Australian
Private Hospitals
Association

Private health insurance reform

15 AUGUST 2023

CONTENTS

Introduction

The Australian Private Hospital Association's (APHA) response to the reports released for comment by the Department of Health and Aged Care in June 2023 is framed in the context of an acute financial viability crisis being faced by the Australian private hospital sector.

The Australian private hospital sector, providing 40 percent of acute care services and 60 percent of surgery, is facing a challenging environment which many operators are describing as the worst in living memory. A range of factors are converging and impacting the sector as a whole, including:

- The after effects of COVID-19 on financials, depressed levels of activity, changes in clinical practice and risk mitigation requirements.
- Slowed growth in activity (from 2018 onwards) and delayed/uncertain recovery post-COVID.
- Serious and worsening workforce shortages across medical, nursing and allied health to the point where this is a rate-limiting factor on activity.
- Potentially profound changes in specialist practice in some areas e.g. psychiatry.
- Steep cost increases due to general inflation and a range of sector specific issues.
- Pressures to invest in systems and infrastructure to update/replace assets, meet new standards/accreditation/compliance requirements, implement strategies to increase efficiency coupled with impaired capacity to raise additional capital.
- Delays by health insurers in indexation of payments to private hospital and a failure of indexation to meet rising costs.

The context in which these reports have been released for consultation is vastly different from the one in which they were first commissioned. Private health insurance participation has risen and while there are emerging concerns around cost-of-living pressures, demand for private health care remains strong, particularly amongst people keen to avoid public elective surgery waiting lists. This keenness is reflected not only in the growth in private health insurance participation but also the willingness of consumers to self-fund care in the private hospital sector.

Where previously the government prioritised concerns for the sustainability of private health insurance, now closer attention must be placed on the viability of private hospitals, without which the value proposition of PHI will fail and, moreover, an even greater burden will fall back on the public hospital system, inevitably resulting in pressure on the Commonwealth to increase hospital funding to the states.

The following table summarises APHA's position on the reforms which should be carried forward in the immediate and medium term, and those issues which require further consideration. Importantly these priorities include recommendations that were not made in the reports released for consultation, but which have emerged as being of increased importance in light of the challenges now faced by the sector.

FOR IMMEDIATE IMPLEMENTATION

- Volume weighted approach for determining contract averages (EY Consulting).
- Address issues with hospital categories and known ambiguities in regulatory interpretation (APHA).
- Introduction/trial of default benefits for out of hospital services provided by hospitals (APHA).

MEDIUM TERM IMPLEMENTATION (NOTING THAT WORK SHOULD COMMENCE IMMEDIATELY TO ACHIEVE THIS TIMELINE)

- Harmonisation of existing requirements between the Commonwealth, states/territories, insurers and other funders to remove all unnecessary duplication of existing requirements (APHA).
- Improvement of efficiency in transactions and business practices between hospitals and health insurers and hospitals and government agencies (APHA).
- Reforms to reduce the administrative burden and risks associated with claim assessment and retrospective audits conducted by private health insurers.
- Increased accountability for private health insurers for their obligations under the Private Health Insurance Act and for actions which impose unreasonable financial pressures on private hospital operators (APHA).

FURTHER CONSIDERATION REQUIRED

- Standardised operational expectations for all hospitals (subject to successful implementation of harmonisation of existing requirements) (EY Consulting).
- A process for independently setting default benefits (EY Consulting).
- A single level of default benefits (EY Consulting).
- More radical funding reforms including:
    - The role of patient gaps in the private sector including gaps charged by hospitals in balancing the affordability and sustainability (APHA)
    - Capitation models for sub-acute care and chronic disease management (APHA).

The financial viability crisis

THE CURRENT SITUATION

- Data for the financial year 2021-22 shows that the private hospital sector is in a state of significant and system-wide vulnerability and anecdotal feedback suggests that this situation has continued to worsen.
    - Data from the Australian Bureau of Statistics shows that for FY 2021-22, only 30.1 percent of businesses in the private hospital sector achieved a break-even or better result. This is down from 88.9 percent in financial year (FY) 2019-20 and 93 percent in FY 2020-21.
    - For the sector as a whole, the profit margin (operating profit before tax: sales and service income) as a whole was only one percent in 2021-22, compared with a high of 9.6 percent in 2017-18.
    - APHA members across the board report the current situation as being the worst in living memory.
    - APHA is aware of a growing number of hospitals forced to close, sell or significantly restructure their operations:
        - Healthscope has turned two private hospitals over to be run as public hospitals under contract to the Victorian government.
        - Healthscope has closed a psychiatric facility in Tasmania.
        - Sportsmed in South Australia has sold a significant facility of long standing, specialising in orthopaedic surgery, to Burnside War Memorial Private Hospital.
        - APHA is aware of seven psychiatric hospitals at risk of imminent closure in addition to facilities that have already closed.

