Australian
Private Hospitals
Association

EY consultation on default benefits

SEPTEMBER 2022

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Executive Summary

The importance of default benefit arrangements lies in the assurance they provide to consumers. By guaranteeing a minimum level of value for the health insurance product Australians hold and protecting their freedom of choice and access from the arbitrary decisions of health insurers to contract, or not, with particular private hospitals[1].

Private hospitals play a crucial role within the health sector as a whole. They also face significant challenges including rising costs and power imbalances in relation to private health insurers.

Default benefit provisions are important across the private hospital sector and it is false to assume they are more important to one segment of the private hospital sector than another. Many factors contribute to a consumer requiring or preferring one facility over another. While larger operators are generally more likely to be given the opportunity to negotiate contractual agreements with private health insurers, recent experience has shown that even large operators risk losing those contracts in the current environment. The emergence and growth of second-tier episodes in large hospitals underscores the importance of these arrangements for facilities of all types.

The apparent low-level reliance on default benefits in the private hospitals sector, suggested by analysis of the Hospital Casemix Protocol (HCP) data, also belies the flaws in current arrangements:

- The lack of coverage for all hospital services as defined by the Private Health Insurance Act (the PHI Act).
- Anomalies in the way second-tier rates are calculated leading to gaps in the schedules.
- Disparity between contracted rates and rates paid, and the impact this has for second-tier schedules.
- Ambiguities in the regulations leading to health insurers refusing access to second-tier rates for services not included in the contracts they hold.

The one area where default funding arrangements are not justified and should be discontinued, is the provision of minimum default benefits for the treatment of private patients in public hospitals. This policy results in outlays of around $1 billion in private health insurance benefits annually in exchange for little real consumer benefit. Consumers holding private health insurance are eligible to receive treatment in public hospitals as public patients, so concerns about protecting freedom of choice and access do not apply. Removal of these arrangements would immediately deliver a significant saving to consumers, relieving upwards pressure on private health insurance premiums. This reform would also release scarce public hospital resources for redirection to urgent public patient demands.

Rare instances where, due to market failure, private hospital services are not available are better remedied by allowing private health insurers to contract with public hospitals within a policy framework which prioritises Medicare obligations but, where necessary, permits contracting with private health insurers on the basis of competitive neutrality.

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[1] Unless specifically indicated, the term 'private hospitals' is used to include both private day hospitals and private overnight hospitals. It does not include public hospitals operated by private companies or as public private partnerships.

Minimum default benefits and second-tier benefits are sometimes mistakenly regarded as two discrete levels of payment, with the implication that one or other of them might be dispensable. In fact, they are two parts of an integrated policy framework. Minimum default benefits are referenced in several different ways in regulation to guarantee a minimum level of value for consumers. Second tier default benefits provide additional, and more effective, protection from excessive out-of-pocket costs than that provided by minimum default benefits alone They ensure consumers retain the opportunity to access the hospital services they require at prices responsive to the market within which they are provided. This ensures a level of fairness, sustainability and market responsiveness to all parties.

The term 'second tier' arises from historical decisions which set additional criteria, over and above those required for private hospitals to be declared under the PHI Act. Changes since then, specifically the Australian Health Service Safety and Quality Accreditation Scheme (the AHSSQA Scheme) mean the original purpose of these additional criteria has been negated because of the overlap with the criteria for declaration. The time is ripe, therefore, to reduce the administrative burden for government in managing a separate assessment process on top of their responsibilities for managing the declaration of private hospitals.

APHA proposes three broad areas of reform in relation to default benefit arrangements:

- Reduce administrative burden for government and redirect effort more effectively towards protecting the interests of consumers.
- Remove provision for a minimum default benefit for treatment in a public hospital providing savings and reducing upward pressure on private health insurance premiums.
- Better support the private hospital sector to provide contemporary models of care to meeting the needs of consumers.

These proposals are discussed in more detail in the three cases for reform outlined in this submission. The submission also provides responses to each of the questions posed in the consultation paper cross referencing where appropriate to the body of the submission. Lastly, this response details some points of error and omission in the consultation paper.

Recommendations

1) Remove separate qualification requirements so all private hospitals meeting the requirements for recognition as private hospitals automatically qualify for second-tier arrangements.

2) Calculate second-tier benefits based on benefits paid.

3) Increase Department of Health and Aged Care (the Department) oversight of the implementation of default benefits arrangements by health insurers.

4) Clarify regulations to confirm that default benefit arrangements, including second-tier benefits, should be paid for services that are hospital services, but not covered in a contract (i.e. the health insurer has excluded some services from the contract with a private hospital).

5) Ensure hospitals with service mixes that fall outside the category to which they are assigned have access to the next most relevant schedule so second-tier rates are available for all the services provided.

6) Give further consideration to provision for calculating second-tier benefits on a national basis when the number of contracts for a hospital category within a state is too small.

7) Give further consideration to provision for calculating second-tier benefits for a specific service on a national basis if there are no contracts covering that service within a given jurisdiction/hospital category.

8) Remove default benefit payments to public hospitals, while allowing health insurers to contract with public hospitals within a framework of competitive neutrality.

9) Expand the scope of default benefits to cover all hospital services provided by private hospitals including psychiatric, rehabilitation and palliative care services provided on an 'ambulatory basis[2]' and hospital in the home.

[2] The term 'ambulatory' is used to collectively describe services provided by private hospitals as day programs for mental health, rehabilitation or palliative care patients and services provided by private hospitals on an out-reach basis to people in their homes.

The importance of default benefit arrangements

THE ROLE OF THE PRIVATE HOSPITAL SECTOR IN PROVIDING TIMELY ACCESS TO HEALTH CARE

The private hospital sector plays a crucial role in providing timely access to health care.

- In 2020-21, the private hospital sector:
    - Treated 4.9 million patients, more than 40 percent of all hospital admissions.
    - Treated one-in-20 public patients as part of the COVID-19 pandemic response and through partnerships with jurisdictions to address backlogs in demand for public patient services[3].
    - Provided one in three of all level-three intensive care unit separations, an increase of 44 percent and 18 percent of patients requiring continuous ventilatory support.

