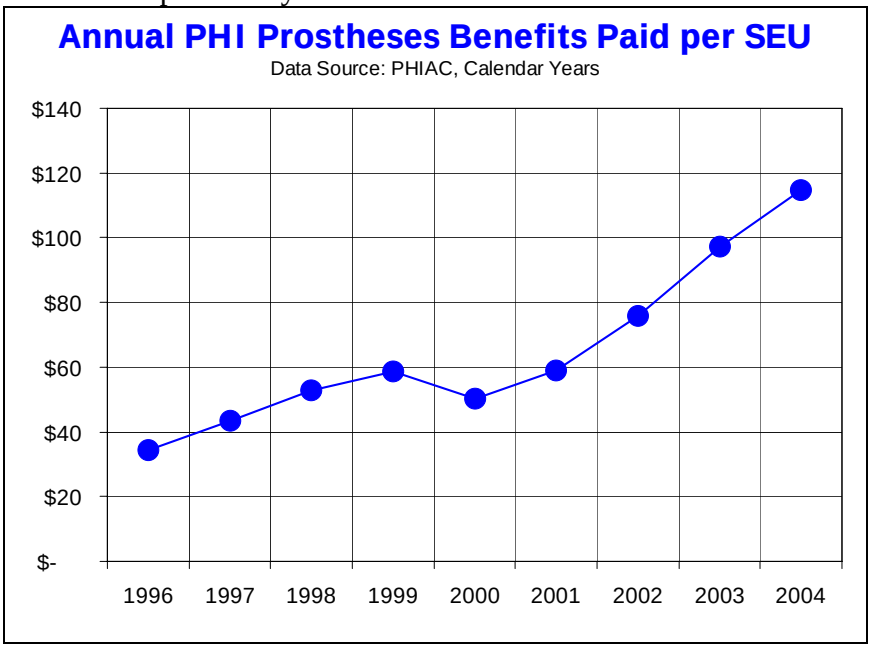
Private hospital accommodation benefits paid per SEU have increased by 6% in the last year and by 17% over the past 4 years. The actual benefits paid per bed day have increased by 4% over the past year, and 25% over the past four years.



As well as an increase in utilization there has also been an increase in the cost of providing the accommodation costs for the new procedures. This creates a multiplier effect on the cost of providing treatments for people with private insurance - more patients multiplied by higher benefits equals higher total costs than the percentage increase in unit benefits.

(d) Technology

Technology drives utilisation and expenditure in both the public and private sector.
The cost of prosthetic devices funded by the private insurance sector has increased by 18% in the last year and 110% over the past four years.

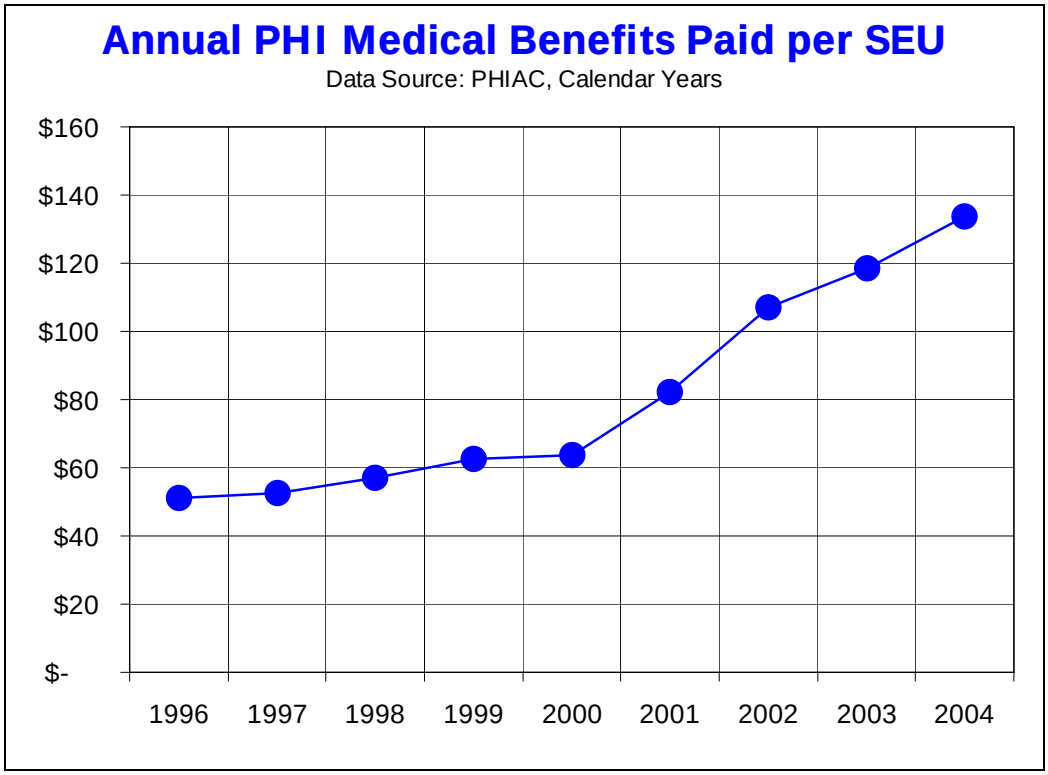


(e) Addressing Medical Gaps

Research shows that people with private health insurance would prefer not to pay medical gaps for in hospital procedures, especially without informed consent. The private health insurance industry has gone a long way to addressing this issue by providing medical gap payments above the schedule. In the December quarter 2004, 3,665,370 in-hospital medical services (representing 80.9% of all medical services) were provided to patients with no out-of-pocket costs.

To continue to provide benefits for these services, and ensure a high proportion of services are funded at no "out of pocket" cost to the consumer, health insurance organizations must review benefits paid to medical providers each year. Funds have no control over the charges made by doctors.

The graph below shows the increases in medical benefits paid per SEU and illustrates the ever increasing cost pressures on health funds which ultimately are passed onto the consumer via premiums. Between 2003 and 2004 the medical "gap" benefits paid per SEU has increased by 13%., and by 92% over the last four years.



The Hospital Arms Race

Another component of technology driving costs is demonstrated in the "hospital arms race". Rather than medical technology being provided consistently and fairly across the population, there would appear to be competition between hospital providers to buy and install the latest technology to attract medical providers, on the basis doctors supply patients and therefore income from health funds. In its 1999 report on private hospitals in Australia, the Productivity Commission reported:

> *"Private hospitals told the Commission that doctors are continuously seeking new equipment so they can undertake more advanced surgical procedures. Even if investment in such equipment is not justified on normal commercial grounds, hospital management must take into account the risk of losing the business of its doctors if it does not agree to their requests….a number of hospitals pointed to downsides of this form of competition between hospitals for doctors, noting the potential for wasteful duplication of equipment, particularly in the major cities."*

The problem with this situation is that it drives up costs unnecessarily, initially for hospital operators but ultimately through higher insurance premiums, to the consumer. In addition proliferation of high cost equipment can often lead to it being under-utilised, creating further inefficiencies but also raising questions about safety.

The "hospital arms race" is facilitated by an attitude that health funds are obliged to pay for each and every piece of equipment purchased by any hospital and used by any doctor the hospital is prepared to allow use it. The existence of even a basic default benefit which underwrites to some extent equipment duplication is not good for the system and fuels private health care inflation. The provision of a higher "second tier" benefit lends even more fuel. As well as being required to meet higher quality and safety criteria, ***2nd tier benefits should not be applied in respect of technology which may be available in a reasonably accessible contracted hospital.***

Regulatory Costs

The cost of health insurance is also influenced by a regulatory environment which seems aimed at providing all licensed providers with a guaranteed income equal to their expectations. Regulations and legislation require health funds to pay a minimum 25 percent of the MBS for all medical services provided to insured patients in hospital (and it should be noted insurers have no involvement in setting the MBS fees). In addition Funds are required to provide cover above the Schedule to avoid patients facing out of pocket expenses. All hospitals licensed by a State Government receive a Commonwealth Government Provider Number entitling them to a mandatory minimum benefit for each day an insured patient occupies a bed, regardless of whether the patient is in fact receiving professional attention.

Health funds are prevented from providing cover for medical services outside hospital, even if these services can be quite safely and effectively provided in other settings. Thus, to the extent financial incentives influence behaviour, there are very strong financial incentives on both doctors and patients to admit rather than treat outside the hospital environment. If the patient is not admitted the only third party reimbursement is a Medicare benefit of 85 percent of the MBS fee. If the patient is admitted, Medicare pays 75 percent of the Schedule and the health fund pays 25 percent plus an additional "gap" benefit which averages 26 percent above the schedule. In addition the Fund must pay an absolute minimum default benefit of $160 for admission to a day surgery. If one of the treating doctors has a financial interest in the day surgery there are even more potential perverse financial incentives imposed by regulation.

To make matters worse doctors (and hospital operators) are aware of the different "gap" payments and other benefits offered by different health funds. If the doctor wishes they can encourage a patient to transfer from a fund which pays a lower gap benefit to one which pays a higher gap benefit, virtually on the day of the procedure!

Portability entitlements were never intended to allow providers of care to arbitrage.

Portability

In 1988 the Parliament passed legislation, at the request of AHIA, to provide for portability of benefit entitlement to allow contributors to transfer between funds without the imposition of new waiting periods. This was intended to ensure that contributors with chronic conditions or pre existing ailments were not "locked in" to a particular fund but were as free as healthier members to transfer without renewed waiting periods. However up-grading of coverage was not permitted to occur, either within a fund or between funds, without serving a waiting period for higher levels of cover. This was intended to ensure that contributors could not take out low cost cover until about to receive treatment and then upgrade strategically. It was a measure aimed at protecting long term members of the particular higher cost product from "hit and run" activity.

At the time this was introduced contributors had a specific dollar entitlement depending on the product on which they were enrolled, and this specific entitlement was the maximum that could be paid for the first 12 months after transfer between funds. For example, if Fund A paid $300 per day for treatment in a particular hospital and Fund B paid $350 per day, a person transferring to Fund B would only be entitled to a benefit of $300 per day for their first 12 months membership with Fund B. Conversely if a member paid from Fund B to Fund A they would only receive the new Fund's (lower) benefit of $300 per day.

This arrangement was relatively easy to understand and transparent, for the benefit amounts were spelt out in brochure and other material relating to the product.

In 1995, however, the Parliament legislated to encourage hospitals and funds to enter into negotiated contracts with the aim of eliminating out of pocket expenses (other than those for which the patient had opted via excesses, co payments etc when choosing their level of cover). Contract amounts varied extensively and were based on a range of items including facilities, quality measures, provision of services etc. This, plus commercial confidentiality, blurred the visibility of the actual amount a fund paid to any particular hospital. In addition funds did not always have contracts with the same hospitals. However, for administrative convenience, funds usually accepted a transferee who had served out waiting periods with another fund without extensive checks to establish whether the former fund had the same contractual relationships.

Until recently portability of benefit entitlement was not an issue. However in 2003-04 the hospital group *Healthscope* entered into a contract dispute with a major health fund in South Australia based on the level of benefits *Healthscope* demanded for several hospitals in that State. During the dispute *Healthscope* encouraged members of the health fund to transfer to other funds although, in fact, the health fund in dispute had made extensive arrangements to ensure pre-booked and other classes of patients remained covered. The application of portability rules required the receiving health funds to accept very significant and unexpected increases in their own benefit liabilities. Subsequently, the Managing Director of *Healthscope* claimed portability had been an essential ingredient in his group's strategy to force the original health fund to pay higher benefits.