- By contrast, data from the Australian Prudential Regulatory Authority shows:
    - Private health insurance sector recorded a gross margin of 16.9 percent and a net margin of 7 percent for 2021-22. Very similar levels were maintained for the year ending March 2023.
    - Of the 34 insurers reporting data to APRA only four funds, all of them very small, failed to break even in 2021-22.
    - As at 30 June 2022, the private health insurance sector held total assets of $19.8 billion and liabilities of only $9.9 billion.

- The following table shows that the sector is in a worse position than other comparable sectors including residential aged care.

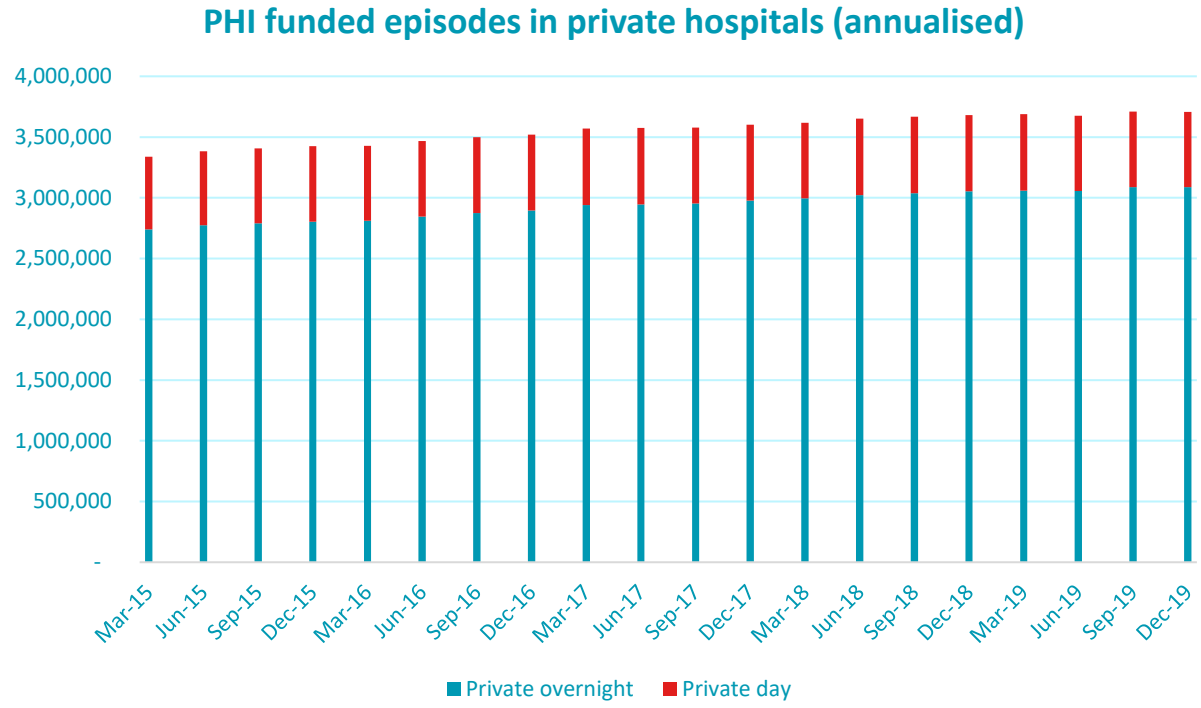
Table 1: The Percentage of businesses (ABN's) reporting a profit or break-even result

	2019-20	2020-21	2021-22
Hospitals (private)	88.9	93.0	30.1
Medical and other health care services (private)	91.9	92.5	90.5
Residential care services (private)	72.4	48.5	43.1
Social assistance services (private)	85.7	75.4	77.8
Total health care and social assistance (private)	90.5	89.1	87.2
Total selected industries	80.3	81.1	79.9

