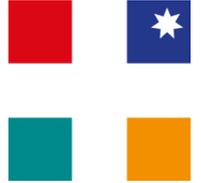


Australian  
**Private Hospitals**  
Association



# Federal Budget Submission 2019-20

19 December 2019

Australian Private Hospitals Association ABN 82 008 623 809

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# PRIVATE HEALTH – WHAT NEEDS TO BE DONE

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## Private health remains integral to the Australian health sector

The private hospital sector provides 34,300 licensed beds, a resource that would cost taxpayers more than \$34 billion to replicate in the public sector.

During the last decade, private hospitals have driven efficiencies, just at the time when the age and complexity of patients has been increasing:

- The average length of stay in the private hospital sector has decreased by eight percent<sup>1</sup>
- The complexity of overnight patients in private hospitals has increased by nine percent<sup>2</sup>
- Total expenditure per separation has increased in real terms by less than three percent over the decade as whole and has, in fact, decreased in real terms in five of those years<sup>3</sup>
- In the year ending 30 September 2019, private health insurance benefits paid to private hospitals increased four percent, but this was entirely due to increased utilisation. The benefit paid per separation actually decreased in real terms<sup>4</sup>
- Expenditure growth in the public hospital system was 4.2 percent in real terms over 2014-15 to 2017-18. In the private hospital system it was only 2.6 percent<sup>5</sup>.

Costs have increased but so have health outcomes for patients, and cost increases would have been much worse if hospitals were not already driving efficiencies year-on-year. Contracts between health insurers and hospitals are renegotiated every two-to-three years giving insurers the opportunity to press for savings and increased efficiencies. Some health insurers also apply penalties incentivising private hospitals to ensure the best quality care.

The biggest driver of private health insurance outlays is utilisation. Annual utilisation of hospital cover has increased from 312 per 1000 people covered to 418 per 1000 people covered<sup>6</sup>. In summary:

- Consumers, particularly younger people, who perceive themselves less likely to need private health insurance are dropping their cover or electing not to take cover
- Consumers who retain private health insurance are using their cover
- The average age of the insured population is rising.

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<sup>1</sup> AIHW Admitted Patient Care, 2008-9 and 2017-18.

<sup>2</sup> AIHW Admitted Patient Care, various years.

<sup>3</sup> AIHW Admitted Patient Care, various years, Health Expenditure Australia, 2017-18

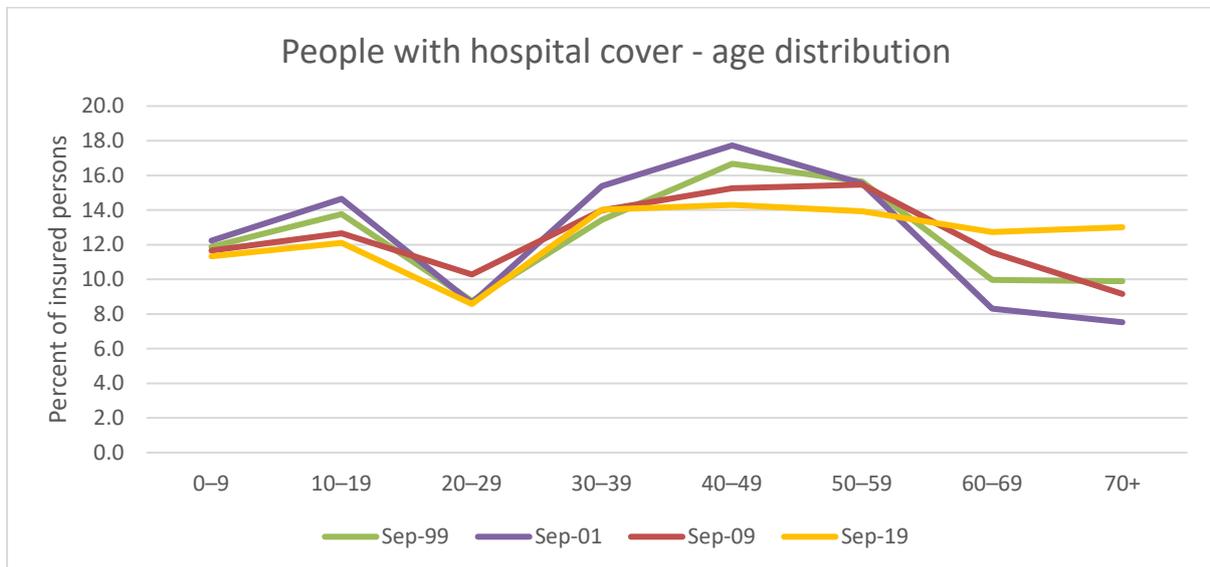
<sup>4</sup> APRA, Private Health Insurance Statistics

<sup>5</sup> AIHW Health Expenditure Australia, 2017-18

<sup>6</sup> APRA, Private Health Insurance Statistics

Left unaddressed these trends will likely exacerbate to the point where a growing number of people will be forced to rely exclusively on the already overburdened public health system.

Recent reforms introducing an age-based discount from 1 April 2019 have not increased youth private health insurance participation<sup>7</sup>.



In this context, three challenges must be met:

- The affordability of private health needs to be improved
- Consumers and taxpayers need to be assured of value
- The health sector, public and private, needs a workforce equipped for the future.

This submission outlines a comprehensive range of budget measures and other policy proposals to address each of these issues.

### **Affordability of private health needs to be improved**

The policy measures introduced 20 years ago to ensure affordability of private health insurance should be reviewed.

Households in lower and middle-income brackets need immediate relief from policy settings that penalise them unfairly with each annual premium increase.

Policies that were previously effective have, over time, been rendered ineffective either through lack of indexation or by failure to adjust in response to social trends. In some instances, policies designed to incentivise uptake of private health insurance now act to block that choice.

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<sup>7</sup> Department of Health, Private Health Insurance Reform Data

## Consumers and taxpayers need to be assured of value

Government, insurers and health service providers can work together to deliver greater value for consumers and taxpayers.