The current situation is both unstable and inflationary. It means that providers of care, whether hospitals, doctors or others, can organise for patients to transfer from one fund to another at the point of treatment based on the benefit arrangements the provider has with various funds: i.e., encouraging transfers based on which fund pays the provider the most for their services (without consideration of other services the fund may provide). This constructive upgrading of cover by providers was never intended to be part of portability arrangements, and creates unfair imposts on longer serving members of a receiving fund. It should be remembered that in many cases smaller funds may, for a variety of reasons, pay higher benefits to some providers than larger funds. This would make them an attractive target for such selective upgrading by providers, but if it occurred on a large scale could result in the fund's prudential situation being threatened. In the case referred to above, AHIA understands the transfers which were so encouraged led to increases in liabilities of the receiving funds of more than $10 million in a very short period (even though the original fund had guaranteed payment for pre-booked patients). This shift is totally unfair to the longer term members of the receiving funds, whose own contributions have to be used to cover an influx of patients and is not much different from the "hit and run" situation. The sudden increase in liabilities could have bankrupted a small health fund.

AHIA has endeavoured to resolve this situation in an amicable way with the Australian Private Hospitals Association (APHA) and the Catholic health sector. At this stage we have reached agreement on various conditions that should apply in respect of a cessation of contract to ensure that pre-booked patients, those in courses of treatment and emergency situations are not disadvantaged. In general these arrangements provide for a run-on of fund benefits and acceptance of these benefits in full by the hospital. As a result such patients would not be out-of-pocket as a result of a cessation. The Private Health Insurance Ombudsman has been advised of these arrangements and has adopted them as his own protocols to be applied in a dispute.

Unfortunately, the hospitals have been less willing to agree to any arrangement which would prevent them encouraging transfers of members to maximise the benefits paid to them. As a result the AHIA Executive has now agreed that the best solution to this situation is ***to allow/or require health funds and hospitals to come to agreements about the charges and benefits to be paid in respect of members in the first 12 months after transfer from one fund to another. In effect hospitals would be required to apply agreed charges (corresponding to benefits) for such members for that period which may differ from those applying to longer standing members.***

This arrangement is intended to ensure that contributors' rights of transfer are not impeded, that any members who do transfer will be fully covered (other than product specific copayments, excesses etc), but discourage deliberate encouragement of transfers at point of treatment.

Although it would involve (presumably) a lesser charge/benefit to be paid to hospitals. In practical terms this arrangement is unlikely to have much impact on hospitals - unless they specifically plan to encourage large scale selective transfers as a negotiating tactic. The fact is very few members transfer between health funds each year, and even fewer who are undergoing or expect to undergo treatment. The number of patients who individual hospitals would admit under these arrangements would be very small.

Hospitals will argue this represents a "different benefit entitlement" for patients. However, different benefit entitlements already apply between and for patients. Contract benefits provided by health funds vary, sometimes significantly, between hospitals and within a hospital. Different payments are made for patients undergoing different treatments. Unless we return to the days of a specific

published dollar figure per bed day, the principle of differential payments is already embedded in the system.

This arrangement does, however, take the problem of hospital-fund disputes back into the commercial area - where it should always have been, while ensuring a member's right to transfer from one fund to another without penalty is seamless. Patients could no longer become the pawns used to politicise a contract dispute.

If this proposal is unacceptable ***AHIA suggests that the Government adopt the necessary measures to restore the original concept of portability being a dollar entitlement. Under this proposal, provided a fund gives adequate notice of cessation of a contract, a transferring member's entitlements should be the dollar amount which their former Fund provided to a particular hospital on the day of transfer. Thus if a member transferred after a contract ceased the member would only be entitled to the former fund's own default benefit arrangements for the first 12 months with a new fund. Members who transfer before a contract expires would, for the first 12 months of membership, only be entitled to the former contracted benefits provided by the original fund up to cessation of the contract. To overcome commercial confidentiality an external party - the Department or Ombudsman - could ascertain benefits which would have applied based on MBS item or some other objective measure.***

Hospitals would be required to accept these benefits in full payment (other than co payments required in the policy) as a condition of receiving a provider number. This would ensure the member was not financially disadvantaged by transfers. Given that very few members transfer between funds in normal circumstances, and even fewer do so when planning hospitalization, this would have virtually no impact on hospital incomes. It would, however, discourage hospitals from attempting to use portability to arbitrage. It would also protect contributors from a sudden increase in their fund's liabilities (and premiums) due to a sudden influx of transferring members.

Providers Use Insurance to Subsidise Uninsured Patients

AHIA analysed the 30 most commonly performed Diagnostic Related Groups (DRG's) performed in private hospitals. These 30 DRG's represent 42% of all procedures performed in private hospitals in 2002-03. The analysis shows in 22 of the top 30 classifications private health insurers are charged more for the same procedure than a self insured patient. The relativity between the numbers of procedures performed by the insured/self insured is high – 16% of all procedures are for self insured patients. This indicates the cost structures should be similar between the two groups of patients. Where there is a higher cost for insured patients compared to those self insured the variation is as high as 16%. If the insurers' costs were the same as the self insured patient in the 22 procedures shown to be more expensive, the industry would save approximately $60 million in these 30 DRG's alone.

Examples of variation in cost

Diagnostic Related Procedure	**Insured**	**Self Insured**
Same day colonoscopy	$505	$425
Major Lens procedure (Cataract)	$1,684	$1,460
Hernia procedure	$2,015	$1,818
Follow up after treatment (endoscopy)	$496	$445

AHIA believes it is inappropriate that privately insured persons should be used by providers to subsidise their costs of treating the uninsured (or seek to take profits based on insurance status). While appreciating the need for competition, AHIA points out that any unnecessary inflation of private hospital charges flows through to contributors AND taxpayers as a result of the Federal Government's rebates, and therefore Government has a right and a responsibility to avoid this occurring. ***A condition of the issue of a provider number should be that a hospital either publishes (and adheres to) a "rack rate" of charges for uninsured persons, or agrees that it will charge uninsured persons at least the average of its contracted rates.***

Public Hospitals and Insured Patients

AHIA has for many years been concerned at the tendency of some public hospitals to "pursue a more aggressive policy of securing private patient revenue" (Citigroup Smith Barney analysis of the Australian Healthcare Sector, April 4 2005) and that "despite the sustained level of pressure placed on public hospitals, the recent increase in private health insurance has prompted both the NSW and Victorian Governments to set ambitious private patient revenue targets into hospital budgets."

AHIA has no objection to health funds paying benefits for privately insured patients who make an informed election to be treated as a private patient in a public hospital. This inherently means the patient chooses the doctor who will treat them prior to admission. Attempts to use emotional blackmail, such as claims the hospital will get more money if the person declares their insurance, ignore the fact that the patient is not getting what their insurance is supposed to be paying for! This practice is direct cost shifting from the States to privately insured persons and the Commonwealth because the funds and the Commonwealth are then forced to pay Medicare benefits for medical services which would otherwise be funded by the State. Privately insured patients have already paid income taxes, GST, and State taxes and charges, and have earned their right to a public hospital bed as a Medicare patient. These practices represent a breach of the spirit, if not the letter, of the Medicare Agreements. ***The Commonwealth should claw back any increase in revenue State Governments make by raising inappropriate charges on privately insured patients who do not receive bona fide private status.***

Broaden Coverage

At the moment health fund benefits are effectively limited to the coverage of medical treatment in hospital. Hospital treatment, especially when it involves high technology, is the most expensive part of the health care system. An efficient health care system, private or public, should always aim to encourage treatment at the lowest cost, clinically appropriate environment. This is not currently possible. Indeed, the current regulations create a number of perverse incentives which actually add to costs.

The legislative ban on health funds providing cover for medical treatment other than for admitted hospital in-patients means that there are very strong financial incentives on both patients and doctors to opt for treatment in hospital rather than lower cost settings such as the doctor's own rooms or in the home. It also means health funds cannot provide any financial or similar incentives for doctors outside hospital - GP's or specialists - to provide or oversee prevention programs, early discharge arrangements or other services which would both reduce costs and allow more appropriate care. In many cases this adds to Medicare expenditures, public hospital casualty costs,

and health insurance costs. (Medicare medical benefits and public hospital casualty can both be affected by unstable or poorly managed patients seeking additional treatments by either GP's or Casualty, in or after hours, while health funds have to pay for avoidable admissions)

Although health funds are unable to pay for medical treatment outside hospital they are able to pay for a variety of allied health services. A health fund can, for example, pay for an acupuncturist to treat a patient but cannot pay a GP for providing acupuncture! An even more absurd (and disturbing) example is the fact that a health fund can pay for a podiatrist to cut a diabetic patients toenails to minimise the chance of infection, but it cannot reward a GP for referring the patient to a podiatrist; and if the patient's toes become so infected that an amputation is necessary the Fund must pay when the patient is admitted to hospital for the amputation. This is neither good economics nor good health care.

AHIA believes many of these difficulties, and the costs associated with them, could be avoided if the Government were to remove the current legislative restrictions on health funds providing or paying for medical services outside the hospital setting. The new environment should be permissive rather than mandatory*:* i.e., insurers should be able to choose whether and which services they will fund rather than being forced to do so via government "default" benefits or other regulatory devices, as these would add to costs rather than reduce them. A permissive approach, on the other hand, would allow insurers to determine which services would be genuinely cost effective and direct their efforts to their provision.

This would be further enhanced by changing the current definition of "hospital table" to allow funds to provide benefits for those services which either substituted for hospitalisation or reduced the length (and cost) of hospital stays. These could include, for example, home dialysis, hospital in the home, early discharge programs, home support. Although funds can currently provide these services from ancillary tables they are not eligible for reinsurance as they are not "hospital table" benefits. Given the management costs involved, plus the cost of the services themselves, the net cost to a fund of providing alternatives to hospitalisation may in fact be greater than having the patient remain in hospital!

This would be of considerable importance in respect of the treatment costs of older people. In many cases frail elderly persons are retained in hospital longer than medically necessary for social reasons - i.e., they may be medically fit but not able to provide adequately for themselves after discharge without assistance. Some of the programs that would be encouraged would overcome this problem, creating further economies for both funds and the rebate.

Psychiatric

At the moment many psychiatric patients participate in same day programs, which AHIA supports. However, because of the restrictions of the legislation, Funds can only provide benefits for these programs if the patient is an "admitted in-patient", which in effect means their treatment can only be provided within the confines of a high cost institution. There is no inherent reason why these programs could not be provided in lower cost settings with equal outcomes. This would result in at least equally effective care, but lower costs to the patients and overall health insurance contributors. ***Funds should be able to provide benefits for approved psychiatric same day programs delivered outside hospital.***

Chemotherapy

Another area in which admission to an acute hospital facility are not clinically essential but effectively mandated by legislation would include chemotherapy.

Fund Innovations

Despite the various regulatory, institutional and other barriers, individual health funds have introduced or supported a number of innovations aimed at improving patient care and reducing costs. Because of regulatory inhibition, these moves have required considerable courage on the part of fund management, and their extension has been slow and limited. It is unlikely to be accelerated while existing barriers to Funds extending their benefit coverage "beyond the hospital gate".

These include:

(i) Enhanced Care programs
These target anyone who has been admitted to hospital twice in the last 6 months and provide intensive counselling, advocacy and care coordination support services which includes service substitution. The programs are very popular with terminally ill/palliative care patients and those with complex co-morbidities.

(ii) Pregnancy Support
A structured support and information line for pregnant women.