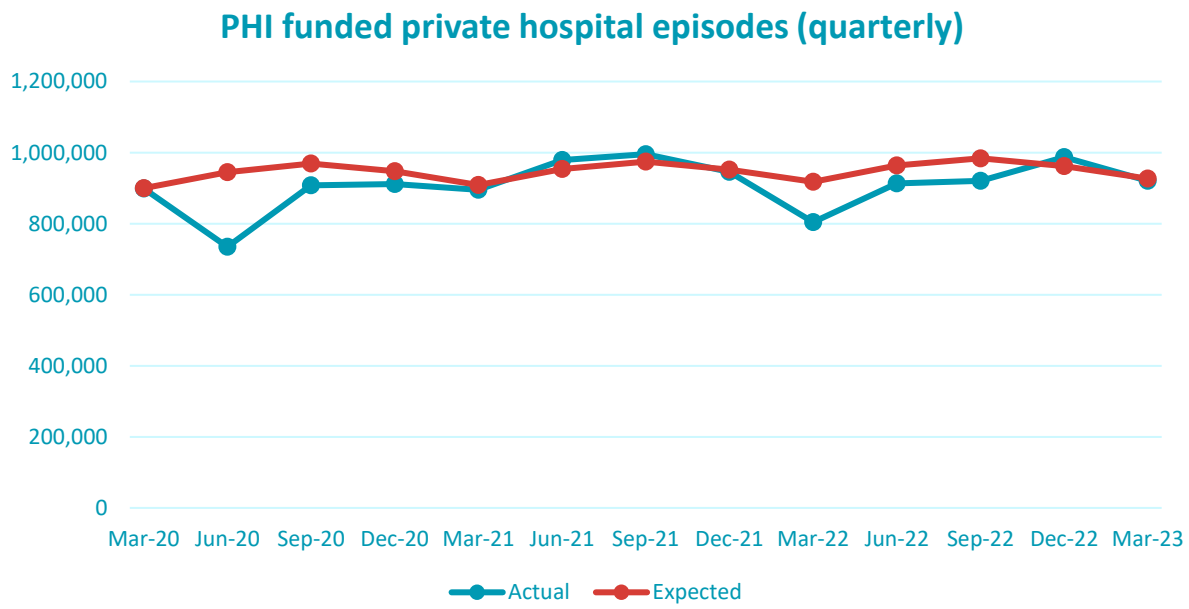
Source ABS Australian Industry, 2021-22, May 2023.

TRENDS OVER TIME

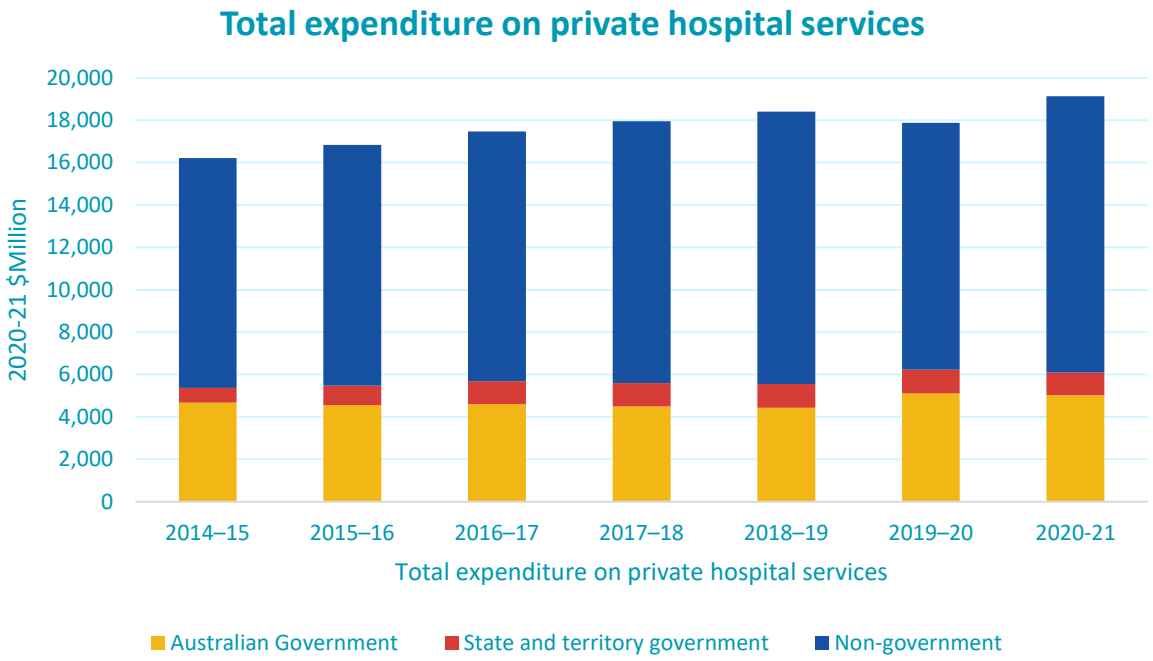
- Prior to the COVID pandemic growth in privately insured admissions had slowed and participation in private health insurance had fallen, early signals of concern for private hospital operators.