- The private hospital sector provides:
    - 60 percent of all surgical services:
        - 50 percent of cardiovascular procedures
        - 60 percent of all musculoskeletal procedures
        - 70 percent of all eye procedures
        - 75 percent of procedures on the brain, spine and nerves.
    - 80 percent of all in-patient rehabilitation.
    - 45 percent of all acute adult psychiatric beds.
    - At least 30 percent of all chemotherapy[4].

THE ROLE OF DEFAULT BENEFIT ARRANGEMENTS

The consultation paper reports that, over time, HCP data has consistently indicated that around two percent of privately insured separations are funded through second-tier arrangements. A further 16 percent of separations are funded as 'non-contract' episodes, the majority of which are provided in the public hospital sector.

The Australian Private Hospitals Association (APHA) is of the view that this data understates the importance of default benefit arrangements in the private sector, because the utilisation of second-tier benefits is likely under-reported. Simply put, a hospital eligible for second-tier benefits does not need to specifically record a flag in their claim in order to receive a second-tier benefit. The mere fact they do not have a contract with the fund in question will mean second-tier is the only benefit they are entitled

[3] This is in addition to those public hospitals which are operated by private and not-for-profit organisations.
[4] AIHW Admitted Patient Care, 2020-21.

to claim. Consequently, the flags recorded in the HCP data collection used to calculate the utilisation of second-tier benefits are not routinely used in the making claims.

We suggest that a better understanding of the way in which second-tier arrangements operate, and their impact on patients, could be ascertained in two ways:

- An analysis of the number and distribution of services contracted by health insurers would more accurately demonstrate the importance of second tier in ensuring patient access to private hospital care.
- An analysis of the second-tier schedules provided to the Department by health insurers to ascertain not only their regulatory compliance, but also the level of benefits provided, and the range of services covered.

APHA does not have access to the second-tier schedules provided by health insurers, but feedback from members indicates they frequently find gaps and anomalies. This results in either no rate being available for specific services, or rates that are abnormally low, including rates below the default minimum benefit.

Data giving insight into the number and distribution of contracted facilities is more readily available, even though this does not reveal the extent to which contracts exclude or circumscribe the coverage provided for specific services. The results of APHA's analysis, using data held by the Commonwealth Ombudsman, are detailed below.

This analysis shows 76 percent of overnight hospitals and 51 percent of day hospitals held contracts assuring fully-funded access formore than 90 percent the insured population[5]. But 15 percent of overnight hospitals and 31 percent of day hospitals had contractual coverage of less than 60 percent of the insured population.

Most of the facilities with lower levels of coverage are small. Those facilities with less than 60 percent coverage of the insured population account for an estimated 7.6 percent of private hospital sector activity, and those with less than 90 percent coverage account for an estimated 15.6 percent of private hospital sector activity. However, these figures confirm that HCP data likely under-estimate the incidence of reliance on default benefits. More importantly, they indicate the importance of these arrangements for consumers.

The following tables show the distribution of market coverages hospitals have through their contracts with insurers. The market coverages are based on the individual market shares of insurers in each state and territory and the insurers with which each private hospital is contracted.

[5] In this instance 'fully-funded access' means that these consumers would have no hospital out-of-pocket costs for services detailed in the contract beyond those excess payments and/or co-payments detailed in their policy. It does not mean that there would be no medical out-of-pocket costs or other expenses.

Table 1: Private overnight hospitals and day hospitals by decile of the insured population covered by insurers with which they are contracted.

COVERAGE	OVERNIGHT HOSPITALS		DAY HOSPITALS		ALL HOSPITALS
0-10%	27	8.6%	59	17.3%	86
10-20%	1	0.3%	2	0.6%	3
20-30%	5	1.6%	10	2.9%	15
30-40%	4	1.3%	6	1.8%	10
40-50%	6	1.9%	13	3.8%	19
50-60%	4	1.3%	17	5.0%	21
60-70%	10	3.2%	21	6.2%	31
70-80%	14	4.4%	14	4.1%	28
80-90%	6	1.9%	25	7.3%	31
90-100%	238	75.6%	174	51.0%	412
Total	**315**	**100.0%**	**341**	**100.0%**	**656**

Data source: Agreement Hospitals 1-Sept-2022, September 2022 release of the PrivateHealth.gov.au data and Operations of Private Health Insurers Annual Report data 2020-21, APRA (released 27 October 2021).

Table 2: Private hospitals within each state by decile of the insured population covered by insurers with which they are contracted.

COVERAGE	NSW	VIC	QLD	SA	WA	TAS	ACT	NT	TOTAL
0-10%	16	27	21	11	8		3		**86**
10-20%		1		1				1	**3**
20-30%	9	1		1	2	1	1		**15**
30-40%	1	5	3	1					**10**
40-50%	11	2	2	2	2				**19**
50-60%		11	5	1	1	2	1		**21**
60-70%	10	13	3	2	1		2		**31**
70-80%	12	10	1	2	1	1	1		**28**
80-90%	4	12	6	6	2	1			**31**
90-100%	143	95	81	33	37	12	9	2	**412**
Total	**206**	**177**	**122**	**60**	**54**	**17**	**17**	**3**	**656**

Data source: Agreement Hospitals 1-Sept-2022, September 2022 release of the PrivateHealth.gov.au data and Operations of Private Health Insurers Annual Report data 2020-21, APRA (released 27 October 2021).

Many of the facilities with very low levels of contractual coverage (less than 10 percent) are highly specialised. They do not necessarily rely on private health insurance for the majority of their revenue.

However, for the consumers who rely on their services, the availability of default benefit arrangements is extremely important. Those with no contracts or contracts covering less than 10 percent of the insured population provide services such as:

- Palliative care
- Cancer care – particularly radiation oncology
- Addiction treatment – both hospital services and non-hospital services
- Dialysis services
- Reproductive health
- Dental surgery
- Plastic and reconstructive surgery – both Medicare Benefits Schedule (MBS) services and non-MBS services.