(iii) Member Support Programs
This program allows members who wish to do so to leave hospital early and recover in their own home or, if more appropriate, in an assisted care facility. The patient's medical practitioner must be agreeable to the discharge from hospital and is involved in stipulating the medical, nursing and other support services necessary to care for the member at home. These services not only find favour with patients, but can also help release urgently needed beds in busy public hospitals, and greatly reduce risk of infection.
Current legislation only allows recognised "Hospital in the Home" programs run by hospitals to be included for reinsurance purposes. Such Member Support Programs are therefore fully funded by health funds outside of the reinsurance pool and can therefore be more costly than leaving the patient in hospital..(see section on Reinsurance).

(iv) Health Risk Appraisals
These programs generally invite members to self assess their risk exposure via questionnaire. Those assessed as being at high risk (which may involve a number of factors such as weight, age, smoking, etc) are provided with a telephonic health coaching program which sets firm goals around modifiable behaviours and how the person is currently managing the disease, backed up by information and help lines..

(v) AUSeMED Program
This program is run by emergency physicians and consists of a care maintenance program over a 12 month period for persons with a history of hospital admissions due to one or more of the following chronic illnesses; Diabetes, cardiac failure, C.O.A.D.S. and Osteoporosis. Members with a history of these conditions are invited to participate in the program in liaison with their GP or specialist free of any charges as all services under the program are funded by funds involved. Services include a full patient assessment and report, confidential electronic medical record available to all

medical providers, free Accident and Emergency service, 24 hour medical advice service and a 12 month care plan.

(vi) Healthtrac Program.
Healthtrac is a voluntary program where members complete a series of questionnaires and receive feedback on lifestyle, eating and exercise changes that will assist them in achieving and maintaining better health. The program caters for all ages and risks.

(vii) General assistance to members at risk.
A number of health funds have for many years paid additional ancillary benefits and allowed ex gratia payments to individual members who are at risk of developing or already have chronic and life threatening conditions/illnesses. These include but are not restricted to diabetics, asthmatics, post cardiac/stroke patients, psychiatric patients including depression and patients requesting palliative care at home.

Many Funds believe these payments could and would be increased greatly if part or all fees charged by ancillary and para-medical providers could be claimed under reinsurance arrangements, where the patient/member had been assessed as an ongoing risk of being hospitalised and the patient's illness/condition fell within agreed eligibility criteria. An example of these providers would include diabetes educators, podiatrists, general and specialist nurses, lactation consultants and psychologists.

Legislative change to allow funds at their own discretion, and in circumstances determined by the fund, to provide medical gap benefits above the MBS for outpatient services provided to these at risk members would remove the financial disincentive to attend regular check ups and additional consultations at times of acute need. Importantly such payments should be determined by the fund, and not mandated. If they were to be mandated it would risk an increase in services and add to rather than lower costs.

(viii) International Diabetes Institute "On Track" Program
A disease management pilot program commenced in August 2004 with the aim of improving members' compliance with diabetes management guidelines and to motivate them to take a more active role in their care. Members who made a claim for the purchase of a blood glucose monitor in the last 5 years were mailed a patient centred record/diabetes passport. The passport provides diabetes management guidelines and space for recording key pathology test results and annual screening attendances. It may be used as a tool to help members monitor their diabetes and as a reference when visiting their doctor.

Interested members were invited to participate in a 12 month monitoring program by submitting key health results on 3 occasions during the 12 months and then receiving individualised written feedback and self-management information from a diabetes nurse educator.

The first baseline results received indicate that many participants have risks that are contributing to poor management of their diabetes and that there are opportunities to improve compliance with their diabetes management including visiting their doctor more regularly to have foot and eye checks done and screening tests completed.

AHIA believes these and similar initiatives, if adopted on a wider scale by most if not all funds, would provide overall benefits to the privately insured population both in terms of improved health

and reduced hospitalisation, and slower growth in premium costs. It would also reduce the number of emergency or avoidable admissions to public hospitals, and therefore further relieve strain on that sector. However this is unlikely to occur given current impediments to Funds providing such care, the greatest of which is the requirement that the hospital table be limited to payment for "admitted in patients" and the Reinsurance system. For this reason ***AHIA stresses the need to widen the benefits that can be paid from the hospital table and allow the inclusion of appropriate programs in reinsurance.***

A Standard Product

Recently it has been suggested that it would be helpful if insurers offered a "standard" product, with standard benefits, ensuring consumers who have to go to hospital have no surprises, and the product varying only in premium price.

This concept has superficial appeal and AHIA and its members support the concept. AHIA strongly believes that members want their health insurance to provide them with security and ensure that unexpected financial problems do not confront them should they need hospitalisation. We do, however, note that all funds currently offer a product – "top cover" by whatever name, which offers coverage of medical gaps and attempts to cover all hospital costs. Unfortunately this product tends to be more highly priced than many consumers are able, or willing, to pay. More significantly, even with such a product, contributors can still find themselves facing unexpected "gaps" should their doctor, or uncontracted hospital, choose to impose charges above the fund benefits.

It would not be difficult for Government to require funds to offer identical coverage, but this would not solve the problem of uncertainty, unless providers - hospitals, doctors, diagnostic services and technology suppliers - were all prepared to tie their fees to the "standard" benefit. If funds were required to cover whatever a doctor (or hospital) charged the system would face an immediate cost explosion. In the absence of any controls, regulatory or voluntary, on doctor's charges the provision of a "standard benefit" cannot provide a guarantee against unexpected expenses.

AHIA believes a standard product which ensured no uncertainty would be a very desirable outcome but notes that it can only be achieved if the Parliament is prepared to take action to ensure the fees and charges rendered by doctors, hospitals and other health care providers are similarly standardised.

Informed financial consent

In the absence of any controls on fees, AHIA strongly supports the concept of informed financial consent, or prior agreement on fees. While "no gaps" remain a preferred objective, "no surprise gaps" would enhance private health care. Unfortunately, although many in the medical profession do advise patients in advance of their fees and any out of pockets, this is by no means universal. In addition few surgeons advise patients of the charges made by other doctors involved in an operation or course of treatment, such as an assistant surgeon or anaesthetist, diagnostic costs, etc.

The use of debt collection agencies to recoup unexpected bills adds insult to injury for the unsuspecting patient. AHIA supports the development of informed consent forms to assist patients in understanding the extent to which they may face fees which are not covered by their insurance, but does not regard this as a perfect solution.

The best way to ensure agreement on fees occurs would be to make any medical fee for hospital treatment which has not been agreed by the patient beforehand unenforceable. This would not prevent a doctor seeking a higher payment from a patient should the unexpected occur, but it would take the debt collector out of the equation. ***AHIA therefore recommends the Government take the necessary steps to ensure that any medical fee for hospital treatment which has not been previously agreed by the patient is unenforceable at law.***

Avoiding Gaps - better informed GP's

In AHIA's experience very few patients and not many specialists like to discuss financial matters prior to an operation. In addition a patient facing surgery may be hesitant to discuss fees with their surgeon once they have been examined. Much of this could be avoided if, all things being equal, the initial referral by their GP was made to a "no/known gap" specialist.
Obviously the decision of to whom a referral should be made should be based on the best clinical grounds. However if in the view of the GP no gap specialists are as appropriate as those who may impose higher charges the patient should be given the choice at the time the referral to a specialist is made—i.e., in the GP's rooms, not the surgeons.

To assist GP's who may wish to help their patients avoid gaps, AHIA has made arrangements with the developers of the most widely used GP software, Medical Director, to include lists of "no/known gap" specialists. This allows the GP to instantly determine which specialists will not, or are unlikely to impose a gap, at the time of creating a computer generated referral. ***It would assist if the Committee could add to fund recommendations that GP's attempt to establish whether the surgeon to whom they refer a patient is a "no gap" doctor.***

Reinsurance

At the moment all health funds share in a risk equalisation pool which shares, to an extent, the hospital table costs for members aged more than 65. This is an essential component of community rating.

Several years ago the Department of Health proposed changing the existing scheme, which is based on utilisation, to a prospective Risk Based Capitation scheme, in which the potential risk of all members was to be shared. However a number of Funds were concerned at the likely perverse incentives which an RBC could encourage. Although it was intended to encourage "efficiency" by rewarding funds that lowered their benefit outlays, the scheme overlooked the fact that this is best done by cost shifting rather than effective benefit risk management, or assisting members to reduce their own need for high cost health care.

This is a fundamental flaw of the proposal for a scheme within a Community Rated system, as it would effectively encourage risk shedding instead of better risk management. The impact of such incentives would be most felt by older and sicker members who would either face higher premiums or larger out of pocket costs, or transfer from the private to the public hospital system. This would be totally contrary to the Government's policy of encouraging older people to be insured and would adversely affect public hospitals.

AHIA engaged consultants along with respected industry actuaries and HIRMAA to determine whether the proposed risk based reinsurance (RBC) scheme could be adapted to overcome these problems and secure industry acceptance. The consultants conclusion was that no variation of the RBC was likely to address the fundamental concerns of the industry about the inequities to patients

and contributors that would be created. As a result AHIA and the Health Insurance Restricted Membership Association (which covers non AHIA members) have agreed to recommend to Government that the existing scheme be modified and improved with a view to achieving genuine efficiencies, better risk sharing, and encourage the development of benefit regimes and treatments which minimise hospitalisation, improve outcomes, and lead to lower costs than the existing system.***The AHIA in consultation with HIRMAA recommends:***

The following formulae be applied in respect to benefit equalization between health insurers.

Age Group	*% Benefits included*
0–50	***0.0%***
50–54	***0.0%***
55–59	***15.0%***
60–64	***42.5%***
65–69	***60.0%***
70–74	***70.0%***
75–79	***76.0%***
80–84	***78.0%***
85–89	***82.0%***
90–94	***82.0%***
95	***82.0%***

- ***Benefits to include all hospital and medical benefits, and***
- ***Benefits to include appropriate out of hospital benefits. AHIA believes such benefits should be provided when the substituted admission or treatment program is less costly than in patient treatment if it is to be included within reinsurance, would be subject to industry agreed admission and quality criteria, and subject to measurable cost-benefit analysis. These could be expected to include the various programs outlined earlier in this submission.***
- A number of other minor administrative changes. Details can be provided on request.

Hospital Costs

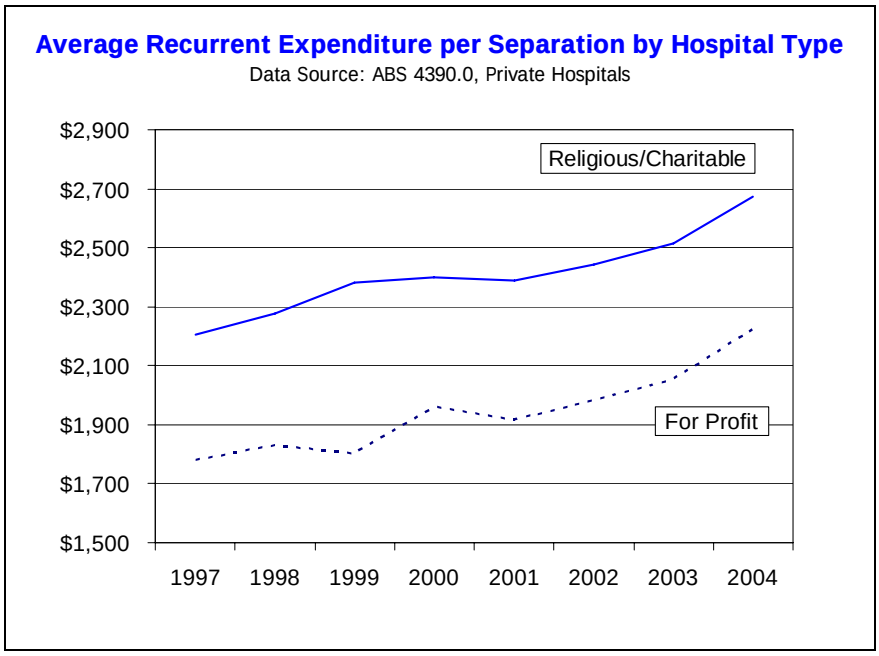
Health fund premiums (and therefore the PHI rebate costs) are mainly driven by the cost of hospitalisation, which is itself affected by the cost and introduction of new health technology. This has a multiplier effect - the technology usually makes it possible to provide new treatments or treat new people (or both) and the cost of the technology is usually higher than that which it has replaced (and in many cases it does not substitute but supplements existing technology).