- The COVID pandemic resulted in a dramatic fall in private patient activity and this has been slow to return to anything near normal levels due in large part to workforce shortages. There are still 490,000 private hospital episodes “missing” since March 2020.



- As shown in the following chart, even with the Commonwealth's private hospital sector viability arrangements, a measure that was essential to secure the sector's readiness to meet the COVID-19 pandemic, total expenditure on private hospital services fell in real terms by three percent in 2019-20[1].



- Although total expenditure returned to trend in 2020-21, funding has not kept pace with increases in costs. The pressures now being experienced by the sector include areas such as wages, energy, food, medical technology, and consumables. APHA estimates that overall, cost increases for 2022 averaged five to six percent, well in excess of the indexation levels offered by health insurers of two to three percent.

- The drivers of cost increases include not just general inflation but also:

    - Ongoing additional COVID-19 risk mitigation strategies some of which have continued as standard risk mitigation requirements.
    - Frequent disruptions to supply chains, many of which are international, and recurrent shortages of medications, medical equipment, and other supplies.
    - Workforce shortages resulting in increased staffing and recruitment costs.
    - Increased costs of energy required for essential services such as air-conditioning, air-filtration and sterilisation.

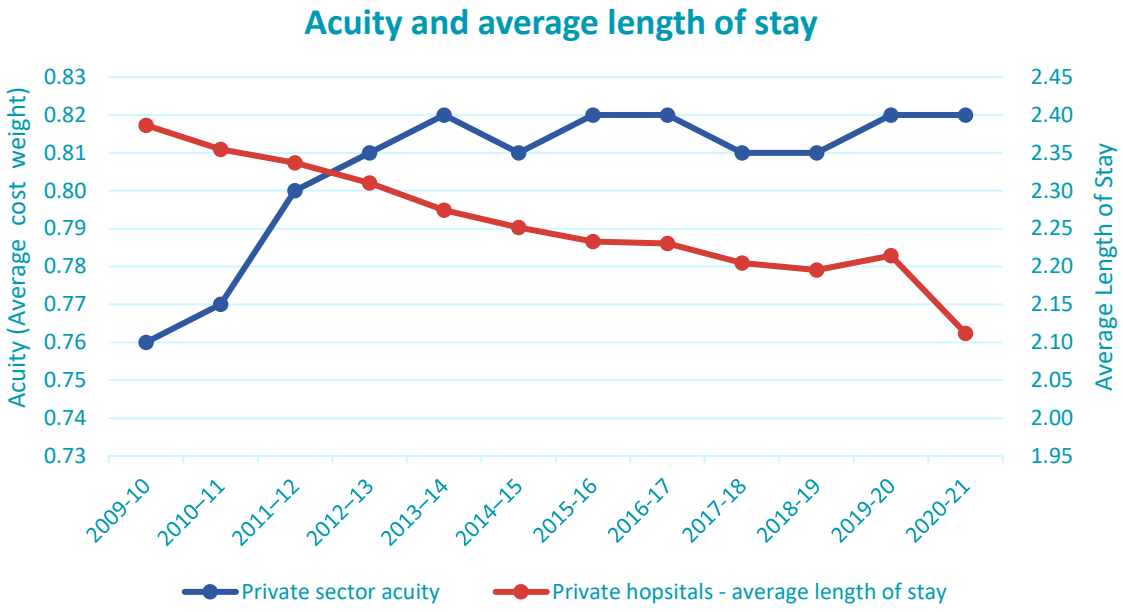
- On top of business as usual, investment in infrastructure and systems is urgently needed. The health sector needs digital technologies to drive efficiencies. The private hospital sector significantly lags behind in its ability to adopt these technologies. This lag threatens to impact the sector as a whole as system-wide connectivity becomes more important.

---

[1] AIHW Admitted Patient Care, Health Expenditure Australia, 2020-21 adjusted using the ABS government final consumption expenditure (GFCE) hospitals and nursing homes deflator. Note expenditure on medical services (i.e. fees paid directly to medical practitioners) has been excluded.