- The Medicare Benefits Schedule (MBS) Review is rightly reforming the benefits schedule and associated rules to reflect contemporary medical practice
- The agreement between the Federal Government and the Medical Technology Association of Australia (MTAA) outlines a program of reform that needs to be followed through to ensure technologies are made available at a realistic price and the Prostheses List reflects changes in medical technology
- Private health insurance benefits for treatment in a public hospital should only be claimable when the consumer has exercised a free and fully informed choice, and informed financial consent, to access treatment that would not have been provided them as a public patient (e.g. treatment by a doctor of their choice, not the doctor on call or assigned to them by the hospital).

Initiatives that help minimise the risk of potentially avoidable admission to hospital care focusing on key areas of risk should be more strongly incentivised. These include:

- Pharmacy services for consumers during a hospital admission and immediately following discharge
- Rehabilitation including rehabilitation-in-the-home services for patients referred for specialist rehabilitation care either following an acute episode of care or to address functional impairment
- Prompt and appropriate access to services for people with psychiatric conditions including:
  - outreach, day programs and community-based services for people discharged from private hospital admitted patient care.
  - access to medical and surgical treatment to address physical co-morbidities
- Palliative care services including home-based services.

The private health sector should be more transparent for consumers through the provision of:

- Information on medical out-of-pocket costs
- The availability of independent information and advice for consumers.

Government enabled systems on which the sector relies in order to deliver value to consumers requires further investment:

- The ECLISPE system supported by the Department of Human Services
- My Health Record.

## **The health sector needs a workforce equipped for the future**

University and vocational education and training enrolments for medical, nursing and allied health professions are at an all-time high. However, these graduates will be unable to enter their intended professions without adequate access to clinical placements.

The recently completed independent review of nursing education conducted by Emeritus Professor Steven Schwartz AM for the Federal Government has strongly recommended a greater emphasis and more funding, for clinical placements in nursing education<sup>8</sup>.

Skilled migration remains a crucial mechanism of last resort in meeting urgent skill shortages. Reforming skilled migration regulations will reduce the cost and complexity involved in recruiting skilled and experienced clinicians to positions that Australian graduates cannot fill.

- The charges to employers need to be reduced
- Pathways to permanent residency for highly skilled employees should be restored
- Government investment in training and workforce development needs to align with skill shortages.

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<sup>8</sup> Department of Health, 'Educating the Nurse of the Future—Report of the Independent Review into Nursing Education' Author: Emeritus Professor Steven Schwartz, Commonwealth of Australia 2019.

## **Key budget measures outlined in this submission**

**1. Restore the Private Health Insurance Rebate to 30 percent for households in the lowest income tier.**

Restoring the rebate for households in the lowest income tier to 2013-14 levels: 30 percent for under 65 year olds; 35 percent for 65-69 year olds and 40 percent for 70 year olds, would effectively reduce premiums for these households by between 2.02 percent and 3.67 percent. Cost: \$1.4 billion in 2020-21.

**2. Increase the Medicare Surcharge Levy**

Doubling the Medicare Surcharge Levy will provide a more realistic incentive to higher income households to invest in private health insurance. Estimated Revenue: up to \$260 million.

**3. Curb claims to private health insurance for private patients in public hospitals within the next national hospital funding agreement.**

Reduced private health insurance benefits for private patients in public hospitals would reduce health insurer outlays immediately, reducing upwards pressure on private health insurance premiums and the Private Health Insurance Rebate.

Saving: \$380 million.

This reform would also enhance the return provided to the Federal Government by the Private Health Insurance Rebate and allow redirection of public hospital resources to deliver better outcomes to public patients.

**4. Reduce avoidable hospital admissions by increasing remuneration through the Pharmaceutical Benefits Schedule (PBS) for hospital-based pharmacy recognising the essential role of pharmacists in supporting patient safety, preventing avoidable admissions and minimising wastage of high cost drugs.**

Cost: Dependent upon outcomes of the 7<sup>th</sup> Community Pharmacy Agreement.

**5. Reduce the administrative burden associated with implementation of the 1 April 2019 Private Health Insurance Reforms by upgrading the ECLIPSE system and updating and enforcing the ECLIPSE standards.**

**6. Ensure government initiatives to support e-health are appropriate and responsive to private hospital requirements, specifically in relation to My Health Record.**

**7. Increase funding for clinical placements for university and vocational education and training sector undergraduates.**

Cost: Dependent upon further analysis by relevant departments.

**8. Reduce the cost and complexity of skilled migration arrangements.**

Waive the Skilled Migration Levy for the sponsorship of registered nurses and midwives. Cost: \$2 million in foregone revenue to the Skilling Australia Levy.

# IMPROVING ACCESS TO AFFORDABLE HEALTHCARE

- **Restore the Private Health Insurance Rebate to 30 percent for households in the lowest income tier.**

Restoration of the 30 percent rebate for the lowest income tier would materially improve the affordability of private health insurance for those households. Currently, the lowest tier experiences the ‘double whammy’ of the increase of health insurance premiums and the reduction (due to Consumer Price Index adjustments) in the value of the private health insurance rebate.

In 2017–18 the full private health insurance rebate was restricted to single households with incomes of \$90,000 or less and families with incomes of \$180,000 or less (not including additional allowances for dependent children). For these lowest-income households, the maximum rebate for people under the age of 65 years has decreased from 30 percent in 2013–14 to just 25.059 percent in 2019–20.