WHAT DOES THIS MEAN FOR CONSUMERS?

It is crucial to note that, for most consumers, their primary choice will be the selection of their treating specialist. This decision will often be made on advice from their general practitioner, although some may rely on recommendations from friends and family, and some may research a variety of sources information provided by their health insurer and government websites. The choice of hospital is secondary and dependent on multiple factors including the facilities with which their specialist has rights of admission.

APHA's analysis shows that in many instances consumers, depending on their choice of insurer, can be confident that hospital to which they are admitted will be fully covered. They can simply follow the advice of their treating clinician and, together with them, select the facility best suited to their needs at a time and place convenient to them. But, there are also a significant number of circumstances where, depending on the health insurer and the particular services required, the facilities for which their treating clinician holds admission rights, constraints of time and place and the degree of urgency, a consumer may have no option but to rely on default benefit arrangements.

Because private hospitals are diverse in the services they provide and because a significant number of them are geographically dispersed meeting the needs of specific communities, it is important consumers have access to the hospitals that meet their particular requirements.

The diversity of private hospitals is explored further below. Private acute medical/surgical hospitals have been classified by the Australian Institute of Health and Welfare (AIHW)[5] into four broad groups:

- Group A hospitals are private acute hospitals with a 24-hour emergency department and an intensive care unit, providing a number of specialised services such as coronary care, special care nursery, cardiac surgery and neurosurgery.
- Group B hospitals have intensive care units and a number of other specialised services including coronary care, special care nursery, cardiac surgery and neurosurgery.
- Group C hospitals are those with specialised services in a range of clinical specialities.
- Group D hospitals are private acute hospitals with a narrower, often more specialised range of services. Some of these have as few as 200 separations per year.

In addition to these groups, there are a number of more specialised categories of private hospital including: women and children's hospitals, hospitals specialising in the treatment of drug and alcohol addiction, psychiatric hospitals, hospitals specialising in (non-drug/alcohol) rehabilitation. Key points to note are:

- Around 58 (25 percent) of overnight private hospitals (groups A and B) have the capability to provide emergency and intensive care support to high-risk services. The capabilities of these hospitals are significantly greater than other facilities.
- Around thirty percent of private overnight medical/surgical private hospitals are in regional areas. So, although most private hospitals are in major cities there are a significant number which cater for the needs of specific communities.
- Around forty percent of private overnight medical/surgical private hospitals are relatively specialised.
- Around 20 percent of private overnight hospitals are specialised hospitals providing specific services such as maternity services, psychiatric care, rehabilitation and drug/alcohol addiction.

All these points highlight the importance for consumers in accessing the specific facilities that meet their needs.

Day hospitals are also highly specialised and often focus on a narrow case mix. They play a crucial role in meeting specific demands and care must be exercised in making generalisations about this part of the sector. The following table shows the main types of day hospital and their geographical distribution. Once again, the number of options available to an individual consumer is often quite small, particularly if they have already selected a specific clinician and require timely treatment.

Table 3: Day hospitals, 2012–13

DAY HOSPITALS	MAJOR CITIES	INNER REGIONAL	OUTER REGIONAL	TOTAL
Dialysis clinics	14	0	0	14
Endoscopy centres	53	3	0	56
Eye surgery clinics	38	3	1	42
Fertility clinics	8	0	0	8
Haematology/oncology clinics	10	1	0	11
Hyperbaric treatment centres	4	0	0	4
Mixed day procedure hospitals	40	15	4	59
Oral and maxillofacial	13	0	0	13
Plastic and reconstructive surgery clinics	28	0	1	29
Reproductive health centres	6	1	1	8
Sleep centres	3	0	0	3
Total Day Hospitals	**217**	**23**	**7**	**247**
	88%	9%	3%	100%

Data source: AIHW report *Private Hospitals 2012-13,* the most recent report providing this level of detail.

The following two tables show the role of the private sector and day hospitals in providing services commonly delivered on a same-day basis.

Table 4: Same-day acute separations for the 20 most common principal diagnoses in 3-character ICD-10-AM groupings, total separations, performed in private hospitals, percent of private hospital separation performed in day hospitals, 2020–21

	PRINCIPAL DIAGNOSIS	TOTAL SEPARATIONS	PRIVATE: TOTAL	DAY HOSPITALS: TOTAL PRIVATE
Z49	Care involving dialysis	1,601,932	21%	57%
Z51	Other medical care	641,030	53%	27%
H26	Other cataract	261,836	74%	55%
R10	Abdominal and pelvic pain	149,428	51%	36%
R19	Other symptoms and signs involving the digestive system and abdomen	114,010	63%	29%
D12	Benign neoplasm of colon, rectum, anus and anal canal	106,840	79%	36%
C44	Other malignant neoplasms of skin	105,017	71%	42%
R07	Pain in throat and chest	102,798	8%	12%
H35	Other retinal disorders	82,913	89%	83%
K21	Gastro-oesophageal reflux disease	80,769	74%	34%
Z45	Adjustment and management of drug delivery or implanted device	80,525	70%	9%
Z31	Procreative management	79,606	95%	65%
K01	Embedded and impacted teeth	76,896	94%	27%
K92	Other diseases of digestive system	70,859	60%	27%
Z09	Follow-up examination after treatment for conditions other than malignant neoplasms	70,337	64%	32%
D50	Iron deficiency anaemia	60,829	38%	39%
E61	Deficiency of other nutrient elements	60,177	56%	23%
M54	Dorsalgia	56,084	66%	12%
Z08	Follow-up examination after treatment for malignant neoplasms	55,123	56%	12%
K50	Crohn's disease [regional enteritis]	53,086	43%	14%
	Other	3,001,123	44%	28%
Total		**6,911,218**	**45%**	**35%**

Data source: AIHW report *Admitted patient care 2020–21*

Table 5: Interventions reported for the 20 most common procedure blocks for same-day acute separations, percent performed in private hospitals, percent of private hospital interventions performed in day hospitals, 2020–21