- The indexation granted by health insurers has consistently lagged behind increases in costs as independently estimated by KPMG for the Department of Veteran's Affairs.

- Private hospitals have driven efficiencies over more than a decade even though the age and complexity of patients has been increasing[2]. Despite these gains, the sector is now at a crisis point.



[2] AIHW Admitted patient care, various years. Average cost weights (AR-DRG version 6.0x overnight private hospitals cost weights for 2012–13) account for shifts in case-mix and acuity.

Assessment of reform proposals tabled in this consultation process

DEFAULT BENEFITS AND THE VIABILITY OF THE SECTOR

The circumstances summarised in the first part of this response underline the importance of Second Tier default benefits. Second Tier default benefits will become even more important for consumers in an environment where it may be more difficult for hospitals and health insurers to settle on sustainable contracted terms. Second Tier default benefits must be set using a more transparent mechanism.

In the first instance the most direct way to ensure greater transparency is to adopt the recommendation of the EY report and use a volume weighted approach for determining contract averages. This will have the effect of ensuring that benefits reflect contracted rates as paid and should be implemented immediately.

The financial viability concerns facing the private hospital sector also mean that the following recommendations are inappropriate:

- Introduction of a cap on hospital out-of-pocket costs that can be charged when associated with default benefits would only place further pressure on services that are already struggling to continue. The benefit to consumers from a cap on out-of-pockets needs to be weighed against access to services.

- Any reforms which further add administrative costs and compliance burden for private hospitals will be highly detrimental to patient access and the sustainability of the private hospital sector.

It is also extremely disappointing that the EY report has failed to document and address problems raised by the private hospital sector associated with hospital categories and ambiguities in regulatory interpretation including:

- The problems faced by hospitals with case-mixes that are atypical for the category to which they are assigned.
- Disputes over whether minimum default benefits apply to some services including day programs for mental health, rehabilitation and palliative care.

It is essential that these issues are resolved as quickly as possible.

APHA reserves comment about the recommendation for a single level of default benefits as there is insufficient detail provided in the report to demonstrate how this single level would meet regulatory requirements in respect of both the minimum levels of benefit payable to hospitals and the minimum levels of cover provided in Basic, Bronze and Silver health insurance products. If a single level of default benefit default is adopted the result must not be to further expose consumers to out-of-pocket costs by

providing default benefits that are lower than those currently provided through Second Tier arrangements.

DEFAULT BENEFITS AND THE RESPONSIVENESS OF THE SECTOR

It is disappointing to see EY Consulting reject the need for more immediate action to support the expansion of ambulatory services in mental health and rehabilitation citing the belief that such expansion can be left to the market. To the contrary, data collected by Australian Prudential Regulation Authority (APRA) and the Australian Institute of Health and Welfare (AIHW) explicitly demonstrates that current policy settings have not enabled the market to respond despite clear and consistent demands from both consumers and clinicians for innovations to match models of care already widespread in the Australian public sector and internationally.

EY Consulting recommends longer-term reform work to describe a framework for contract negotiations. There may be value in such an exercise to drive broader insurer funding of "innovative services" such as HITH but this should not be a precondition to the advancement of work to establish a default benefit for such services. There are a range of initiatives that have already been funded on a pilot basis; some of them for many years. At the very least there should be immediate reforms so that providers of 'pilots' are able to expand access to the members of other funds on a default basis.

Industry guidelines for rehabilitation and mental health services already provide the foundation for recognition of these services and APHA has already indicated interest in collaborating as soon as possible with insurer representatives and clinicians to update these guidelines to meet contemporary requirements.

EY Consulting makes a longer-term recommendation that default benefits should be set independently. While this is theoretically possible there are significant technical issues to be resolved particularly for mental health and rehabilitation services. The report comments: *"In combination with Opportunity 2.C below, the independently set funding model could be designed to provide a framework for broader insurer funding of care types such as HITH where appropriate*." Again, while this is theoretically possible, more immediate solutions are required so that the private hospital sector can provide better access to models of care that are already routine in the public sector.

Not only will establishing default benefits for ambulatory and out of hospital services enable provision of a contemporary standard of care, new models of care such as mental health outreach services that support patients post-discharge are essential in light of fundamental changes in the mental health workforce and service demands. APHA has documented these proposals in the paper 'Mental Health: crisis and response, a private hospital perspective'.

AVOIDANCE OF ADDITIONAL ADMINISTRATIVE COSTS AND COMPLIANCE BURDEN

EY Consulting proposes introduction of additional standardised operational expectations for all hospitals. Standardisation has merit if it reduces administrative costs and streamlined compliance measures but it should not result in a further increase in the eligibility requirements for Second Tier benefits.