**Impact of premium increases and rebate reductions on base tier households**

| Year<br>1 April -<br>30 March | Base tier<br>rebate | Industry<br>average<br>increase | Premium<br>before<br>rebate | Premium after<br>rebate | Increased<br>cost to the<br>consumer |
|-------------------------------|---------------------|---------------------------------|-----------------------------|-------------------------|--------------------------------------|
| 2013–14                       | 30.00%              | 5.60%                           | \$3,892.90                  | \$2,725.03              | 5.60%                                |
| 2014–15                       | 29.04%              | 6.20%                           | \$4,134.26                  | \$2,933.67              | 7.66%                                |
| 2015–16                       | 27.82%              | 6.18%                           | \$4,389.76                  | \$3,168.53              | 8.01%                                |
| 2016–17                       | 26.791%             | 5.59%                           | \$4,635.14                  | \$3,393.34              | 7.10%                                |
| 2017–18                       | 25.934%             | 4.84%                           | \$4,859.49                  | \$3,599.23              | 6.07%                                |
| 2018–19                       | 25.415%             | 3.95%                           | \$5,051.44                  | \$3,767.62              | 4.68%                                |
| 2019–20                       | 25.059%             | 3.25%                           | \$5,215.61                  | \$3,908.63              | 3.74%                                |
| 2020-21                       | TBA                 | 2.92%                           |                             |                         |                                      |

Source: APHA analysis using private health insurance rebates and income tiers as published by the Australian Taxation Office and the Department of Health.

This table shows that since 2014–15, the lowest income earners have experienced increased insurance costs that are significantly higher than the average premium increase, due to the ongoing erosion in the value of the rebate.

Seventy-five percent of private health insurance policy holders are in the base tier households. This tier has the greatest influence on private health insurance participation; shaping the trends that determine the sustainability of private health insurance. Yet current policy settings mean these households are the most affected by upwards pressure on health insurance premiums, even though they are the least able to absorb them.

This inequity could be addressed by one of two options:

1. Retaining the Private Health Insurance Rebate at the current effective level (i.e. 25.059 percent for people aged under 65 years) for households on the lowest income tier (under \$90,000 for singles and under \$180,000 for couples). This would protect these households from the 'double whammy' of an effective average increase of 2.92 percent and a decrease in the value of the rebate. Cost: \$100 million in 2020-21.
2. Restoring the rebate for households in the lowest income tier to 30 percent for under 65 year olds; 35 percent for 65-69 year olds and 40 percent for 70 year olds would effectively reduce average premiums for these households by between 2.02 percent and 3.67 percent. Cost: \$1.4 billion in 2020-21.

- **Reform to the Lifetime Health Cover Loading**

The Lifetime Health Cover (LHC) loading is applied to premiums paid by people who have not taken out and maintained private patient hospital cover from the year they turned 31 years old. When it was introduced in 2000, the policy was effective in persuading a significant percentage of the population to take out private health insurance at an age when they might otherwise have deferred this decision. However, the policy now acts as a deterrent to the growing number of people who have not taken out health insurance by the age of 31.

At the end of the March 2019 quarter, there were 933,275 people with a certified age of entry of more than 30 and subject to a LHC loading; a net decrease in people paying a penalty over the preceding 12 months of 63,770.<sup>9</sup>

Reform of this policy is a complex task because of the need to recognise that many people are liable for this loading or have been liable for it in the past. Failure to do so however, may result in a blowout in the number of uninsured people in higher age groups and an unsustainable burden on the public health sector.

Potential reform options for consideration include:

- Adjusting the LHC entry age
- Adjusting the LHC penalty level
- Conducting an amnesty for 12 months to allow people over the age of 31 to take out private health insurance without incurring a LHC penalty.

- **Reform to the Medicare Levy Surcharge**

The Medicare levy surcharge (MLS) is applied to Australian taxpayers who do not have an appropriate level of private patient hospital cover and earn above a certain income.

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<sup>9</sup> APRA Quarterly Statistics March Quarter 20sHRA

The MLS is designed to encourage individuals to take out private patient hospital cover, and to use the private hospital system to reduce demand on the public Medicare system. The MLS rate of one percent, 1.25 percent or 1.5 percent is levied on taxable income, total reportable fringe benefits and any amount on which family trust distribution tax has been paid.

In 2016-17, this surcharge levy was paid by 196,807 people. The average levy paid was \$1,308 and the median was \$1,027. This is less than the annual premium for a bronze level of cover for a single person, the minimum level of cover required to provide access to a private hospital.

If this incentive were increased to a more realistic level, those impacted would be more likely to take out private health insurance for themselves and their dependents, increasing the number of people with private health insurance by several hundred thousand.

Australian Private Hospitals Association (APHA) advocates that this levy should be reviewed and consideration given to whether an increase could make the policy more effective.

Doubling of the levy would increase the average amount paid to \$2,616, comparable to the premium for a bronze tier hospital cover policy for a couple. This measure could initially generate additional revenue of \$260 million. Revenue would be reduced if the reform achieved its intended effect of increasing participation in private health insurance.

# ENSURING THAT PRIVATE HEALTH DELIVERS VALUE

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## Appropriate claiming

- **Curb claims to private health insurance for private patients in public hospitals within the next national hospital funding agreement.**

APHA sees scope for major relief of upwards pressure on private health insurance benefit outlays through curbing claims for private patients in public hospitals.

Stopping public hospitals from ‘harvesting’ private patient revenue could save health insurers \$1.5 billion each year that would result in a six percent reduction in premiums<sup>10</sup>.

Ten percent of the total inflation-adjusted increase in private health insurance benefits outlaid for hospital care over the decade to 2017-18 is due to public hospitals chasing private health insurance revenue. During the decade, growth in private patients in public hospitals averaged 6.3 percent per annum, a rate of growth that exceeded the growth in number people covered by private health insurance and a rate that is only explicable by the aggressive and deliberate policies adopted by State governments<sup>11</sup>.

During the same period the increase in private patients in private hospitals and day surgeries averaged just 3.6 percent<sup>12</sup>. State governments have set revenue targets for public hospitals and allocated resources to the collection of private health insurance revenue even when the clinical care provided to the patient is identical to that which they would have received as a public patient.

This is a waste of private health insurance benefits – waste that has not delivered any benefits to patients.

States also use this practice in order to cost shift to the Commonwealth by claiming Medicare rebates for the medical services provided to patients.