	PROCEDURE BLOCK	TOTAL	PRIVATE: TOTAL	DAY HOSPITALS: TOTAL PRIVATE
1910	Cerebral anaesthesia	2,687,633	69%	31%
1060	Haemodialysis	1,609,328	22%	59%
1920	Administration of pharmacotherapy	1,025,455	48%	24%
911	Fibreoptic colonoscopy with excision	562,337	74%	33%
1008	Panendoscopy with excision	468,839	75%	34%
200	Extraction of crystalline lens	303,790	74%	58%
193	Insertion of intraocular lens prosthesis	296,975	74%	58%
905	Fibreoptic colonoscopy	287,989	71%	38%
1909	Conduction anaesthesia	280,581	67%	50%
1620	Excision of lesion of skin and subcutaneous tissue	244,864	68%	34%
1893	Administration of blood and blood products	219,747	40%	32%
1916	Generalised allied health interventions	187,675	15%	19%
458	Surgical removal of tooth	156,325	93%	27%
72	Percutaneous neurotomy of other peripheral nerve	153,919	96%	11%
1265	Curettage and evacuation of uterus	143,014	60%	35%
209	Procedures on retina, choroid or posterior chamber	121,904	84%	81%
1089	Examination procedures on bladder	114,702	55%	9%
1297	Procedures for reproductive medicine	88,058	95%	70%
1005	Panendoscopy	80,003	71%	44%
1259	Examination procedures on uterus	78,182	56%	11%
	Other	2,724,128	62%	24%
	Interventions reported	**11,835,448**	**59%**	**33%**
	No intervention or not reported[(b)]	827,165	4%	10%
	Total same-day acute separations	**6,911,218**	**35%**	**45%**

Data source: AIHW report *Admitted patient care 2020–21*

The context in which reform is contemplated

The context in which reform is contemplated is marked by significant constraints on the market power of private hospitals, significant and increasing financial pressures on private hospital operators, and increasing market power on the part of health insurers.

CONSTRAINTS ON THE MARKET POWER OF PRIVATE HOSPITALS

The private hospital sector is fragmented in ownership and diversified in size. There are only two large operators: Healthscope Ltd and Ramsay Health Care. This is a major limiting factor on the ability of many hospital providers to exercise bargaining power with health insurers. The following diagram shows the major private hospital operators and their size relative to the sector as a whole. In this diagram, the size of each slice represents APHA's estimate of the share of the overall volume of private hospital activity attributable to each operator.

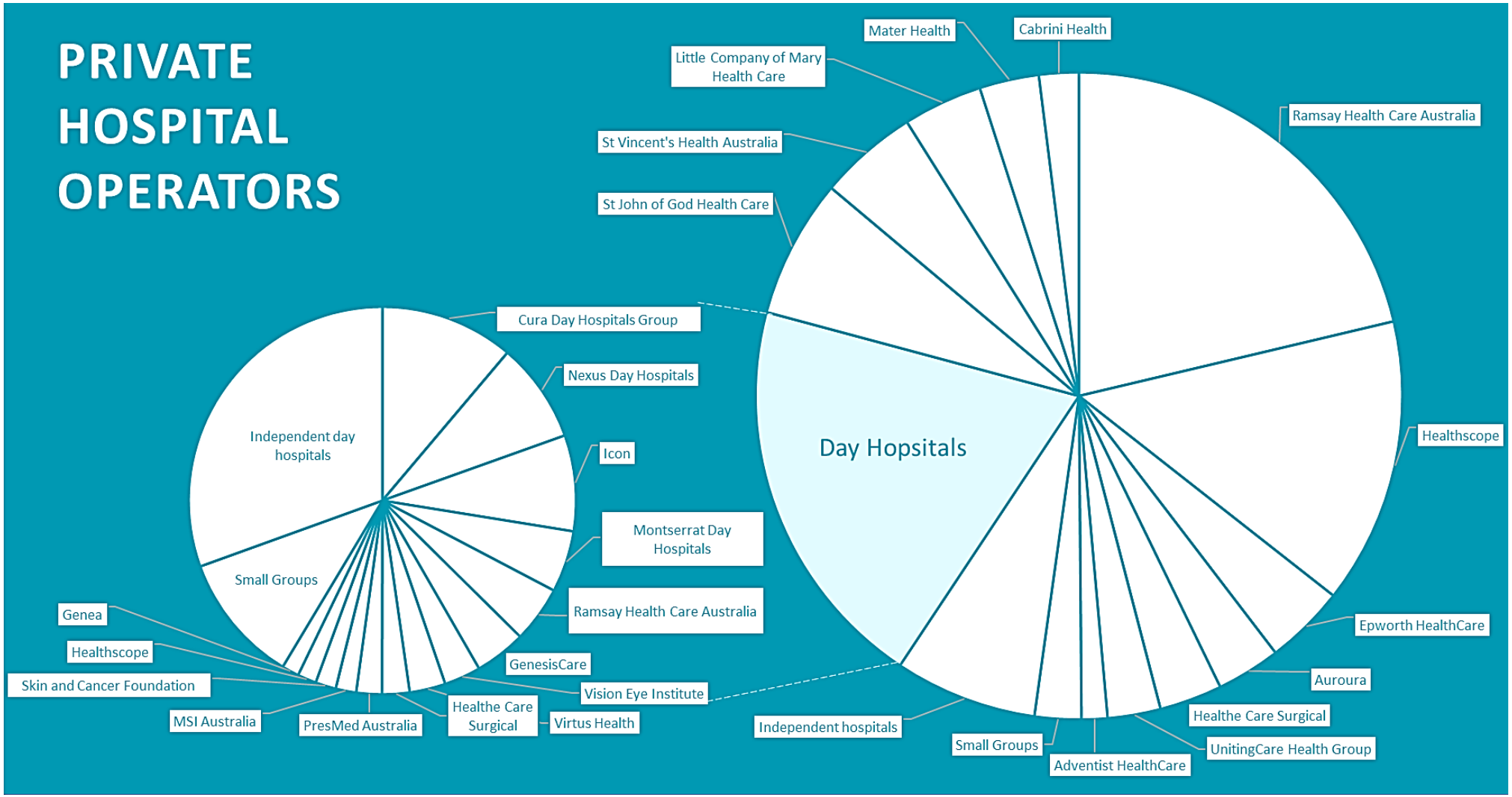
Contracts are generally negotiated at corporate level, but this does not mean all services or all hospitals operated by that corporation will be included in the contract. Health insurers are at liberty to pick and choose with whom they contract based on their assessment of the needs of their membership and settlement of favourable terms.

