Australian
Private Hospitals
Association

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Dear Professor Robinson

MBS Review – Report from Specialist and Consultant Physician Consultation Clinical Committee

Thank you for the opportunity comment on the Report from Specialist and Consultant Physician Consultation Clinical Committee.

The APHA notes that the Committee has recommended the introduction of a new time-based framework of standard attendance items. While noting the intent to provide transparency to consumers, we wish to bring to the Review's attention a number of practical contingencies relevant to the application of these recommendations within a private hospital context:

- The admitting specialist carries a duty of care to their patients which cannot be delegated to the private hospital. Unlike the public hospital sector, specialists cannot delegate to medical staff or junior doctors employed by the hospital. Consequently hospital attendances are crucial to the provision of safe and appropriate care.
- During ward consultations, specialists do necessarily have access to diagnostic imaging or other information held in their specialist practice (a separate entity to the private hospital) consequently physicians must invest time away from the face to face consultation to support the efficacy of the ward visit.
- Specialists frequently have responsibility for patients in a diversity of locations, across different wards and even different facilities, and as a consequence ward attendances can be less time efficient and less easily managed than those conducted in a single room.
- When visiting a hospital, specialists can frequently be detained by the need to answer questions from nursing staff, or family members, complete clinical documentation and other administrative tasks that are not always directly related to clinical attendances.

There is a risk that in shifting to a time-based approach to remuneration, some specialists may regard hospital admissions as a less efficient and lucrative mode of practice particularly as the rate of complexity and complications amongst admitted patients increases. The private sector is already seeing a trend in some specialties away from admitted patient care and towards room-based practice. If this trend were to exacerbate, the consequences for the health sector as a whole could be adverse with increased pressure on public hospitals to take medical admissions and surgical admissions for patients with medical co-morbidities.

The use of attendance items has increased by 4.2% per year over the past five years. However, this utilisation is not markedly out of step with trends in private hospital separations published by the Australian Institute of Health and Welfare (AIHW), shown in the table below.

Table: Separations in private hospitals by selected care types, past five financial years

	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	Average annual change since 2012-13
Medical total	1,187,619	1,213,449	1,248,109	1,313,010	1,365,615	1,410,211	3.5
Emergency	145,669	145,309	150,848	158,020	171,550	180,308	4.4
Non-emerg'y	1,041,950	1,068,140	1,097,261	1,154,990	1,194,065	1,229,903	3.4
Other acute care	769,554	840,136	875,491	894,639	904,369	914,257	3.5
Subacute and non-acute care	249,341	264,623	318,020	343,026	382,140	408,799	10.5
Rehabilitation	240,510	255,555	309,849	331,997	349,934	372,120	9.3
Total (this table)	3,634,643	3,787,212	3,999,578	4,195,682	4,367,673	4,515,598	4.4

Source: AIHW, Australian hospitals statistics multiple years.

The APHA welcomes the recommendation acute, urgent or unplanned consultations be recognised by a higher fee. It is also important the fee structure does not provide a disincentive to specialist providing medical cover for patients admitted over a weekend.

The issue of out-of-pocket costs and informed financial consent is of crucial importance to consumers. For patients in private hospitals, the medical out-of-pockets charged by specialist consultants is low with private health insurance benefits covering 99% of medical charges in the December quarter 2018, as shown by the following chart. It is important changes to the MBS Review do not give rise to changes in charging that would be detrimental to patients.

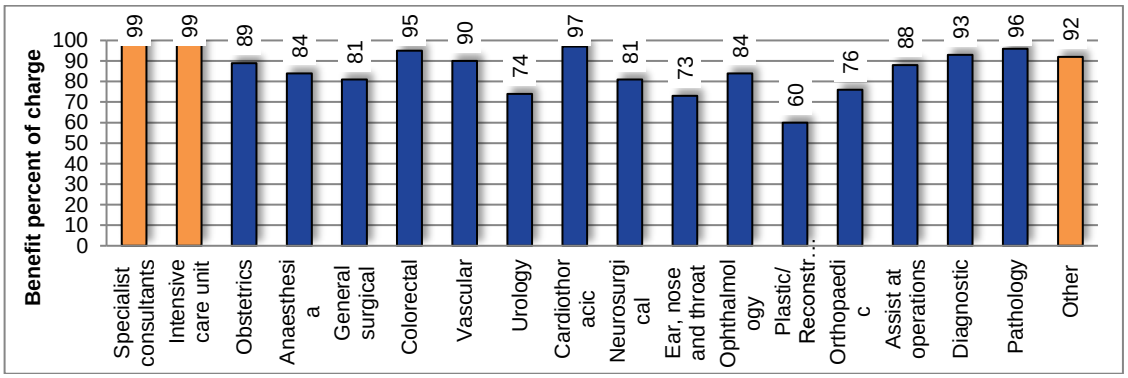

Figure: Benefits paid as proportion of total charges, by medical specialty, December quarter 2018

Source: APRA quarterly statistics on private health insurance.

Medical gaps are rarely if ever charged for in-hospital consultations. This is an important source of assurance for patients, particularly if the need for the services of a consultant arises in order to address a complication occurring during admission.

It is also important for patients to know they will be cared for on weekends, or when their admitting doctor is on leave, by physicians willing to consult “on-call”. Under current arrangements, physicians are readily available and medical gaps are non-existent. Under the proposed recommendations there is a risk that “on-call” rosters would become more difficult to fill and patients might find \ they were subject to out-of-pocket charges from “on-call” specialists not within the control of their admitting doctor. Informed financial consent processes under such circumstances would be complex and impractical.

The APHA welcomes the recommendations to establish a new framework for telehealth and reinvest in this area. The APHA also welcomes recommendations facilitating case conferencing. However APHA notes that further consultation may be required to ensure that the proposed conditions associated with these items are practicable. Attendance by the patient and their general practitioner at a multidisciplinary team may be desirable but should not be mandatory. Similarly upload of an outcome report to MyHealthRecord may be desirable but this requirement is not currently feasible across whole of the private hospital sector.

The APHA welcomes recommendations to support the update of MyHealth Record. It is important to note however that the barriers to uptake remain significant and rates of uptake are likely to vary between specialties and sub-specialties. Unlike the public sector, there has been only limited funding support from governments to enable investment in the infrastructure required to support MyHealth Record in the private sector. While a growing number of private hospitals can provide clinicians with access to MyHealth Record and can upload discharge summaries, it should be noted that, in that in the current business climate when private hospitals are under pressure to minimise costs, it may be some time before full implementation of MyHealth Record is standard in the private and day hospitals sector.

Recommendations regarding the use of data to inform quality care and patient choice echo discussions in other quarters, and the private hospital sector looks forward to the opportunity for further engagement on these issues. Such initiatives cannot be driven by MBS reforms alone and require a flexible and integrated approach in which all stakeholders are involved in order to be successful. The APHA has a significant role in working with its members to advance the effective use of data in the private health sector, and is ideally placed to contribute to this discussion.

We welcome the opportunity to comment on this report and we look forward to further discussions regarding the implementation of recommendations once these are finalised.

Yours sincerely

Lucy Cheetham
Acting Chief Executive Officer
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