This practice is also a waste of government resources, diverting them away from patient care to revenue generation. The Victorian Auditor-General this year found that public hospitals did not know the cost of this activity and could not accurately measure the net

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<sup>10</sup> AIHW, Health Expenditure, APRA Private Health Insurance Statistics

<sup>11</sup> AIHW Admitted Patient Care, various years.

<sup>12</sup> AIHW Admitted Patient Care

financial result<sup>13</sup>.

Curbing of wasteful private health insurance benefits for public hospital services will require a comprehensive policy framework. APHA advocates:

- A removal of the rebate on 'public hospital only' (basic tier) policies as these products only provide access to public hospitals
- Removal of the obligation for private health insurers to pay for private patients treated in public hospitals
- Strengthened patient election provisions
- Removing financial incentives for public hospitals to admit insured patients ahead of public waiting list patients.

The potential saving from these reforms is \$380 million per year in reduced payments of the Private Health Insurance Rebate.

Key facts:

- Private patients took up three million days of care in public hospitals, an estimated 14.7 percent of all public hospital days of care in 2017–18, more than 1.7 times the share from a decade ago (9.6 percent in 2007–08). This equates to more than 8,000 public hospital beds.
- In 2017–18, 905,599 Australians used private health insurance payments in public hospitals, according to the Australian Institute of Health and Welfare (AIHW). This was 13.5 percent of all public hospital admissions.
- In many individual public hospitals, the proportion of patients admitted privately is far higher – up to 41 percent.
- Transferring the more than 100,000 surgeries (elective and emergency) currently performed on private patients in public hospitals to private hospitals, would increase the number of public patient elective surgeries by 15 percent.
- About half (49 percent) of all private patient admissions in public hospitals are for emergency care, and in some states these percentages are much higher. However, many of those privately insured emergency patients could have been transferred and treated in a private hospital, freeing up beds, reducing ambulance ramping and lessening pressure on public emergency departments. Public hospitals do nothing to facilitate such transfers.
- Choice for private patients is limited when admitted through a public emergency department. Patients are treated by the available clinicians, so there is no real choice of doctor for the privately insured.

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<sup>13</sup> Victorian Auditor General

- **Implement evidence-based reform of the Prostheses List to ensure technologies are made available at a realistic price and the Prostheses List reflects changes in medical technology.**

APHA supports fully implementing the agreement between the Federal Government and the MTAA signed in 2017 (the Agreement).

APHA is working with the Department of Health and other stakeholders on the review of the General and Miscellaneous Category of the Prostheses List announced in late 2019.

APHA strenuously opposes the removal of low unit cost items from the Prostheses List, which would amount to an uncompensated cost shift to private hospitals.

When announced, the Agreement was forecast to deliver a reduction in projected private health insurance benefit outlays \$1.1 billion over four years<sup>14</sup>. As a consequence of the Agreement:

- Prostheses benefit outlays for the 'premium year', the year ending 31 March 2018, fell 0.3 percent while the number of claims increased, marginally above the long term average, by 9.5 percent
- Prostheses benefit outlays for the year ending 30 September 2019 increased just 1.5 percent, while prostheses claims increased 8.4 percent.

These results were delivered while at the same time adding important life-saving, but high cost, technologies to the Prostheses List, including catheters used in the treatment of atrial fibrillation.

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<sup>14</sup> Total savings from reductions made in the period 2018 to 2021. Department of Health website accessed on 19 December 2019.

<https://www1.health.gov.au/internet/main/publishing.nsf/Content/private-health-insurance-reforms-fact-sheet-prostheses-list-benefit-reductions>

## Reduction in avoidable hospital admissions

- **Reduce avoidable hospital admissions by introducing appropriate remuneration through the PBS for hospital-based pharmacy, recognising the essential role of pharmacists in supporting patient safety, preventing avoidable admissions and minimising high cost drugs waste.**

Medicine-related problems cause 250,000 hospital admissions and 400,000 emergency department presentations in Australia each year, costing the healthcare system \$1.4 billion annually. At least half of this harm is avoidable.

Medicine-related problems are a major cause of hospital acquired complications and unplanned readmission to hospital, thereby contributing to the cost of hospital care and pressure on private health insurance.

Over the years, price disclosure has dramatically reduced the 'terms of trade' available to pharmacies dispensing PBS drugs. These 'terms of trade' previously enabled pharmacy services to fund the clinical services provided by pharmacists in providing expert advice to clinicians and patients and intervening to prevent medication-related harm. These costs cannot be realistically absorbed by private hospitals or passed on to private health insurers when both sectors are already committed to containing costs to the consumer.

The sustainability of hospital-based pharmacy services was placed under further pressure when the 2019-20 Federal Budget reduced the wholesale mark-up payable to Section 94 pharmacies for Section 85 drugs. The impact of this change varied across the private hospital sector because of the different ways pharmacy services are structured. Many pharmacy services are provided through Section 90 arrangements, but some are reliant on Section 94 arrangements. The impact of this change was most severe on hospitals dispensing significant quantities of high cost Section 85 drugs under Section 94 licences. These drugs include therapies used to treat cancer patients. The unintended consequence of this change was to force highly specialised pharmacy services treating complex patients to reduce their level of professional staffing.

In order to place hospital-based pharmacy on a sustainable footing and to ensure patient-centered care, safety and the minimisation of avoidable hospital presentations, APHA advocates:

- Extension to private sector Section 94 pharmacies of existing administration and handling charges that apply to Section 90
- Permission for Section 94 pharmacies to dispense to non-inpatients, thereby supporting continuity of care and reducing risk of readmission
- Access to provision of medication review funding (noting that medication review programs are likely to be reviewed)
- Incentives to promote the uptake of biosimilars.

- **Reduce avoidable hospital readmissions by providing insurance cover for patients admitted for day procedures, but not stable enough for same-day discharge because of travel distance or lack of home/medical support.**

Improvements in technology and surgical technique have increased the range of services provided on a day-admission basis. The number of these admissions is increasing. This trend reduces the cost of such procedures and is incentivised by the Private Health Insurance Rules that classify specific MBS items as day procedures or procedures that do not usually require a hospital admission.