Sometimes a relatively small operator will be able to exercise significant power in negotiating with a health insurer because its services and location are of particular relevance to the insurers' customer base.

Competition law allows health insurers, as purchasers, to act collectively, but precludes hospital operators from doing so.

Although larger operators have the advantage of attracting the interest of health insurers, they are by no means assured of being able to negotiate sustainable contracts. As recent experience has shown, they too are at risk of going out of contract with insurers; with devastating consequences for consumers faced with the loss of fully-funded access to a large number of hospitals.

Contracts are renegotiated every three to four years. Although many smaller funds negotiate through one of two groups, the Australian Health Services Alliance and Australian Regional Health Group, each individual fund chooses which contracts it will hold. With so many different payers, the profile of contracts held by an individual hospital is at constant risk of changing.

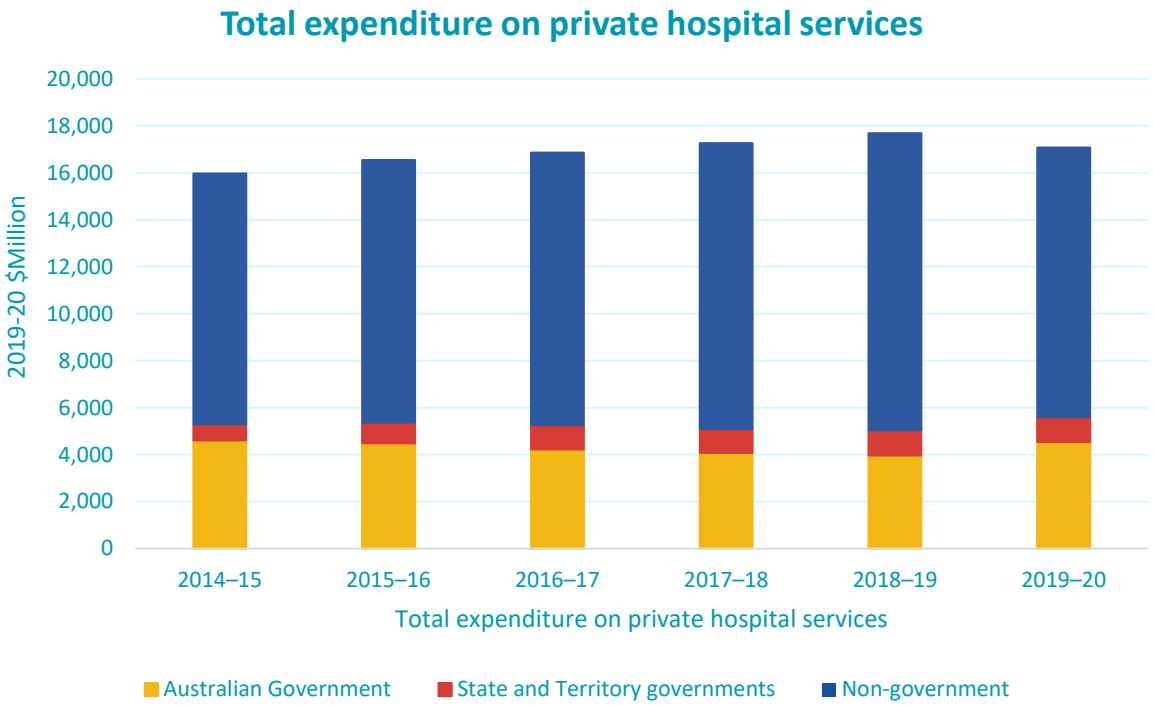

PRIVATE HOSPITAL OPERATORS
Mater Health
Cabrini Health
Little Company of Mary Health Care
Ramsay Health Care Australia
St Vincent's Health Australia
St John of God Health Care
Healthscope
Epworth HealthCare
Auroura
Healthe Care Surgical
UnitingCare Health Group
Adventist HealthCare
Small Groups
Independent hospitals
Day Hopsitals
Cura Day Hospitals Group
Nexus Day Hospitals
Icon
Montserrat Day Hospitals
Ramsay Health Care Australia
GenesisCare
Vision Eye Institute
Virtus Health
Healthe Care Surgical
PresMed Australia
MSI Australia
Skin and Cancer Foundation
Healthscope
Genea
Small Groups
Independent day hospitals

AN EFFICIENT INDUSTRY UNDER SIGNIFICANT FINANCIAL PRESSURE

- Prior to 2020, in ordinary circumstances, the sector had a turnover of $17 billion[6] and operated with an overall profit margin of just 4.5 percent[7].

- The hospital sector's resilience has been significantly tested over the last two years and it remains under pressure.

- As shown in the following chart, total expenditure on private hospital services fell in real terms by three percent in 2019-20[8] and is expected to remain below trend in 2020-21 and 2021-22.