> ***Multiplier Effect:*** *One fund recently decided to increase benefits paid for chemotherapy by nine percent, expecting that the total cost increase would rise proportionately. However, although the average cost for chemotherapy rose by 9 percent, the number of treatments increased by 15 percent, leading to a total increase in benefits for chemotherapy of 25 percent! Fortunately for the fund chemotherapy benefits were not its major expenditure.*

In addition to technology costs (investment and use) hospitals are continually seeking higher benefits from health funds to cover their operating costs. This at times leads to public confrontations between funds and hospitals either before or at the time of a contract dispute (and, it might be said, confirms that funds are in fact trying to hold down benefit costs). Hospitals also continually complain that health fund benefits are inadequate, even after contract negotiations have resulted in increases in benefit payments.

Insurers have little data about individual hospital performance, and in most cases can only rely on relatively broad data. Listed hospital organisations annual reports to provide more information than that of unlisted, or church or charitable hospitals, but this is rarely sufficient to allow a full understanding of hospitals costs or relative efficiencies. Even the Productivity Commission in its 1999 report on private hospitals was unable to explain differences in unit costs, saying that there were marked variations in financial outcomes within the industry. "In particular, for-profit group hospitals tend to have the lowest costs…" it said, but added "considerable caution is required in drawing any conclusions about the relative efficiency" due to lack of information.

The following graph shows the broad differences between the "for profit" and "religious or charitable" sectors, but there is insufficient published data to allow proper analysis.



AHIA believes there could be significant improvement in these relationships if more details of hospital performance, individually and comparatively, were published (as is the case with health funds via the PHIAC Annual Report). These would include both financial and clinical performance data. This would allow health funds, government and the public to better understand the financial relativities between hospitals and health funds. It would also assist encourage best practice and assist in reducing variations between facilities. AHIA believes these variations currently increase costs to both health fund consumers and taxpayers.

Information that should be put into the public arena, perhaps via tabling in Parliament as with the PHIAC report, should include detailed operating statements: profit and loss, hospital balance sheets, management expense ratios, payments to charities, ex gratia payments, and cost

data on particular services, hospital size, whether for profit or not, staff numbers, average length of stay by procedure and insurance status, occupancy rates, charges by insurance status (i.e., insured, not insured). In the case of hospital groups, this data should be provided by hospital.

It would also be informative if information on specialist fees, medical ownership of hospitals, corporate medical services (radiology, pathology, etc) and prostheses suppliers' financial position could be made public, and AHIA recommends this be done.

Default benefits

Mandatory "default" benefits are used by hospitals as a negotiating lever to force funds to pay higher prices. They may also reduce the quality of care provided by facilities that are unable to secure a contract. Licensing arrangements for hospitals are also unsatisfactory: hospitals are licensed by State Governments without any consideration for their cost implications and provider numbers are issued virtually automatically by the Department of Health & Ageing. The issue of a provider number guarantees the hospital or day hospital receives at least default benefits. The retention of 2nd tier has exacerbated this problem. ***AHIA continues to believe the 2nd tier default should be removed. If this is not successful health funds should be given an opportunity to comment on whether issue of a provider number should proceed or be withheld.***

Prostheses

Parliament recently passed legislation aimed at creating a more competitive market for prostheses. Prostheses costs have been a significant premium cost driver over recent years, both in terms of the cost of the devices and the fact that, for a variety of reasons, utilisation of new devices has increased considerably.

Prosthetic Device	**Costs (up to) – excludes hospital and medical associated costs**
Defibrillator + Leads	$62,000
Dual Chamber Pacemaker + Leads	$17,000
Total Hip	$16,500
Total Knee	$15,000
Cochlear Implant	$11,000

This growth has been a particular feature of the private health sector. Under previous arrangements the determination of the price health funds must pay for prostheses has been conducted in a seller's marketplace, as funds are unable to control the supply of devices or seek discounts for volume: these are in the province of hospitals and doctors, some of whom can negotiate lower prices on the basis of their utilisation. Instead they have simply been required to ensure the patient is not out of pocket and the doctor has total freedom to choose and use any device, regardless of cost. While these two principles are separately admirable, their combination has almost totally prevented any effective cost containment by insurers despite the best efforts of health fund management. .

When Cabinet decided to alter these arrangements the intention was to create a more competitive environment which would encourage suppliers to compete on price or risk losing market share. An added refinement, which AHIA strongly supports, was the grouping of devices on the basis of their clinical equivalence. This is the first time such groupings have taken place and will allow clinicians, and the community, to query why some devices may be priced more than others which

are, to all intents and purposes, equally effective. While this may still be the intent, AHIA has concerns about its application in practice. AHIA is concerned that suppliers may continue to try to maximise margins and avoid the intent of the legislation, to the detriment of consumers and taxpayers. Some may insist on prices which impose co payments on consumers in the hope this will give them political leverage to either achieve a higher regulated benefit or destroy the system and maintain and extend margins.

AHIA is also concerned that the new arrangements may allow suppliers with moderate market share to dictate prices even though other suppliers with smaller market share may be willing to offer lower charges.

While the arrangements are intended to encourage competition, AHIA is concerned that suppliers may attempt to collude on their pricing proposals, or simply refuse to negotiate. In addition the legislation does not provide any safeguards in the case of specific devices which may have a monopoly position. One possibility that could occur is suppliers deliberately modifying devices to provide them with unnecessarily unique characteristics, thus avoiding competitive pricing.

AHIA is particularly concerned at the disparity in pricing between the public and private sectors, especially as many devices are used more widely in the private sector than in public hospitals. In these circumstances one would expect any volume discounts to apply in relation to privately funded prostheses rather than lower numbers used in public hospitals. This is not the case.

The table below shows some examples in which the cost to funds for the same devices vary significantly between public and private hospitals. This is particularly disturbing in areas in which the highest volumes of devices are in fact in the private sector, and it cannot be claimed that public hospitals provide higher volumes or economies of scale. Once again it is the consumer and taxpayer who are forced to pay the difference.

Prostheses Device (individual supplier item examples)	**Public Hospital Invoice Price**	**Health Fund Minimum in Private Hospital**	**Percentage Difference**
Drug Eluting Stent	$2,400	$3,220	34%
Bare Metal Stent	$8,00	$1,700	113%
Pacemaker (single chamber)	$4,000	$5,000	25%
Intraocular Lens	$176	$320	81%
Heart Valve	$4,700	$6,250	33%
Hip System	$900	$1487	65%
Knee System	$1820	$2540	40%
Ligation Clips	$26	$181	596%
ECT Screws	$15.50	$57	267%
Bone Cement	$25.80	$166	543%

Even if the new arrangements do help contain costs, technology and the demand for new treatments as they become available will impact on prices. For example, the Ventracor (a cardiac device supplier) website reports that it is moving closer to commercialising its heart assist technology with a global trial now underway. The device is a new third generation cardiac assist system primarily designed as a permanent alternative to heart transplants for patients suffering heart failure. It weighs just 298 grams and measures 60mm (yet costs are indicated to be $100K). The trials of the Ventr-Assist have already begun in Australia.

Foster Stockbroking reported on 21 April 2004 that "*Ventracor is predicting a $100,000 price tag for the VentrAssist device. This is in line with other left ventricular assist devices on the market.* ***Ventracor expects that the gross margin for sales will be between 70-80%"*** (our emphasis).

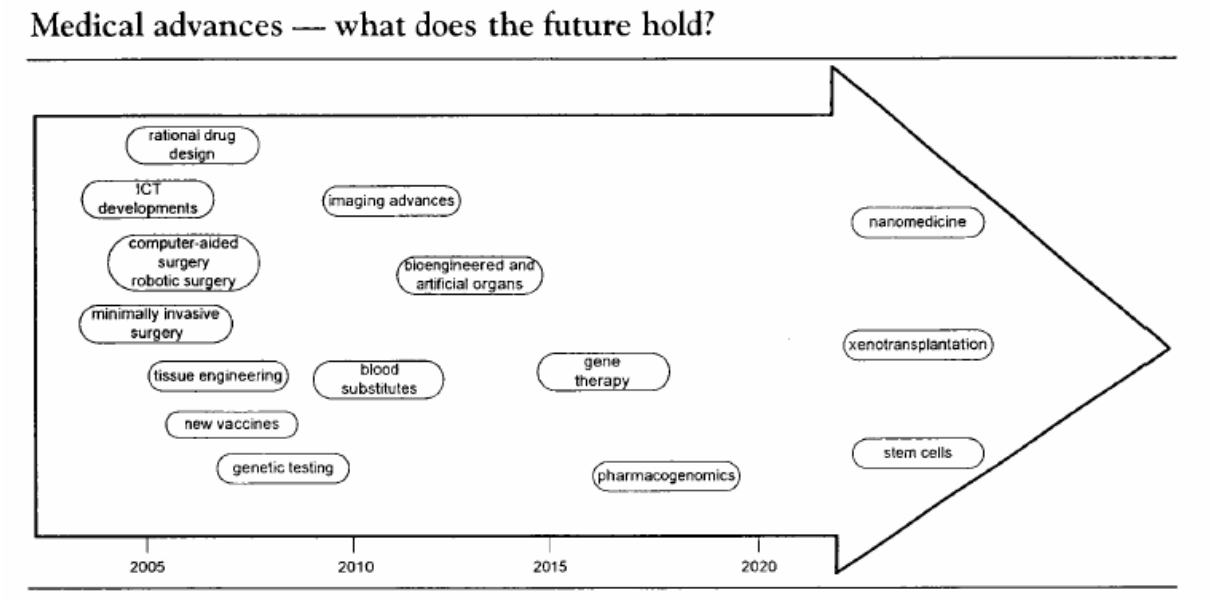
The FDA announced on the 21 April 2005 that it will convene an expert panel of cardiovascular surgeons to review Abiomed's artificial heart and associated clinical trial data. This is the first fully self contained artificial heart to come before the FDA. A decision on the potential approval will be made on 23 June 2005.

Artificial hearts are well on their way…..

As are many other miracle devices.

The Productivity Commission in its latest report *Impacts of Medical Technology in Australia (2005)* illustrates, as best as practical, new developments in medical technologies that will be available to the population over time and ultimately be reflected in the nations health expenditure.

Source: Productivity Commission



The impact of technology, both in benefits and costs, is no longer affected by age. Indeed it is likely that new technological innovations will apply as much to the younger as the older population. To put this into context, the highest priced cardiac prosthesis in 1988 was a cardiac pacemaker, priced at $4200, the then equivalent of 10 single average premiums. Today the most expensive individual cardiac device is a defibrillator priced at $49,000, or 50 average premiums. In other words insurers now need to recruit or retain 50 members who do not claim to cover the cost of one defibrillator…which may be replaced in a few years at an even higher price (for example, it does not seem widely known that high cost items like defibrillators may need to be replaced - at cost to the health fund contributor - every 5-7 years). In addition some devices have been found faulty and the "recall" involves their removal and replacement with a new device, and the procedure (if not the device) generally paid for by insurance.) Health funds accept their responsibilities in this area, but must make the point that these long term liabilities will have a significant impact on price which needs to be understood. This is all the more reason to ensure the prices paid for technology are no greater than absolutely necessary in a proper competitive market in which the regulatory environment neither allows nor encourages unnecessary cost inflation.