Although the Rules provide for certification where there is a clinical reason the patient needs to be admitted on an overnight basis, there is no recognition of patients who would be ready for discharge but are not well enough to travel long distances or lack home/medical support.

Amendment of the Rules to allow for overnight admission of these cases would reduce the risk of readmissions and improve patient safety.

- **Remove barriers to consumer-centred models of care by introducing a default benefit for day /community based/home-based programs for rehabilitation, mental health and palliative care that reduce the risk of hospital readmission.**

Consumer-centred care involves the delivery of care in the most appropriate setting. Existing private health insurance regulations already recognise hospital services can include services provided in the community or home. However, the expansion of such services is impeded by a lack of support from private health insurers.

The Department of Health's Private Hospital Data Bureau (PHDB) reports that 74,209 separations involving a charge for hospital-in-the-home care were delivered in 2017-18. According to the same source, these separations account for 1.7 percent of all those delivered that year. According to the Department of Health's Hospital Casemix Protocol Annual Report for 2017-18, 25,565 private sector hospital-in-the-home separations were funded through private health insurance, just over a third of the private sector hospital-in-the-home separations reported by the PHDB.

Although this type of service has been increasing, it is still only a tiny proportion of the services delivered by private hospitals and the contribution of private health insurance to funding such services remains minute. Hospital-in-the-home services and other outreach services have many potential benefits for patients, particularly in relation to mental health, rehabilitation and palliative care.

Unlike admitted hospital care, there is no provision for minimum default benefits for day programs or home-based services in mental health, rehabilitation and palliative care. Consequently, consumers can only access these programs if their insurer has contracted with the hospital to cover them.

Even when hospitals have put forward evidence-based proposals for outreach and home-based programs and participated in trials, these trials have not translated into ongoing programs because of lack of financial support from health insurers.

Providing default benefits for day programs in mental health, rehabilitation and palliative care would ensure consumers' care options were not restricted by their choice of insurer and mean they could access to the most efficient and clinically appropriate care pathway.

Providing default benefits for community-based and home-based programs would enable hospitals to establish these programs on a sustainable basis, delivering consumers the services they require and reducing the risk of avoidable hospital readmission.

- **Create a level and well regulated playing field for hospital and non-hospital providers – i.e. government endorsed guidelines assuring minimum quality standards.**

Private health insurance regulations allow non-hospital providers to be paid benefits for 'Hospital Substitute Treatment'. Some insurers have advocated for reforms to allow growth in the provision of services by non-hospital providers. If this expansion is permitted, consumers need to be assured these services are provided to the same level of safety and quality required of hospitals.

Hospitals must meet the National Safety and Quality Health Service Standards. Hospitals providing mental health and rehabilitation services are also obliged to meet the requirements of industry-agreed guidelines. These guidelines were developed with the involvement and endorsement of the Federal Government. The Improved Models of Care Committee recognised these guidelines provided a logical starting point for a common framework applicable for both hospital and non-hospital services.

If the Federal Government chooses to encourage the expansion of services by non-hospital providers into other areas such as chemotherapy-in-the-home, it is essential providers should also be required to meet the National Safety and Quality Health Service Standards and specific guidelines relevant to the services involved.

- **Remove barriers for people with a mental health conditions accessing acute medical/surgical care in the private sector.**

The National Mental Health Commission's Equally Well consensus statement aims to reduce the life expectancy gap that exists between people living with a mental illness and the general population by championing the importance of the physical health of

people living with a mental health condition<sup>15</sup>. This aim is reflected in the Fifth Mental Health Agreement.

The private hospital sector plays a crucial role in providing timely access to acute psychiatric care. As such, private hospitals frequently encounter situations where people living with a psychiatric condition need access to acute medical/surgical care. However, the way in which private health insurance benefits are paid to hospitals means it is frequently difficult for these patients to access medical and surgical care in the private sector, even when they have Gold level hospital cover.

The Federal Government's Private Health Insurance Rules assume a patient is either a psychiatric patient or not a psychiatric patient. The regulations do not admit the possibility that a patient might require both medical and psychiatric treatment. As a consequence, health insurers refuse to cover the provision of medical treatment if, in their view, the patient is a psychiatric patient.

Resolution of these difficulties would improve health outcomes for people living with a mental illness. Timely access to acute medical/surgical care would also decrease the risk of subsequent hospital admissions.

APHA advocates for the amendment of the Private Health Insurance (Benefit Requirements) Rules 2011 to recognise:

- There are circumstances where a patient admitted for mental health treatment may also require cover to medical/surgical treatment, including the provision of mental health treatment and medical/surgical treatment on the same day
- There are circumstances where a patient may need to be transferred from a private psychiatric facility to a medical/surgical facility in order to be concurrently treated for both mental and physical conditions
- There may be circumstances where a patient may need to receive medical treatment for a physical condition within a psychiatric facility
- There may be circumstances where a patient admitted to a medical/surgical facility for medical/surgical treatment may concurrently require mental healthcare
- There may be circumstances where a patient requires concurrent physical rehabilitation and mental healthcare.

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<sup>15</sup> National Mental Health Commission, Equally Well Equally Well Consensus Statement: Improving the physical health and wellbeing of people living with mental illness in Australia. Sydney NMHC, 2016.

## Evidence-based Care

- **Ensure MBS Review recommendations facilitate the delivery of consumer-centred care and good clinical practice in private sector settings.**

APHA has contributed to MBS Review consultations to ensure recommendations support the provision of appropriate evidence-based care in the private hospital sector.

Thus far, MBS Review reforms have led to restrictions on the frequency with which colonoscopies can be performed. Clinical committee reports for many services provided by private hospitals have yet to be considered by the Federal Government.

- **Ensure changes to the MBS are appropriately translated to Private Health Insurance Rules and information/education for doctors.**

APHA is an active participant in the implementation liaison advisory groups established to support the implementation of MBS Review recommendations.