- The private hospital sector is challenged by increasing costs including:

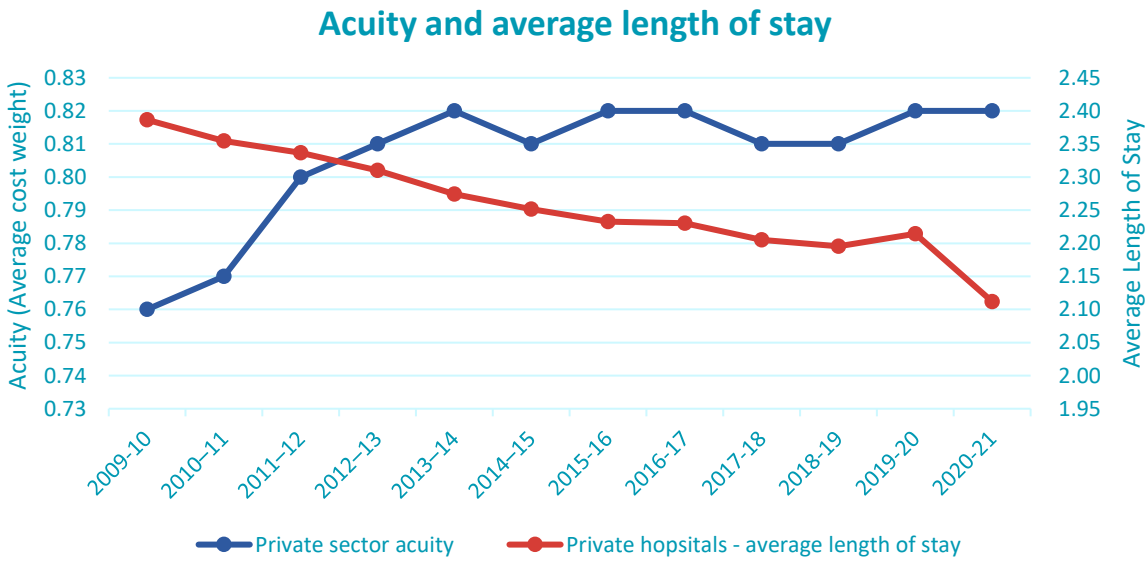
    - Ongoing additional COVID-19 risk mitigation strategies.
    - Frequent disruptions to supply chains and recurrent shortages of medications, medical equipment and other supplies.
    - Workforce shortages resulting in increased staffing and recruitment costs.
    - Increased costs of energy required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

[6] Sales and service income for 2018-19, ABS, Australian Industry, 2018-19, Friday 29 May 2020.
[7] Ratio of operating profit before tax to Sales and service income for 2018-19.
[8] AIHW Admitted Patient Care, Health Expenditure Australia, 2019-20 adjusted using the ABS government final consumption expenditure (GFCE) hospitals and nursing homes deflator Note expenditure on medical services (ie fees paid directly to medical practitioners) has been excluded.

A recent Australian Medical Association (AMA) analysis of public hospital data showed cleaning costs rose 35 percent in the five years to 2019-20. The AMA also found the following examples of cost increases from across the sector[9].

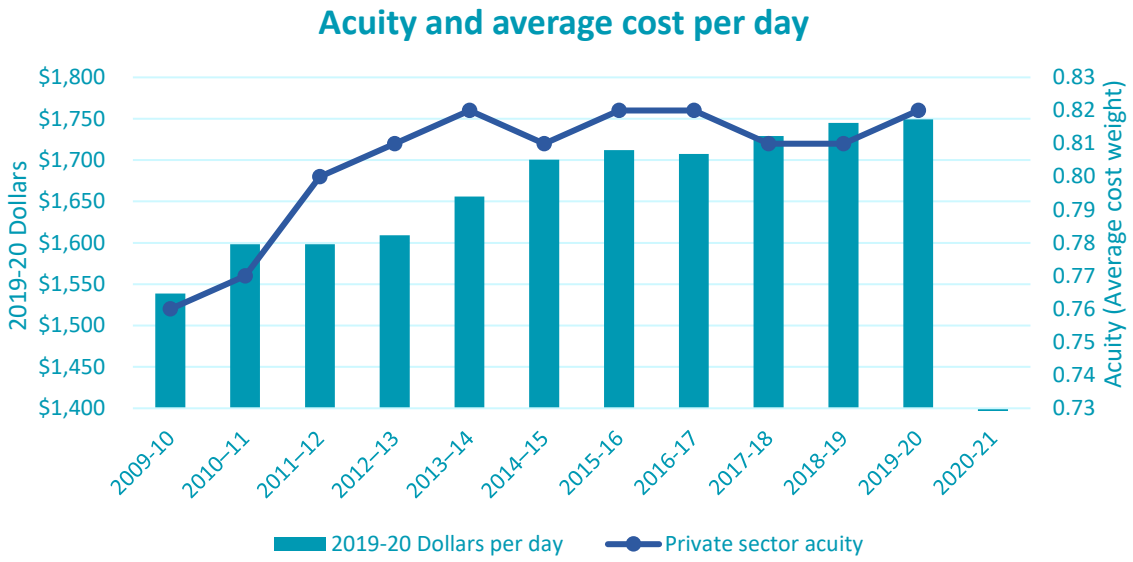
COSTS	INCREASES
Chemicals and cleaning products	up 12% over the past year at a major private hospital
Consumable medical and equipment products	up 4.5% over the past year at a major private hospital
Food costs	up 3% over the past month at a major private hospital
Cleaning costs	up 35% in the five years to 2019-20 across public hospitals
Wage costs	up 5.6% in 2019-20 across public hospitals
Emergency department costs - Treating heart attacks, septicemia and urinary tract infections	up 6-9 percent in 2019-20

- Private hospitals have been instrumental in driving productivity while the age and complexity of patients has been increasing[10]. The following chart shows how the sector has worked to reduce the number of days patients are in hospital while treating patients who over time have required increasingly complex care.



[9] AMA, cited in the Sydney Morning Herald, 2022.
[10] 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.

- Increases in expenditure[11] have tracked increases in patient acuity.



- The COVID-19 pandemic and its aftermath has increased operational costs for the private hospital sector and reduced revenues for many operators. It has severely depleted financial reserves meaning it is extremely difficult for most operators to fund new investments at the present time.

- The increasing acuity of the patient population and the increased rate of private health insurance utilisation by those who hold it, are the two biggest drivers of premium increases.

- These pressures, coupled with the drive from health insurers to minimise premium increases, makes for an exceptionally difficult negotiating environment.

THE MARKET POWER OF HEALTH INSURERS

- The overwhelming dominance of large insurers by virtue of their market share, and the power of negotiating groups acting on behalf of smaller insurers, has been further enhanced by the unprecedented financial windfalls accrued to the private health insurance industry amid uncertainty across the broader national economy.