While supporting the current clinical grouping of devices AHIA is concerned at the haste with which some medical technology is brought to market compared with the much more intense scrutiny of pharmaceuticals. Recently there have been a number of recalls of products arising from adverse incidents. In many cases it has been unclear whether the device has been at fault, or whether the incidents have occurred as a result of inadequate training of clinicians. Whichever is correct, patient safety should be paramount.

AHIA does not resist the introduction of new technology or its use, subject to proper safeguards and evaluation, given the enormous potential such devices have to improve individual and population health. But the question is how will society be able to pay and will the explosion in new

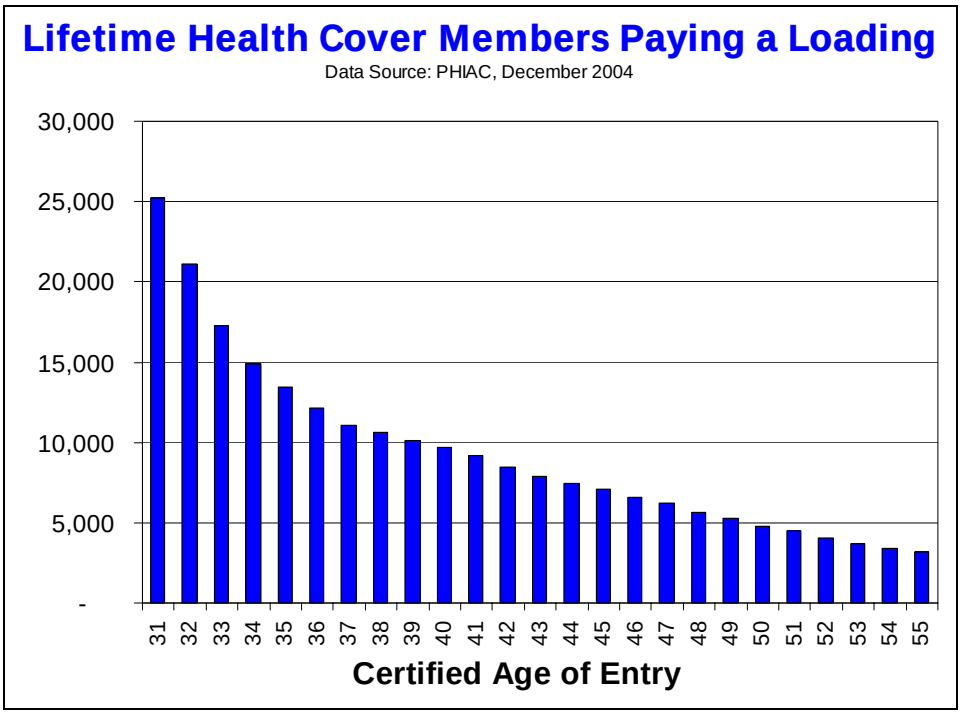
treatments ultimately result in rationing, negating the very benefits to the population that innovation can offer?

As a first step ***AHIA believes there needs to be far more evaluation of the clinical benefits and cost effectiveness of new technology, supported by the development, by expert clinicians, of appropriateness indicators which assist in determining which patients will benefit from its use. Consumers should be better informed about the lifespan of devices and any risks involved in their use.***

Lifetime Health Cover

Lifetime Health cover, which involves a loading on premiums for people who join health funds after turning 30, has significantly increased the insured population and acted as a counter balance to the formerly ageing membership. (It should be remembered, however, that younger members still represent significant costs to the system.)

Market research indicates many young people are still unaware of the detail of Lifetime Health Cover. At December 2004, 255,060 people paid a LHC loading. Although some were late joiners, probably aware they needed or would need treatments, 145,673 were aged between 31 and 40, and 91,996 were aged between 31-35 years. Many of these were probably not aware of the loading until they decided to take out cover. This not only represents a cost to those involved, but also adds to rebate costs (we estimate the additional cost of the rebate to the 31-35 age group paying a loading is about $2.3 million per annum - perhaps not much today, but likely to grow in future) Although health funds attempt to increase awareness more needs to be done. AHIA believes the Government does have a responsibility to alert the community to the impact of its policies, particularly one which may affect them in later years. One relatively low cost way of increasing awareness would be to ***use the Health Insurance Commission data base to identify all persons turning 30-31 and write to them to advise them of the existence of LHC and the impact on them should they postpone taking out PHI.***



Medicare Levy Surcharge

When it was introduced the Government described this as "the tax we expect no one to pay", as it was intended to encourage higher income earners (those who, almost be definition, represent better risk) to take out insurance. This has no doubt occurred. However under current arrangements many people are unaware of the existence of the Medicare levy surcharge until after the end of the tax year, by which time it is too late. ***AHIA believes the Australian Taxation Office should advise paymasters of the surcharge and provide them with details of appropriate PAYE deduction amounts. The system should also require paymasters to alert employees of their potential exposure to the levy prior to deducting the necessary PAYE amount. This would allow prospective surcharge payers to determine whether they wished to take out insurance or pay the surcharge in a prospective manner.***

Investing in Health

The most effective health funding policy are those which keep people as healthy as possible, minimise the need for treatment and when treatment is necessary ensure it is provided in the lowest cost appropriate setting with the best possible outcome. Our proposals above, particularly in relation to allowing funding for services outside hospital, are consistent with this approach. Another aspect of better health, particularly for people in the workforce, is the improvement in productivity that can be achieved. Hospital stays or lengthy recovery periods after hospitalisation add to employment costs and affect the nation's productivity. AHIA believes there is a compelling argument that improved health status benefits the economy.

Health insurance and private health care plays a significant and to date relatively unknown role in assisting improved productivity. People who are privately insured are able to arrange times for elective surgery to better fit in with work commitments; the certainty of treatment times reduces the time necessary to be taken off work (whereas treatments in the public sector may be cancelled even on the day of surgery requiring return visits) and increases in day surgery and average length of stay further reduce time off (and increase productivity).

Australia is, however, one of the few countries in the world which discourages employers from helping their employees to be insured by taxing the value of any premium subsidisation that may occur. Grossing up provisions in relation to FBT in fact make employer subsidisation a very unattractive proposition indeed: it is almost a penal tax. As a result there is very little employer subsidisation even though the overall economy stands to benefit from a higher proportion of insured persons, and the cost of insurance is reduced by including a high proportion of healthy people in the risk pool: and those in the workforce are almost invariably of healthier status than those who are not.

AHIA would therefore like to draw the Committee's attention to the benefits of reducing the disincentive FBT poses to employer subsidised health insurance. There are a number of ways in which modifications to the existing FBT regime could be applied to minimise costs or risks to revenue while still helping to encourage a greater take-up of PHI by lower risk members. These could include, for example, limiting any concessions or exemptions to people below a certain age or salary level. Another way of doing this (which could be combined with the two already mentioned) would be to allow FBT concessions or exemptions to employer funded or subsidised health insurance which included a health maintenance or illness prevention program, reinforcing the productivity aspects canvassed above. AHIA believes action in this area should be seen not so

much as a cost to Government but an investment in a healthier population, a more productive society, and a less expensive health insurance system than would otherwise be the case.

The 30 percent rebate

AHIA notes the Committee's terms of reference acknowledge the need to retain the 30 percent rebate. However, given an on-going campaign of disinformation aimed at undermining public confidence in the rebate AHIA wishes to draw the Committee's attention to its undoubted benefits to our health care system. The fact is all the data proves the rebate has had a very successful track record.

The rebate, combined with other incentives such as the surcharge and Lifetime Health Cover have stabilised the system in terms of age mix and increased the elderly population with insurance – those who need it most. The private health insurance industry now covers almost 42% of the population who are over 65 years of age. This group of members use hospital beds at a rate of 6 times the under 65 population. In total members over 65 claimed more than $2.4 billion dollars in hospital benefits alone, more than the cost of the 30% rebate for hospital cover, and almost the equivalent to the cost of the whole program.

Had the pre-rebate trend continued less than 20 percent of the total population would be insured today. Very few people over 65, if any, would have been able to use private health services.

Opponents of the rebate claim it only benefits wealthy people. This is demonstrably untrue.

The ABS National Health Survey 2001 shows income details for insured people broken into 5 quintiles. Cross-tabulated with PHIAC data this survey shows:

- 25% of the population earning $18,200 or less had PHI. *More than 1 million people with insurance earned less than $18,200 per annum.*

- 34% of the population who earned between $18,200 and $32,916 were insured. One and a quarter million people covered by insurance and were in households with earnings between $18,200 and $32,916 I.e., *more than 2.25 million people with private health insurance cover were on gross household incomes below $33,000.*

- 45% of households (1.6 million people) with incomes between $32,916 and $50,855 had private health insurance.

- 68% of households with PHI had incomes less than $75,816 per annum.

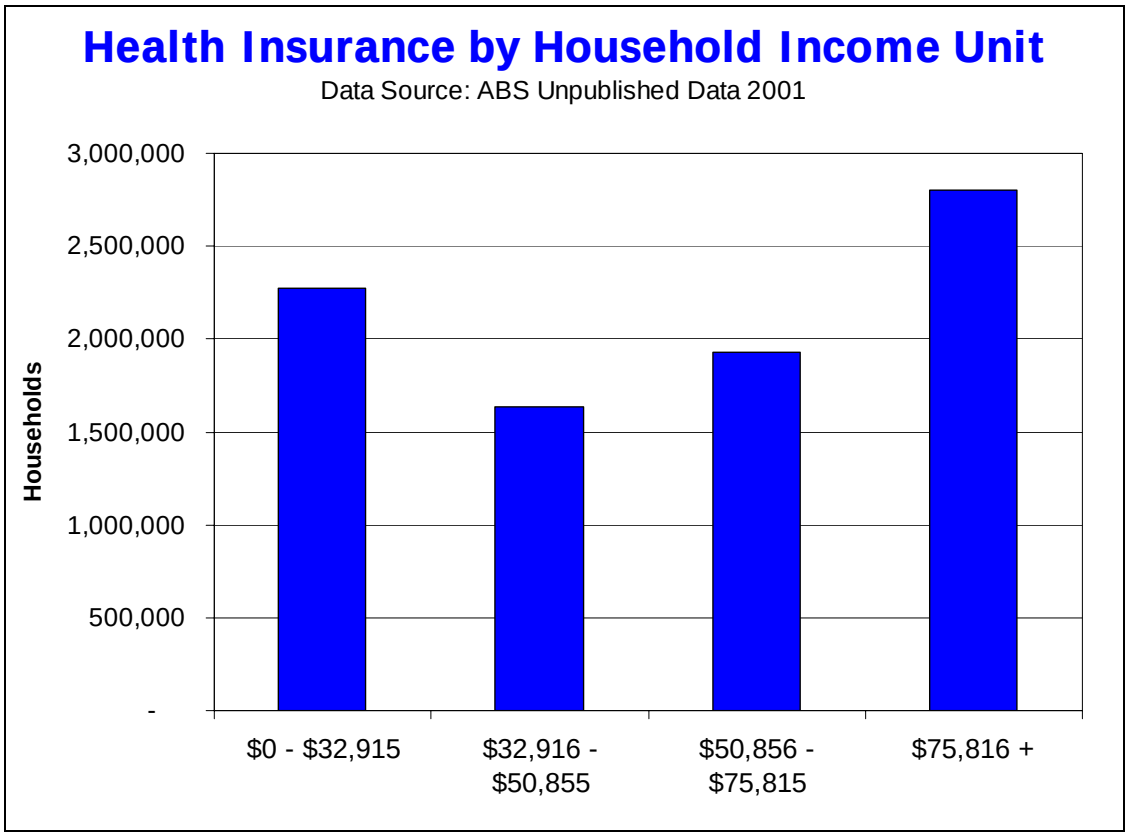
- **12% of the insured population household incomes were less than $18,200 per annum.**

- **26% of the insured population - 2.3 million people had gross household incomes less than $33,000.**

- **Almost half of the insured population (3.9 million) had gross household incomes less than $51,000. Almost four million people with hospital cover were in households that earn less than $51,000.**

- 2 in 3 people insured were from households with incomes of less than $76,000 per annum.