It should be noted that the Australian Commission on Safety and Quality in Health Care (ACSQHC) has commenced work on the third edition of the National Safety and Quality Health Care Standards (the National Standards) against which all declared private hospitals must achieve and maintain accreditation. This is the appropriate mechanism through which to progress standardised operational

expectations. We note a number of health insurance representatives sit on the ACSQHC Private Hospital Sector Committee so have to opportunity for direct input to the review of the National Standards.

The current environment highlights the absolute necessity of government having close regard to the administrative cost and compliance burdens placed on the private hospital sector by both government and private health insurers. Wherever possible additional burdens must be avoided, and existing burdens reduced noting that every dollar hospitals are forced to spend on compliance is a dollar removed from patient care and investment in systems and infrastructure that will support the delivery of sustainable services in the future.

The EY paper states that *"Outside of the NSQHS standards, there are no additional requirements on hospitals claiming second-tier default benefits."* This is false. Each state licencing regime imposes a multitude of requirements on private hospitals, regardless of contracted status. Similarly, a private hospital may be receiving Second Tier default benefits in respect of one or more insurers while retaining contracts (all with differing requirements) with others.

Therefore, there should be no move to implement standardised operational expectations for all hospitals until there has been full harmonisation of existing requirements between the Commonwealth, states/territories, insurers and other funders to remove all unnecessary duplication of existing requirements.

With regard to longer term reforms:

- Adoption of Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs) on a standardised basis while of potential value should not be pursued as a precondition of eligibility for Second Tier default benefits. The adoption of such measures is more appropriate progressed through work being led by the ACSQHC.

- Measures to 'drive operational better-practice' in hospitals should be balanced with measures to improve efficiency in transactions and business practices between hospitals and health insurers and between hospitals and government agencies including streamlining and reducing paperwork requirements, acceptance of electronic transactions for claiming, prompt dispute resolution and curtailment of opportunistic audit provisions which invoke penalties for minor administrative errors which have no bearing on the quality or appropriateness of care provided.

- The Federal Government should ensure that private health insurers are held more accountable for their obligations under the Private Health Insurance Act. Health insurers should be held accountable for actions which impose unreasonable financial pressures on private hospital operators. For example, health insurers should be penalised:

    - For undue delays in negotiation of contracts.

    - For non-payment of mandatory benefits or the incorrect payment of mandatory benefits.

    - For excessive delays in settling claims.

- There should statutory limits placed on retrospective auditing of claims.

PRIVATE HEALTH INSURANCE INCENTIVES

Emergent concerns about the cost of living for Australian consumers mean that conclusions reached by Finity Consulting regarding the price-elasticity of demand for private health insurance products must be treated with caution and further tested before being relied upon for future reform.

Government must have regard not only for overall participation but also to the quality of private health insurance cover purchased noting that this has a direct bearing on the effectiveness of PHI in relieving pressure on the public hospital system. APHA welcomes recommendations aimed at providing greater encouragement for wealthy households to participate in PHI and purchase a higher level of cover.

APHA is also concerned at the lack of attention to the incentivisation of young people particularly in light of the complex range of financial pressures being faced by people in their teens, twenties and thirties and the combined impact of policy settings across government on these cohorts. The sustainability of private health insurance has long depended on maximising participation across age cohorts and it was surprising that an evaluation of current policy settings in relation to younger people did not receive closer attention.

ISSUES NOT COVERED IN COMMISSIONED REPORTS

The challenges now facing the sector also warrant further examination of issues not covered in the suite of reports commissioned by the Department of Health and Aged Care including:

- The role of patient gaps in the private sector including gaps charged by hospitals in balancing the affordability of private health insurance and the sustainability of the private hospital sector noting that the private hospital sector's sustainability provides a fundamental underpinning to the value proposition of private hospitals.
- Reforms to reduce the administrative burden and risks associated with claim assessment and retrospective audits conducted by private health insurers.
- The extent to which legislative reform to allow new funding models, such as capitation for sub-acute care and chronic disease management, might facilitate innovation and expansion of services which are as yet underdeveloped in the Australian private hospital sector.
- Reform of broader governance and regulatory accountability across the private health sector.

APHA would welcome the opportunity to contribute to a further discussion of these issues and strategies which provide a direct response to the challenges facing the private hospital sector and in turn the health sector as a whole.