- In the quarter ending March 2022, the private health insurance industry generated record profits of $2 billion after tax, while total claim benefits decreased by 2.8 percent over the preceding year.[12] In the June 2022 quarter, net margin increased from 5.0 to 7.0 percent over the preceding 12 months. While hospitals have had to contend with increased costs, forced shutdowns of elective surgery and enduring uncertainty, health insurers have been able to invest in data mining and audit processes which further drive their ability to exert power over hospitals.

- Some insurers have also actively pursued vertical integration strategies investing in their own health service assets which they have actively used to accrue revenues from their own insurance arms.

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[11] AIHW Admitted Patient Care, Health Expenditure Australia, 2019-20 adjusted using the ABS government final consumption expenditure (GFCE) hospitals and nursing homes deflator Note expenditure on medical services (ie fees paid directly to medical practitioners) has been excluded.
[12] https://www.apra.gov.au/news-and-publications/apra-releases-quarterly-private-health-insurance-statistics-for-march-2022

Acquisitions in primary care provide increased control over referral pathways. Acquisitions in hospital-substitute services provide a direct mechanism for diverting business away from hospitals towards health insurers' own subsidiaries and joint ventures. Strategic purchase of interests in private hospitals by some insurers strengthens their ability to enforce business models designed to retain profits across the supply chain by selectively targeting profitable services such as short-stay surgery and avoiding more complex services (cherry picking). Vertically integrated insurers are increasingly direct competitors with the very private hospitals with whom they are negotiating.

What does this mean for consumers?

These market pressures and complexities create a constant state of flux and increase the risk that viable contracting arrangements may not be achieved. This means consumers cannot assume their insurer will necessarily continue to contract with hospitals with which they have held agreements in the past. This leaves consumers in a vulnerable position, particularly if it is important to them to receive treatment from a particular doctor or in a familiar environment.

Case for reform – Improving value for consumers, strengthening and streamlining administration

All private hospitals should be eligible for second-tier benefits.

When second-tier benefit arrangements were first devised, a number of specific criteria were required for hospitals to qualify. These criteria were designed to protect consumers and recognise facilities with a demonstrated commitment to safety and quality. Over time, these criteria have become redundant because the requirements for any private hospital recognised under the PHI Act have increased.

All private hospitals are required to be accredited against the National Safety and Quality in Health Care (NSQHC) Standards and these standards include provision of informed financial consent. All declared private hospitals are required to provide data in accordance with statutory data collections .

Consequently, the only remaining requirements are transactional. Service providers must:

1) Not bill patients directly for the minimum benefit payable by the patient's insurer
2) Submit HCP data to health insurers electronically with every claim for second-tier default benefits.

Monitoring of transactional compliance could readily be achieved through enhancement of ECLIPSE and incentivisation to ensure universal adoption by the small number of health insurers and private hospitals not using this system already.

Calculation of second-tier benefits

Under current arrangements, second-tier benefits are calculated based on contracted rates. This means rates can be manipulated by including rates in contract that are never used (i.e. rates for services that are not provided by the contracted hospital).

The calculation method prescribed in regulation is also problematic in some circumstances. Hospitals in small jurisdictions and hospitals providing niche services or services atypical for the category for which they are assigned, are disadvantaged if there are insufficient current contracts in those jurisdictions for rates to be calculated. Examples of the problems which arise are detailed below:

- Health insurers generating a second-tier schedule omitting rates for specific services or groups of services that might otherwise attract a specific rate because of the nature of the service

required.

- Health insurers providing second-tier schedules that either do not provide day hospital rates (because there may be fewer than five such contracts in that state) or that provide day hospital rates that omit specific items (because the day hospital contracts within that state do not include provision for that item even though overnight hospital contracts do).

- There are instances in which not even the minimum benefit is payable to second-tier hospitals for day admissions because the relevant item is not included as either a type B or type C procedure in Schedule 3. One particularly significant issue is the provision of Electro-Convulsive Therapy (ECT), MBS item 14224, a service routinely provided in private psychiatric hospitals on a day-only basis and which much be provided in a hospital setting.

- Schedules that omit rates because there are fewer than five contracts with a rate using a particular funding mechanism. For example there may be insufficient contracts written in a particular Australian Refined Diagnosis Related Groups (AR-DRG) version

- Schedules which provide abnormally low rates because the contracts on which they are based include rates which are never used (and therefore of no concern to the contract holders), rates that are old or funding mechanisms that produce an unusually low result.

Although the Rules make provision for the use of contracts across categories, consideration should be given to the calculation of rates on a national basis as a means of overcoming these difficulties.

Ambiguities in the Rules are exploited to produce rates which are below the minimum default benefit, even though this is not an intended outcome. These issues can be substantially resolved by repairing anomalies in the Rules and calculating benefits based on rates paid.

Access to second-tier benefits for services not covered in contracts

APHA and its members have been concerned for some time at the refusal of health insurers to pay second-tier rates to hospitals for services that are not included within their contracts for that particular hospital. The APHA submits that this is contrary to the Benefit Rules, and to the intent of the second-tier schedule, which is to ensure patient access to services offered by hospitals meeting second-tier criteria.

APHA argues the Benefit Rules rightly support the contention that second-tier benefits should be paid to a hospital, which has a contract with a fund, for the services not included in that contract:

- The "negotiated agreement" (as defined in Part 1, Clause 3 of the Benefit Rules) only applies to episodes of care covered by that negotiated agreement. If a second-tier eligible hospital does not have a "negotiated agreement" in relation to that episode of care, then the health insurer should pay second-tier benefits.

- Health insurers cannot contract out of their legislative obligations, including the minimum benefits, unless the legislation specifically provides for such a right. The Benefit Rules allow insurers to negotiate a rate that is lower than provided in minimum benefit arrangements for “other treatment” (Part 2 Clause 5(2)). APHA would argue that omission of a treatment from an agreement does not constitute an agreement to pay a rate of zero dollars.

However, we also believe that the legislation could be further clarified to remove any uncertainty on this point.