AHIA has extended the analysis of this data across the Australian taxation statistics. **This shows that, on a very conservative estimate, people with private health insurance pay at least $3 billion in the 1.5 percent Medicare levy (which raised a total $5 billion in 2002-03). This means that the 43.4 percent of people with private health insurance paid 60 percent of the Medicare levy. The 43.4 percent of the population with PHI pay more than $10 billion in health fund contributions and Medicare levies. In addition, of course, they pay income tax and various other taxes.**



Below are just a few examples from the hundreds of responses AHIA has received from people on low incomes who benefit from the 30% rebate. (to see more go to www.Privatehealth.com.au)

"The rebate makes health cover affordable as we have a disabled daughter and we do not know where the future lies. It gives you a feeling of safety knowing that the doctor of your choice is going to help you in your time of need. It works for our family and we need this cover to continue."

Ms Barb Goudie, NSW 2710

"It would be impossible for my wife and I to continue with private health insurance if we had to pay the reduction we receive from the Federal Government. I am on a disability pension and my wife receives a carer pension and our weekly budget far exceeds any monies we receive as it is."

Mr Alan Moorhead, NSW 2233

"The total annual cost of my Private Health Cover is $1787 and the rebate of 30% brings it back to $1251 pa. - which is $24 per week - quite a lot for an aged pensioner to pay. I would therefore ask you + your association to continue to very actively urge the government to continue to grant the 30% rebate especially to those on limited income (age pension) who endeavour to make provision for their health care. By paying for Private Health Care we are saving the Government a considerable amount in the annual cost of providing health care for older people."

Mr/s AM O'Neill, NSW 2065

" My wife Marie and I are self-funded retirees who have relied heavily on private health insurance (name of fund) for oncology services during Marie's treatment for non-Hodgkins lymphoma during the past five years. We have received the 30 per cent rebate from its introduction, enabling us to continue to remain with the private health system since joining (fund) on 14 August 1959. That we received a rebate of $995 on the premium of $3318 paid last financial year guaranteed that we could continue with private health insurance. "

Mr Barry A Clarke, NSW 2590

"Without the 30% rebate my wife and I would find it almost impossible to pay for the necessary health protection. We can just manage the payments now and it would be too great a hardship if we were to lose the 30% rebate. We are self funded pensioners and I speak for many of my friends and associates."

Mr David Reid, NSW 2030

"The 30% rebate assists me in paying for private insurance for my young family. My son is 2 and the baby is 10 months old. I paid @ $1700 to (Fund name) this year and the rebate was around $750. That money came in useful when we paid in excess of $6,000 for various medical fees after my two kids started the year in hospital for various reasons. (Fund) picked up $4,300 worth of the bills. we live on a single income and have a farm which struggles in this drought time - we just cant afford to pay more for health insurance, but cant afford not to have insurance when we have two small children who require medical assistance. We pay our taxes like so many others so its nice when we get something back which helps to pay directly for medical expenses."

Ms F Cleret, NSW 2580

"We have a family of 8,6 children & 2 adults with health insurance, I believe we are providing for our family the best we can, and we should be encouraged to do this with the 30% rebate that we get now. We are not using the public hospital system which we would give us more money, if we did not have to find $176.00 with the 30% rebate per month. We are committed to the Private Insurance health system and want to see the 30%rebate STAY.!!!!!!!!!!"

Ms Fiona Jennings, NSW 2103

"Regarding the health rebate which we receive from the Federal Government. It is extremely important to my family to have Private Health Cover and if it is removed we would not be able to afford it. I have been prepared to make provision for my cover and my families health cover with (health fund) since 1974. There 30% rebate the Federal Government provides allows my family to afford this health cover. Due to the drought , loss of income from loss of stock and loss of production off our grazing property the loss of the rebate would not enable us to have private health insurance. Our 30% rebate is of major importance to us."

Mr Paul Kenneth Evans, NSW 2835

Effects on the Australian Health Financing System if PHI Rebate Removed

Prior to the introduction of the 30% rebate on January 1 1999 on private health insurance contributions the number of people with hospital cover stood at 5.7 million and was declining. At that time, the proportion of the population with hospital cover was at its lowest ever level of 30.1% of the Australian population.

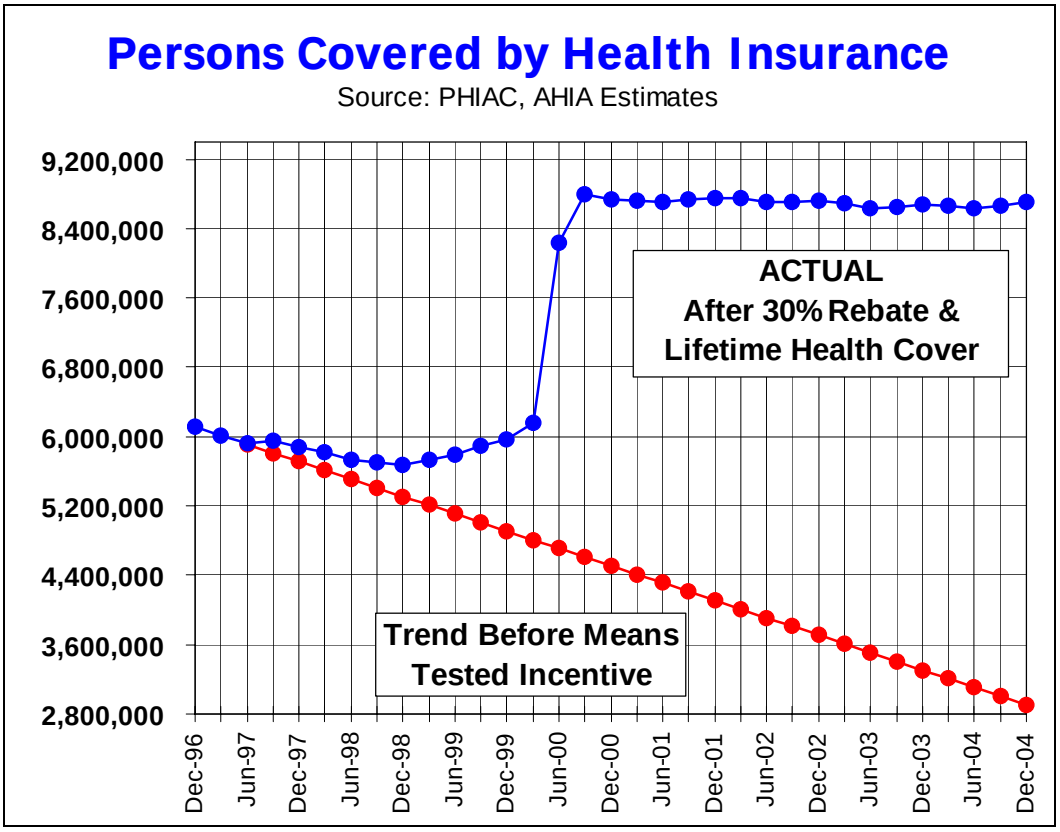
As at December 2004, 43% of the population had hospital cover. This means that 8.7 million have hospital cover – about 3 million more than pre rebate.

In the 12 months leading to December 1998 (pre rebate) benefits paid for privately insured hospital treatment totalled $3.0 billion. In the 12 months to December 2004 health funds paid $5.6 billion for hospital treatments – an additional $2.6 billion dollars i.e, an increase of more than 86 percent.

If the rebate was removed the numbers of people insured would decline and these people would be reliant on the public hospital system. Market Research (TQA) confirms that 35 percent of the insured population would drop their cover. If the pre-rebate trend continued membership would have been less than 20% of the population, and community rating would have been destroyed.

Indeed, if we look at the UK - where a “free” National Health Service operates and there is no rebate, the health insurance pool is around 12 percent of the total population, and premiums are risk rated. This gives an indication of what may have been the bottom of the market had the rebate not been introduced - bearing in mind the social benefits arising from community rating would have been removed in the process. Very few people aged more than 65 have health insurance in the UK. Forty two percent of the over 65 population - more than 1 million people - today have health insurance in Australia.

In any event, the reality is that without the rebate the numbers of people insured was in decline. The graph below shows the impact of the Federal Governments incentives on the numbers of people with insurance, and a projection based on previous trends if the incentives were not introduced.



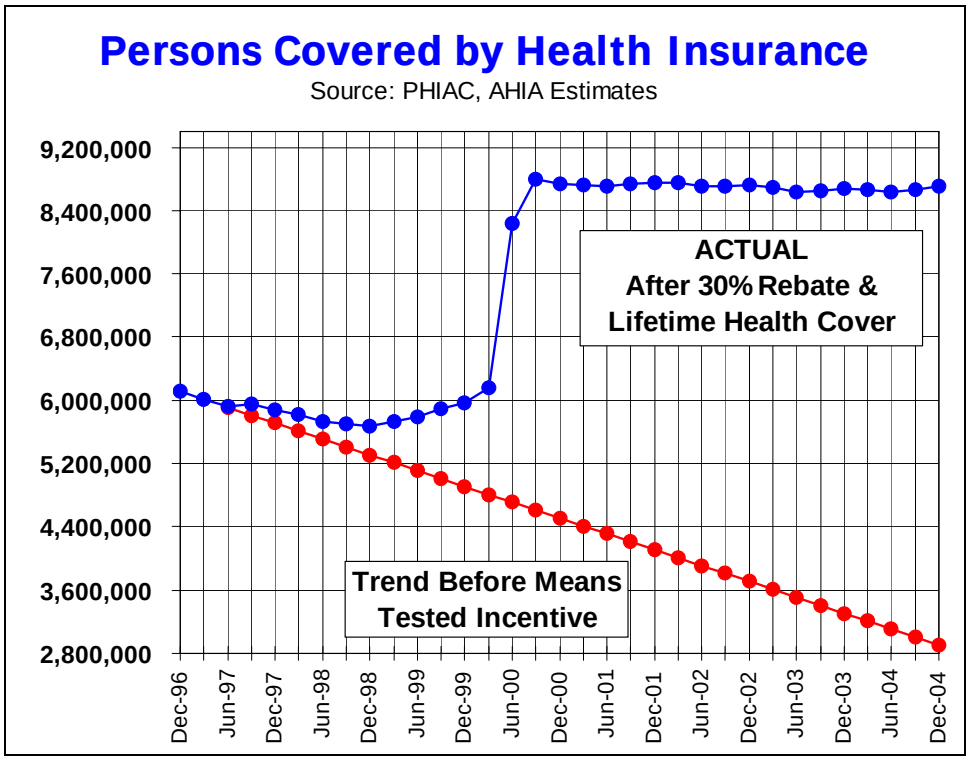
If the rebate had not been introduced AHIA estimates there would be, at best 2.8 million people insured – at least 5.8 million fewer than today. **Without Government incentives 5.8 million more people would be directly reliant upon State hospitals.**