Some health insurers have advocated for some MBS items classified as overnight procedures to be re-classified as day procedures, for the purposes of the Private Health Insurance Rules. APHA is examining each recommendation on a case-by-case basis to ensure recommendations are evidence-based and are (or can be) smoothly implemented in the private sector without the risk of unintended consequences. Such unintended consequences would include:

- An unacceptable administrative burden if MBS items were incorrectly classified for the purposes of the Private Health Insurance Rules
- Increased out-of-pocket charges by doctors
- Cessation of services in the private sector and a consequent increased burden on the public system.

## Consumer Experience

- **Ensure transparency of information on out-of-pocket costs by progressing with the already announced information portal.**

APHA supports the Federal Government's initiative to establish an online portal where consumers can access comparative information on specialists' fees for services and out-of-pocket charges - see the commitment made in the 2019-20 Federal Budget.

- **Protect consumer choice and transparency regarding factors influencing availability of care options and doctor referrals/treatment recommendations.**

APHA is aware of attempts by some health insurers to incentivise doctors to make particular referrals or treatment recommendations either through the design of remuneration arrangements or through limiting cover of treatment options. For example, some doctors are offered increased payments by health insurers to admit a patient to a day hospital rather than an acute hospital.

APHA advocates that, in the interests of transparency, consumers should be made aware of such incentives and limitations where they exist.

- **Address risks arising from vertical integration within private health insurance.**

Several health insurers have acquired companies that provide health services including companies that provide 'hospital substitute' services. As has been seen in the financial services sector, vertical integration can lead to adverse outcomes for consumers where financial incentives exist for service providers.

APHA advocates that, in the interests of transparency, consumers should be made aware of such vertical integration and incentives where they exist. This will minimise the opportunity for health insurers to force a patient into a care pathway that is in the financial interest of the fund, rather than the clinical interests of the patient.

- **Ensure availability of independent and accurate advice and information**

All reform processes require an ongoing commitment to the provision of independent and accurate advice and information for consumers.

## Administrative Efficiency

- **Reduce the administrative burden associated with implementation of the 1 April 2019 Private Health Insurance Reforms, i.e. upgrade the ECLIPSE system and update and enforce ECLIPSE standards**

Implementation of the reforms to private health insurance from 1 April 2019 has placed significant strain on the ECLIPSE system. Specifically the ECLIPSE online eligibility-checking platform is no longer fit for purpose.

Although some minor changes to codes used for online eligibility checking were implemented prior to 1 April 2019, these modifications were not sufficient to avoid the need for extremely high levels of manual and telephone-based checks. This has meant:

- A very significant administrative burden for both hospitals and private health insurers
- Diminished quality of informed financial consent processes because of incomplete information.

The Department of Human Services maintains the ECLIPSE system but there has not been any development work on the online eligibility-checking platform since its inception.

Several problems need to be addressed:

- The ECLIPSE online eligibility-checking platform needs to be redesigned
- ECLIPSE standards need to be revised
- ECLIPSE standards need to be enforced so health insurers are obliged to use the system consistently and provide the required information.

An immediate improvement to the ECLIPSE on-line eligibility-checking platform would be to include the information private health insurers are required to provide to the Commonwealth Ombudsman for each private health insurance product available to Australian consumers.

The standardised format for this information has already been specified, it is used to populate the searchable comparator website [privatehealth.gov.au](http://privatehealth.gov.au). When combined with consumer specific information already provided through ECLIPSE, this single change would ensure that hospitals, consumers and health insurers had access to a common and consistent source of information regarding the coverage provided by each insurance policy.

This work will require allocation of financial resources by the Federal Government but it could be incorporated within the upgrade of the ECLIPSE system to which the Department of Human Services has already committed.

This enhancement would improve the experience of consumers by ensuring the provision of efficient and consistent advice. It would also support the administrative

efficiency in hospitals and health insurers and there-by relieve upwards pressure on health insurance premiums.

- **Ensure government initiatives to support e-health are appropriate and responsive to private hospital requirements specifically in relation to My Health Record.**

As at the end of November 2019, 94 percent of public hospital beds were registered to use My Health Record. These facilities are viewing an average of 80,000 records per month and uploading up to a million documents every month. No recent data has been reported by the Australian Digital Health Agency in respect of the private hospital sector<sup>16</sup>.

As at May 2019 (the most recent information available to APHA), there were only 183 private hospitals and 'clinics' registered to access and/or upload information to My Health Record. To put this result in context, there are about 657 private hospitals in Australia made up of:

- 300 overnight hospitals
- 357 day hospitals

On this basis, APHA estimates less than 70 percent of overnight private hospital beds and less than 30 percent of day hospital beds are registered. This level of registration must be significantly increased to realise the benefits to the health system as a whole.

Apart from a small number of pilot project grants made available to some private hospital groups, there has been virtually no support provided to enable the private hospital sector to participate in the rollout and implementation of My Health Record. It is notable that the uptake of access to My Health Record has focused on the corporate groups that accessed pilot project assistance.

As a consequence further expansion of registrations to cover the remaining 30 percent of overnight hospital beds and 80 percent of day hospitals will be slow without government support.

Full engagement requires a major investment in software, training and information technology. While private hospitals could play a major role in uploading information to My Health Record, it can be difficult for private hospitals to demonstrate a return on their investment required from accessing information.

The benefit of hospitals registering with My Health Record is realised outside the hospital, not inside. This challenge is reflected in data produced by the Australian Digital

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<sup>16</sup> Australian Digital Health Agency, My Health Record Statistics and Insights, March 2019 to November 2019  
[https://www.myhealthrecord.gov.au/sites/default/files/mhr\\_stats\\_marchnovember2019.pdf?v=1576471841](https://www.myhealthrecord.gov.au/sites/default/files/mhr_stats_marchnovember2019.pdf?v=1576471841)

Health Agency that demonstrates that public hospitals upload 12 documents for every one view accessed within the hospital<sup>17</sup>.