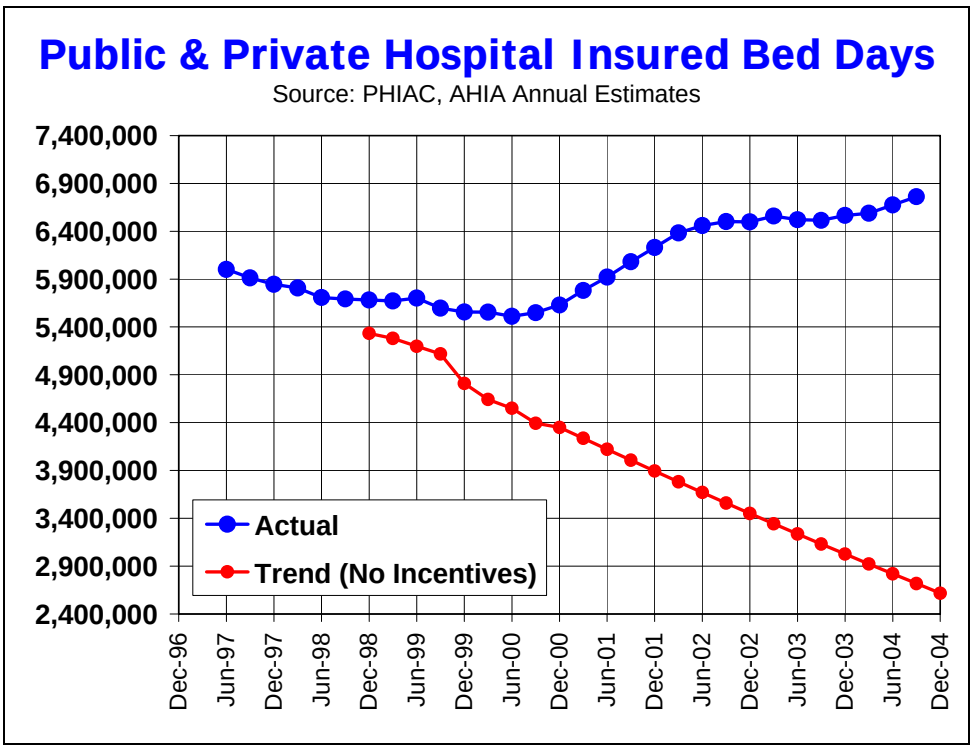
The pre rebate trend in the reduction in the insured population would result in a decline of privately insured utilisation to about 2.5 million bed days or less. This would mean the public sector would have to provide at least an extra 4.3 million bed days, at a total cost of more than $3.0 billion. This alone is $1.2 billion more than the cost of the rebate for hospital insurance ($1.8 billion) in 2003-04.

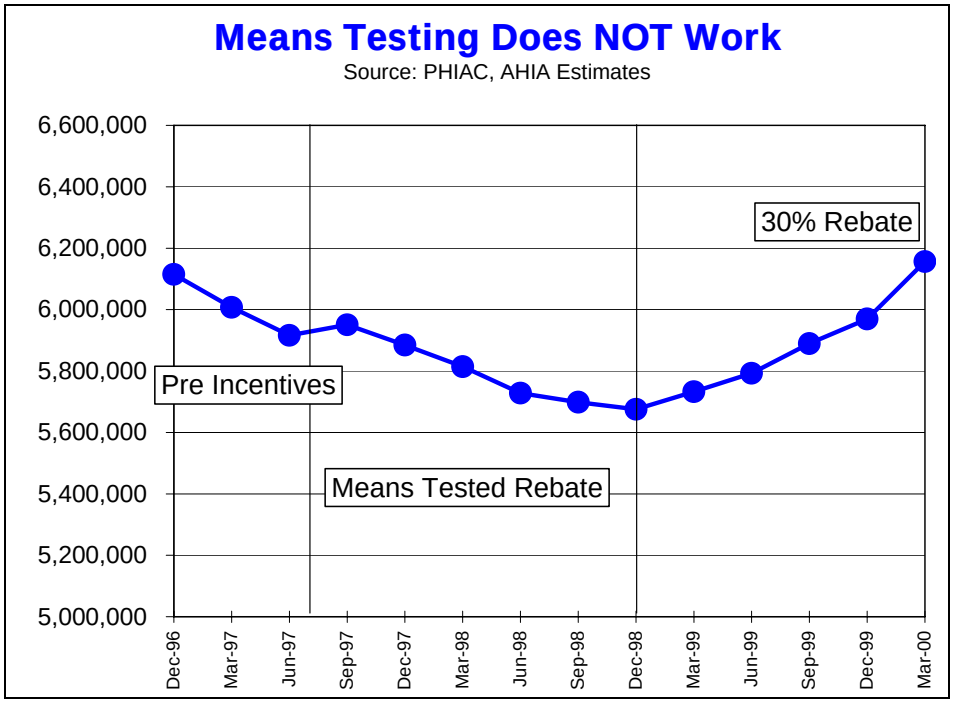
In fact, however, the costs would probably be significantly more. Removal of the rebate would increase the cost of full cover (hospital and ancillary) by between $950-$1600 per annum for a family. Those with top cover are usually people who either need treatment or expect to need treatment: analyses of their membership profiles by a number of funds confirm that drawing rates are much higher on comprehensive coverage than lower priced products (this is why they are higher priced.

Removal of the rebate, and imposition of a charge of $950-$1600 extra, would almost certainly force the old and the sick out of the private health insurance system. Lower risk members would also probably leave. As a result removal of the rebate could well lead to a collapse of the private health insurance system. If this occurred the cost to the hospital system alone would be more than $5.6 billion. In other words, removing the private health insurance rebate (worth $1.8 billion for hospital cover) would cost Governments between a minimum of $3.0 billion and up to $5.6 billion per year to provide the same hospital services as are provided today .

APPENDIX A: The 30% Rebate WORKS






Means Testing Does NOT Work
Source: PHIAC, AHIA Estimates
6,600,000
6,400,000
6,200,000
6,000,000
5,800,000
5,600,000
5,400,000
5,200,000
5,000,000
30% Rebate
Pre Incentives
Means Tested Rebate
Dec-96
Mar-97
Jun-97
Sep-97
Dec-97
Mar-98
Jun-98
Sep-98
Dec-98
Mar-99
Jun-99
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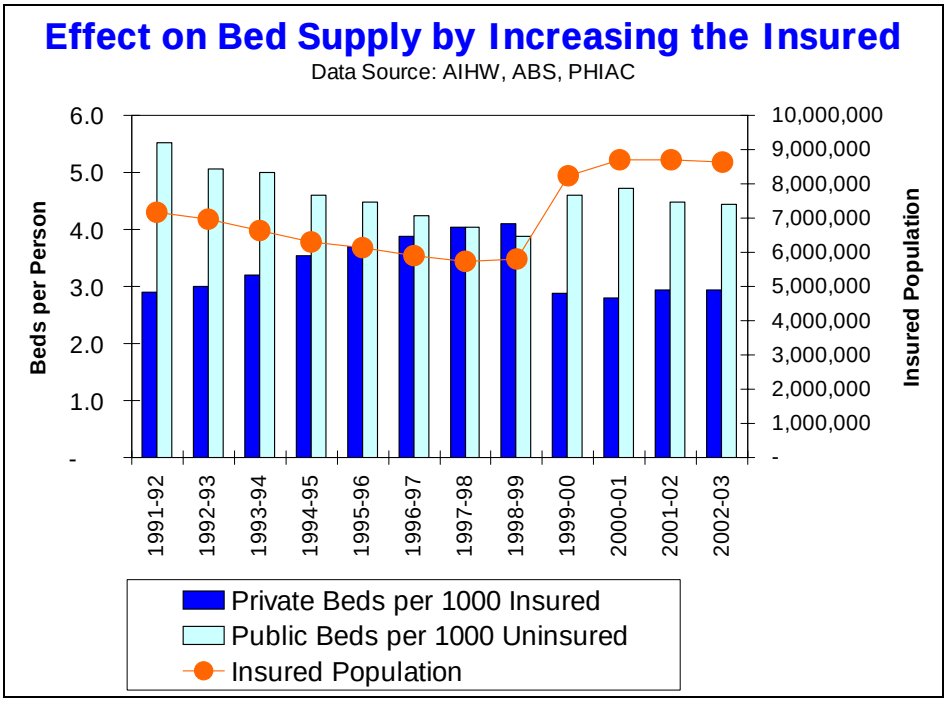
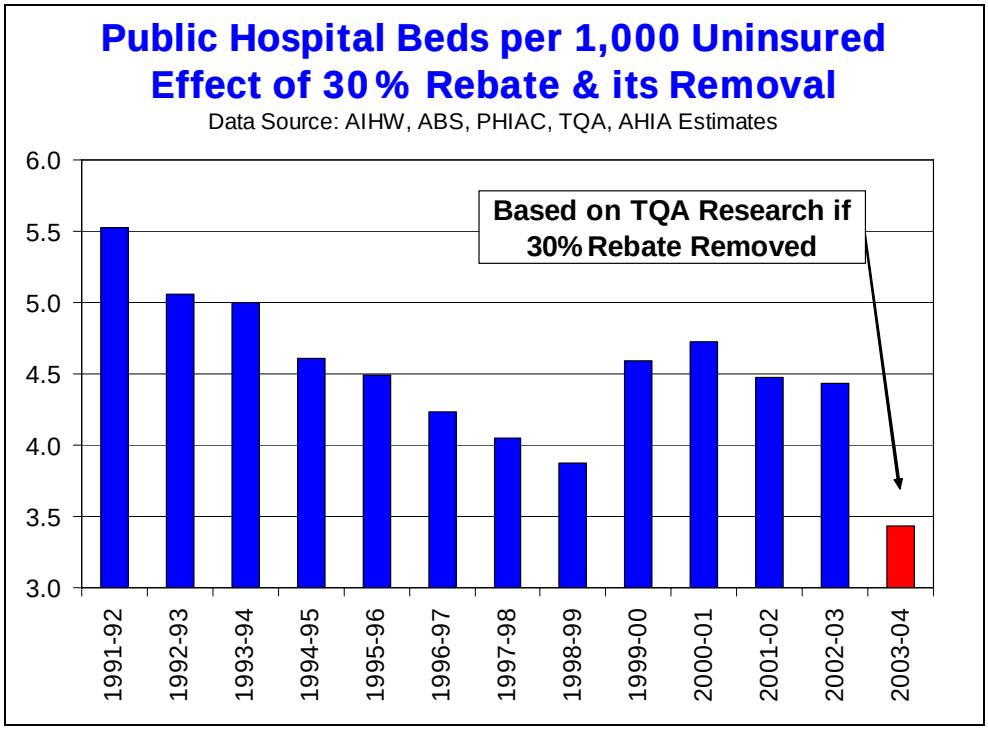
Dec-99
Mar-00


Effect on Bed Supply by Increasing the Insured
Data Source: AIHW, ABS, PHIAC
Beds per Person
6.0
5.0
4.0
3.0
2.0
1.0
-
Insured Population
10,000,000
9,000,000
8,000,000
7,000,000
6,000,000
5,000,000
4,000,000
3,000,000
2,000,000
1,000,000
-
1991-92
1992-93
1993-94
1994-95
1995-96
1996-97
1997-98
1998-99
1999-00
2000-01
2001-02
2002-03
Private Beds per 1000 Insured
Public Beds per 1000 Uninsured
Insured Population

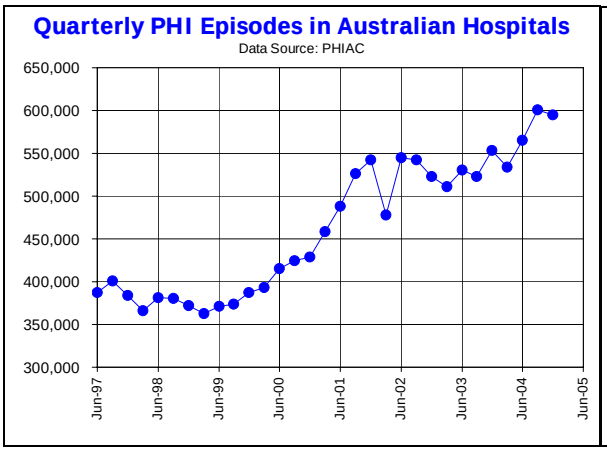


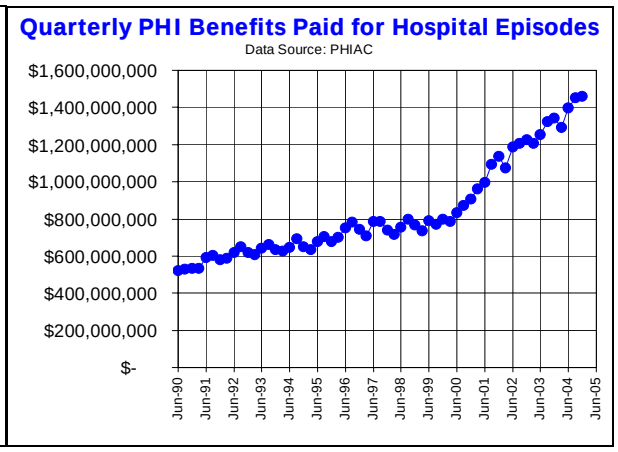
Private Sector Contribution

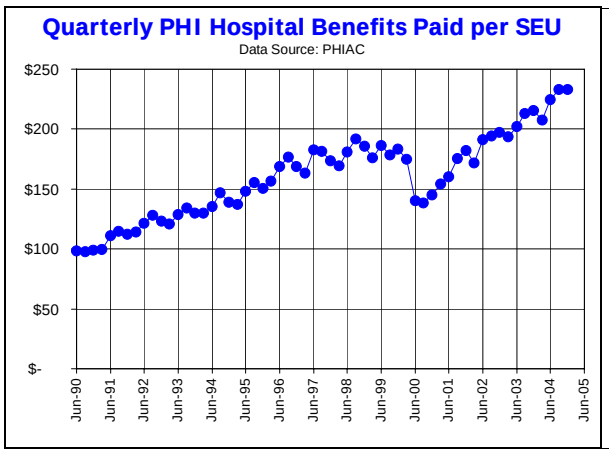
Selected Episodes: Proportion Performed in Private Hospitals
Data Source: AIHW 2002-03

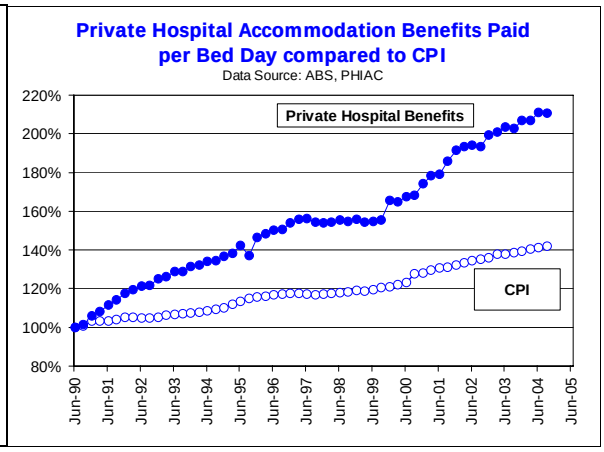
Chemotherapy	52%
Major procedures for malignant breast conditions	54%
Hip Replacements	55%
Other major joint replacement & limb reattachment	64%
Mental health treatment, sameday	68%
Major lens procedures	70%
Major wrist, hand & thumb procedures	71%
Knee procedures	77%

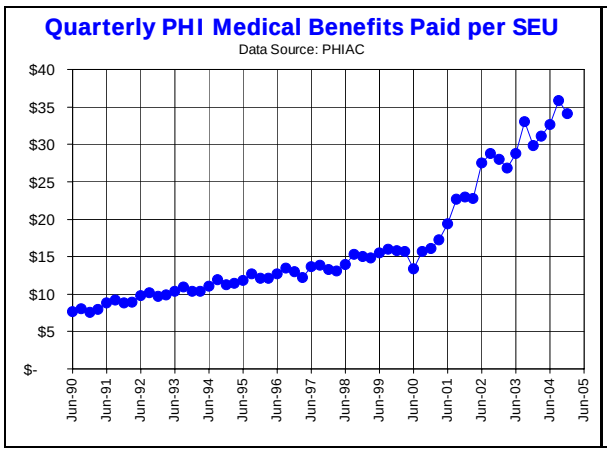
APPENDIX B: Health Fund Cost Drivers

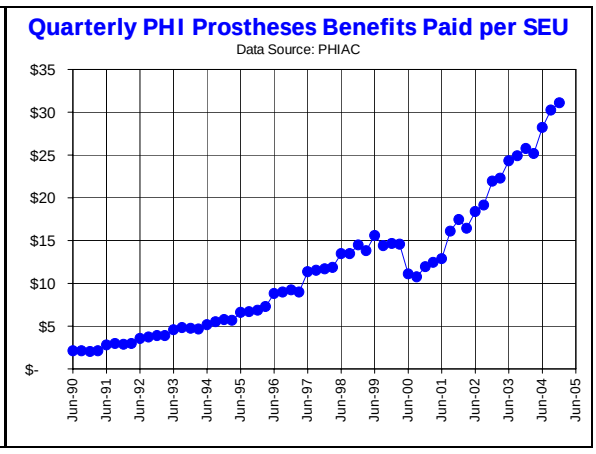












APPENDIX C: SECOND TIER DEFAULT BENEFIT CRITERIA

The Schedule - 1 August 2001
SCHEDULE 6 – SECOND TIER BENEFITS FOR OVERNIGHT AND DAY ONLY TREATMENT

2. Eligibility of hospital or day hospital facility for second tier benefits
Legislative requirements
(a) The facility must:
(i) have a State or Territory licence or registration certificate; and or
(ii) be declared by the Commonwealth Minister for Health to be either:
· a private hospital under subsection 23EA(1) of the *Health Insurance Act 1973*; or
· a day hospital facility under subsection 5B(1) of the *National Health Act 1953*.

Accreditation
(b) If the facility:
(i) Has been established for less than 15 months, it must:
· be certified by an industry recognised accreditation agency as operating according to industry standards; and
· from 1 March 2002, be assessed by an 'approved accreditation agency' as being fully compliant with criteria in clause 3
(ii) Has been established for longer than 15 months, it must:
· be accredited by an industry recognised accreditation agency and have no areas of high priority recommendation; and
· from 1 March 2002, be assessed by an 'approved accreditation agency' as being fully compliant with criteria in clause 3.

Simplified billing
(c) The facility must:
(i) provide patients, within 1 month after the patient has been discharged from hospital, a single account in respect of that hospital treatment, covering all hospital services and related services (not necessarily including professional services); and
(ii) have processes in place that would allow the inclusion of in-hospital medical bills in a simplified billing arrangement.
The facility may also issue interim accounts where an episode of hospital treatment exceeds 7 days (excluding leave periods) and where the patient to whom the admission applies has been advised that this will occur.

Informed financial consent
(d) The facility must have procedures in place to inform a patient or nominee, in writing, of what hospital charges, health fund benefits and out-of-pocket costs (where applicable) are expected in respect of the hospital treatment. The patient or nominee must be informed:
(i) for scheduled admissions, at the earliest opportunity before admission for the hospital treatment; or
(ii) for unplanned admissions – as soon after the admission as the circumstances reasonably permit.

Patient Classification and Data Collection
(e) A facility that wants to claim second tier benefits for rehabilitation patients must classify rehabilitation patients according to the Rehabilitation Branch of the Australian National Sub-Acute and Non-Acute Patient (AN-SNAP Rehabilitation) classification system, including the production of Functional Independence Measure (FIM) scores according to the FIM accreditation standards and submit data monthly to a body notified by the Commonwealth from time to time. For the purposes of the Schedule "rehabilitation" has the same meaning as in the National Health Data Dictionary.

3. Quality Criteria
Management of the operation of the hospital
(a) The facility must apply:
(i) policy(ies), protocols and procedures to facilitate safe management of the equipment, staff and infrastructure (eg. fire systems, food administration, Occupational Health & Safety issues);
(ii) specific infection control policies and procedures, as well as implementing clear mechanisms for their revision and update;
(iii) systems for ongoing monitoring and periodic evaluation of management practices, including mechanisms for taking remedial and improvement action as needed; and
(iv) management systems for recording and analysing adverse events and providing feedback to all relevant personnel on these events and monitoring this aspect of performance subsequent to the feedback.

Clinical practices
(b) The facility must:
(i) support the implementation of clinical practices that are based on best available evidence, supported by a cycle of ongoing review and measurement.
This process should ideally include:
- the implementation of clinical pathways where supported by evidence;
- the development and use of locally generated clinical guidelines; and
- the provision of data to all relevant clinicians and peer review groups on variance, respecting confidentiality.

(ii) apply continuum of care principles for an episode of care (ie. pre-admission, admission, discharge and post-discharge planning), where possible;
(iii) apply early identification, early intervention and active treatment for patients who exhibit risk factors or have a high probability to become long-stay patients, including service co-ordination with outreach services in consultation with the patient (or, where appropriate, their guardian or carer); and
(iv) ensure the maintenance of accurate and comprehensive patient medical records.

Safety and Quality of Medication
(c) The facility must have systems to require/ensure that:
(i) procedures are applied to obtain an accurate and comprehensive medication history at the time of admission including any allergies and complementary medicines;
(ii) procedures for the review of medicines throughout the hospital stay are applied;
(iii) at discharge information regarding his/her medication is provided to the patient in a way which ensures his/her understanding, detailing medication name, purpose, dose, administration schedule and possible significant adverse reactions;

(iv) ideally information regarding the patients discharge medication should be provided to all relevant clinicians involved in the patients ongoing care;
(v) medication incidents are recorded, reviewed and acted upon; and
(vi) the facility has systems to ensure Adverse Drug Reactions (ADRs) and allergies are documented and communicated to the patient, all relevant medical officers and the Adverse Drug Reactions Advisory Committee (ADRAC).

Personnel
(d) The facility must:
(i) apply policies and protocols to facilitate and document that any individual working in or credentialled to the hospital is appropriately qualified and experienced to fulfil their responsibility safely and effectively, including:
· credentialling procedures;
· staff performance is continuously monitored and systems are in place to continuously improve performance in clinical practice; and
· peer review mechanisms are linked to hospital credentialling.
(ii) be able to demonstrate that mechanisms are in place to review and adjust staff mix and numbers to meet the needs of patients; and
(iii) have systems in place to ensure staff satisfaction /feedback is regularly sought and acted upon.

Consumer rights
(e) The facility must have:
(i) information on hospital care provided to consumers in appropriate ways (eg. community languages) including information on patients rights and responsibilities and complaints mechanisms;
(ii) documented policies with regard to patient rights and responsibilities and complaints mechanisms;
(iii) documented protocols in place to facilitate consumer participation in decision making regarding their care including consent to hospital treatment. The facility must demonstrate that such protocols are regularly reviewed;
(iv) interpreting services available to the patient/carer free of charge; and
(v) systems to ensure that:
· patient satisfaction/feedback mechanisms are in place and are used to evaluate clinical and hospital services;
· the facility acts upon the consumer feedback; and
· access to patient records is strictly protected to ensure patient privacy and confidentiality.