The Federal Government has provided a generic portal-based service that allows private hospitals to access information on the My Health Record system. While this option provides an affordable point of entry, the utility for private hospitals and patients is limited because this option does not allow hospitals to upload information.

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<sup>17</sup> Ibid.

## Accountability and Reporting

- **Auspice an industry wide agreement regarding auditing.**

Health insurers have the right to audit claims for benefits to ensure protection from fraud or inappropriate claiming. However, in recent years health insurers have adopted audit practices that are excessive and onerous. Frequently health insurers demand retrospective audits over several years and may even seek to apply rules and criteria to claims that pre-date these arrangements. The administrative costs associated with responding to these audit processes divert resources away from the delivery of patient care.

Health insurers use different criteria and 'business rules' with the result that hospitals must implement complex administrative arrangements to ensure that each insurer's requirements are complied with.

Consistency in approach would reduce administrative costs for both hospitals and health insurers.

Auspicing by Federal Government would provide consumers with assurance that benefits are paid in a transparent and consistent manner. It would also allow the Government to ensure auditing criteria are consistent with the MBS in promoting evidence-based care delivery.

- **Remove duplication and increase standardisation in reporting to governments and insurers.**

Private hospitals are required to meet a multitude of reporting and regulatory requirements at both state and federal level. They are also required to meet reporting requirements imposed by insurers and other payers. Many of these requirements are duplicative of the requirements already enforced through the National Safety and Quality in Health Service Standards.

Removal of duplication and standardisation in reporting requirements would reduce administrative overheads enabling resources to be directed to patient care.

- **Auspice an industry wide agreement by government re data/performance reporting.**

The private hospital sector has been an active contributor to the process led by the Australian Commission for Safety and Quality in Health Care (ACSQHC) to provide advice to Australian Health Ministers Advisory Council (AHMAC) on the development of a framework for the public performance reporting across both public and private sectors. Private health insurers are also represented in this process.

APHA advocates that continued work towards a single reporting platform, auspiced by government, would provide a useful service to consumers and reduce the waste and

duplication of resources which arises from the diverse and duplicative demands of individual health insurers and government agencies.

In addition to the administrative burden, the lack of a consistent framework means resources are diverted away from focussing on collection of consistent data required to drive continuous improvement in patient care and transparency for consumers.

- **Implement the National Strategy on Clinical Registries**

Although this objective does not link directly to private health insurance reform, it is related to the wider issue of data reporting for both clinical improvement and transparency/provision of information to consumers. APHA supports the National Strategy and has welcomed the opportunity to be represented on the implementation advisory committee.

# EQUIPPING THE HEALTH SECTOR FOR THE FUTURE

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- **Continue to work with the private sector to provide training opportunities that would otherwise not be available.**

Government support for training opportunities should be expanded, including:

- Medical internships and junior doctor placements
- Specialist registrar training
- Student placements for medical, nursing and allied health undergraduates.

Australia's future medical workforce faces four challenges:

- Retention of Australian trained graduates and provision of adequate opportunities for junior doctors to complete internships and acquire relevant experience
- Attraction and retention of doctors to regional areas
- Attraction and retention of trainees to specialties in shortage
- Provision of opportunities to equip trainees with the skills they need for their future careers, including exposure to procedures and practices in the private sector.

University and vocational education and training enrolments are at an all-time high for medical, nursing and allied health professions. However, these graduates will be unable to enter their intended professions without adequate access to clinical placements.

The recently completed independent review of nursing education conducted by Emeritus Professor Steven Schwartz AM for the Federal Government has strongly recommended a greater emphasis and more funding for clinical placements in nursing education:

- **Recommendation Seven:** To ensure quality and equity, the Nursing and Midwifery Board of Australia (NMBA) and Australian Nursing and Midwifery Accreditation Council (ANMAC) should consider implementing an accreditation system for clinical placements. Only practice hours spent in accredited placements should count toward meeting practice hour requirements.
- **Recommendation Eight:** Given rising clinical placement charges and the cost of accrediting professional placements (see Recommendation Seven), the Department of Education should review the costs and funding of undergraduate nursing education to ensure it is adequate to provide high-quality theoretical and clinical education.

- Recommendation Ten: To ensure that all nurses are adequately prepared, ANMAC and the NMBA should increase the minimum number of placement hours required for the Bachelor of Nursing degree to 1,000 hours. ANMAC/NMBA should also increase the minimum number of placement hours required for Enrolled Nursing diplomas and graduate-entry master's degree programs proportionately<sup>18</sup>.

These important recommendations come at a time when there are not enough quality clinical placements for university and Vocational Education and Training (VET) sector students. Notwithstanding the points made in the report about the need to prepare graduates to enter a diversity of roles including roles in primary care, the hospital sector, including the private hospital sector, will remain a crucial training environment.

APHA estimates that in 2014–15, private hospitals provided:

- 40,400 days of clinical placement for medical students
- 304,800 days of clinical placement of nursing and midwifery students
- 28,900 days of clinical placement for allied health students<sup>19</sup>.

These figures demonstrate the private hospital sector has a vital role in meeting Australia's clinical workforce challenges by:

- Providing placements for university and vocational education and training students
- Providing graduate placements for nurses and allied health professionals
- Providing internships and junior doctor positions for medical graduates
- Providing registrar positions to train future medical specialists
- Supporting staff to acquire postgraduate and research qualifications
- Providing training opportunities not readily available in the public sector.

In 2015, the private hospital sector spent an estimated \$167 million on training medical, nursing, midwifery and allied health staff. In fact, the private sector plays a particular role in providing training in health areas not readily available in the public sector, including many areas of surgery, mental health and rehabilitation<sup>20</sup>.

If the private sector is to play an even greater role in meeting these future challenges at time when it is also committed to keeping the cost of hospital care as affordable as possible, it will need financial support from Government to provide additional quality clinical training opportunities.

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<sup>18</sup> Department of Health, 'Educating the Nurse of the Future—Report of the Independent Review into Nursing Education' Author: Emeritus Professor Steven Schwartz, Commonwealth of Australia 2019.

<sup>19</sup> Australian Private Hospitals Association and Catholic Health Australia, Education and training the private hospital sector, Canberra 2017

<sup>20</sup> Ibid.

- **Reduce the cost and complexity of skilled migration arrangements.**

Reforming skilled migration regulations will reduce the cost and complexity involved in recruiting skilled and experienced clinicians to positions that Australian graduates cannot fill.

- The charges to employers need to be reduced
- Pathways to permanent residency for highly-skilled employees need to be broadened
- Government investment in training and workforce development needs to align with skill shortages.

National data shows in aggregate, there has been no evident shortage of registered nurses since 2011 and enrolled nurses since 2012. Shortages in midwifery have been “patchy” and regional. However, the Department of Jobs and Small Business reports internet vacancies are now at an all-time high and APHA member hospitals already experience persistent difficulties in recruiting experienced nurses to take on specialised roles including:

- Surgical
- Critical care
- Peri-operative
- Cancer care
- Mental health
- Midwifery
- Nursing manager roles.

The Department of Employment found nearly 80 percent of all qualified registered nurse applicants in New South Wales were considered by employers (all sectors) as either lacking the minimum level of experience required or lacking experience in the modality required<sup>21</sup>.

The Department of Jobs and Small Business has said employment in the healthcare and social assistance industry (a major employer of health professions) will expand at double the pace of all industries over the five years to May 2023<sup>22</sup>. The Royal Commission into Aged Care is likely to highlight the need to address skill shortages in the aged care sector creating further demand for skilled and experienced clinicians, particularly nurses, across both sectors.

Migration remains an essential strategy for employers in recruiting to roles that require specialised skills and experience, particularly registered nurses and midwives. As at 30

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<sup>21</sup> Department of Employment – Registered Nursing June 2017

([https://docs.jobs.gov.au/system/files/doc/other/2544registerednursesnsw\\_2.pdf](https://docs.jobs.gov.au/system/files/doc/other/2544registerednursesnsw_2.pdf))

<sup>22</sup> Labour Market Research, Health Professions, Australia, 2017–18, September 2018

<https://docs.jobs.gov.au/documents/health-professions-australia>

September 2019 there were 2,225 registered nurses on skilled worker visas. They included 1,431 working in specialist areas relevant to private hospitals as summarised in the following table.

**Registered nurses in selected areas relevant to the private hospital sector<sup>23</sup>**

|                | Australia |
|----------------|-----------|
| Critical Care  | 352       |
| Medical        | 386       |
| Mental Health  | 191       |
| Peri-operative | 219       |
| Surgical       | 235       |
| Paediatrics    | 48        |
| Total          | 1,431     |

Reforms to skilled migration in 2018 dramatically increased the cost to employers of sponsoring skilled employees' migration. While acknowledging the Federal Government needed to act to address damaging unintended consequences in some sectors, APHA contends the impact on the health sector has been detrimental.

There is no longer the possibility of retaining skilled and valued employees beyond the initial visa period. Consequently, not only employers but the health sector as a whole, loses the benefit of several years' investment in these individuals; personnel essential to the provision of high quality healthcare.

The loss of highly skilled and experienced employees also reduces the capacity of private hospitals to train the next generation of Australian healthcare professionals.

The Skilling Australia Fund provides no benefit to the health sector because it does not provide funding for university and post-graduate level programs of the type needed to address skill shortages. It does nothing to reduce reliance of skilled migration or develop the Australian health sector workforce.

Without a ready supply of well-trained and experienced clinicians, consumers will inevitably face challenges in accessing timely and affordable high quality care. Furthermore the sectors' ability to training and mentor Australia's future workforce will be constrained.

In the nine months to 30 September 2019, there were 296 temporary resident (skilled) visas granted to registered nurses, a dramatic reduction on past years. This reduction suggests that the increased costs to employers has sharply reduced sponsorship of skilled nurses into Australia.

The cost to an employer (annual turnover of \$10 million or more) includes a skill levy of \$7,200. This levy does nothing to reduce the reliance of the Australian health sector on

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<sup>23</sup> Department of Home Affairs: Temporary resident (skilled) visa holders  
<https://data.gov.au/dataset/ds-dga-2515b21d-0dba-4810-afd4-ac8dd92e873e/details?q=>

immigration. If this levy was abolished, skilled migration sponsorship would once again be a viable option for employers. Sponsorship of skilled registered nurses would benefit Australia in two ways:

- Persistent shortages in skilled and experienced registered nurses would be met
- The capacity of the private health sector to provide clinical placements for nursing students and induction programs for early career nurses would be enhanced because of the increased availability of skilled and experienced nurses to provide supervision.

Judicious use of skilled migration makes sense in the health sector in order to address both present and future skill needs.

The estimated costs of waving this levy for the sponsorship of registered nurses and midwives would be around \$2 million in foregone revenue to the Skilling Australia Levy.

# PRIVATE HOSPITALS IN AUSTRALIA

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The private hospital sector makes a significant contribution to health care in Australia, providing a large number of services and taking the pressure off the already stretched public hospital system.

The private hospital sector treats:

- 4.5 million hospitalisations a year.

In 2017–18 it delivered:

- 60% of all surgery
- 71% of eye procedures
- Almost half of all heart procedures
- 74% of procedures on the brain, spine and nerves.

Australian private hospitals by the numbers (2016–17):

- Almost half (49%) of all Australian hospitals are private
- 657 private hospitals made up of:
  - 300 overnight hospitals
  - 357 day hospitals
- That amounts to: 34,339 beds and chairs (31,029 in overnight hospitals and 3,310 in free-standing day surgeries)
- Employs more than 69,000 full-time equivalent staff.

## **The Australian Private Hospitals Association**

The Australian Private Hospitals Association (APHA) is the peak industry body representing the private hospital and day surgery sector. About 70% of overnight hospitals and half of all day surgeries in Australia are APHA members.