Access to all relevant rates

Some hospitals have service mixes which are atypical for the category for which they are assigned. As a result they find the second-tier schedule available to them does not cover all services. One solution for this anomaly would be to require the use of rates from the next most applicable category. For example a hospital assigned to Category B Rehabilitation which also provides psychiatric services should have access to the next most relevant schedule, in this instance, Category A Mental Health. Another solution may be to consider the calculation of rates on a national rather than state basis.

The specialised nature of many day hospitals and smaller facilities means they are particularly vulnerable to this problem.

Increased oversight

The Department receives audited confirmation of second-tier schedules. While this process may confirm that schedules have been completed in accordance with the Rules, it is not sufficient to confirm the adequacy of protection for consumers.

No account is taken of the extent to which hospital services are covered in second-tier schedules, whether calculations have produced anomalous results or how rates compare with rates charged.

Annual analysis of the second-tier schedules provided to the Department by health insurers should be undertaken to confirm not only regulatory compliance, but also the level of benefits provided and the range of services covered. Only with such analysis can compliance with both the letter, intent and spirit of regulation be confirmed.

The cost of additional oversight would be off-set by removal of duplication in effort in relation to hospital assessments.

Recommendations

1) Remove separate qualification requirements so all private hospitals meeting the requirements for recognition as private hospitals automatically qualify for second-tier arrangements.

2) Calculate second-tier benefits based on benefits paid.

3) Increase the Department's oversight of the implementation of default benefits arrangements by health insurers.

4) Clarify regulations to confirm default benefit arrangements, including second-tier benefits, should be paid for services that are hospital services but not covered in a contract (i.e. the health insurer has excluded some services from the contract).

5) Ensure hospitals with service mixes that fall outside the category to which they are assigned to have access to the next most relevant schedule so second-tier rates are available for all the services provided.

6) Giver further consideration to provision for calculating second-tier benefits on a national basis when the number of contracts for a hospital category within a state is too small.

7) Giver further consideration to provision for calculating second-tier benefits for a specific service on a national basis if the there are no contracts covering that service within a given jurisdiction/hospital category.

The case for reform – removal of minimum default benefits for public hospitals

Why is this reform needed?

At a time when the public hospital system is stretched to meet its obligation to provide care to public patients based on clinical need, it is essential policy settings relieve pressure from the public system and ensure public resources are directed in accordance with clinical priorities.

Consumers are experiencing cost of living pressures and upwards pressure on private health insurance premiums must be minimised by ensuring that policy settings deliver a clear value proposition, while reducing benefit outlays providing no real benefit to the consumer.

The default benefit for the treatment of private patients in public hospitals works against these imperatives:

- Significant public hospital resources are diverted to attracting private patients and 'converting' unplanned presentations to private patient elections.

- Private patients in public hospitals are significantly subsidised by public resources because the default benefit meets only a small percentage of the actual cost.

- Each year almost $1 billion in private health insurance benefits is paid out for the treatment of private patients in public hospitals. In most cases this funds care which is no different to that which is provided to public patients and in many cases, funding care which could be more appropriately provided in other ways (e.g., telehealth or Emergency Care Centres).

Removal of minimum default benefits for public hospitals would:

- Release $1 billion per annum in health insurer benefits
- Reduce premiums by six percent or release funds to deliver greater value in the private sector.
- Free-up 16 percent of public sector beds and resources to meet the needs of public patients.

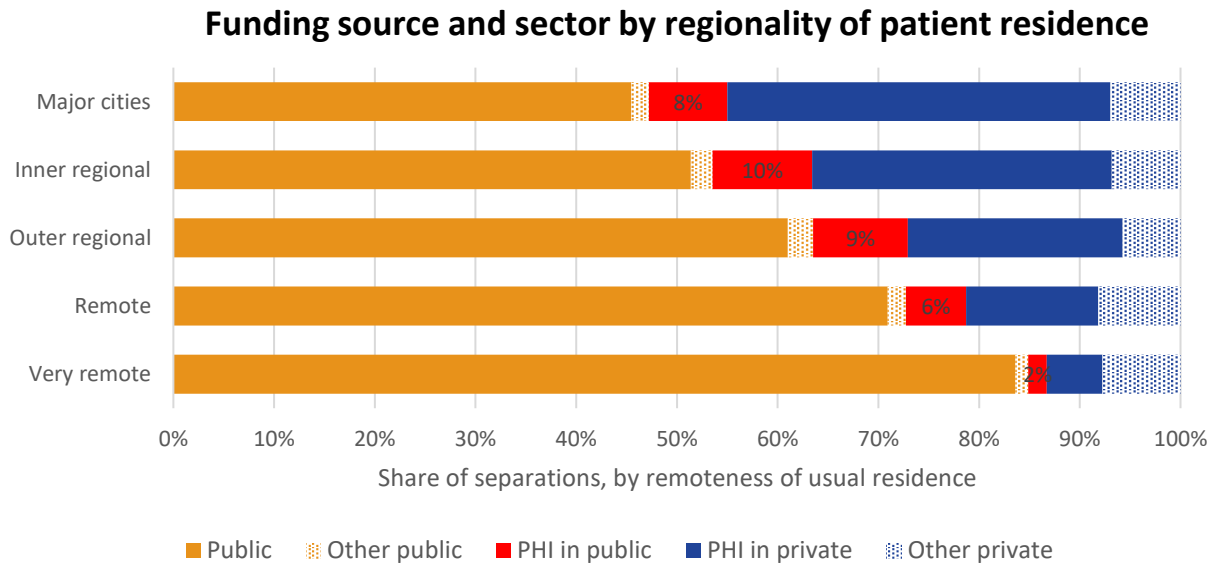
Contested assumptions – public hospital default benefits provide access for people in regional areas

It is sometimes claimed that provisions for consumers to be treated as private patients in public hospitals provide people in regional areas with access to private treatment. Data released by the The

National Health Performance Authority (NHPA) suggests that the vast majority (74 percent) of private patient in public hospital services are provided in metropolitan hospitals[13].

This same dataset also shows there is no correlation between the percentage of services provided to private patients in public hospitals and the presence or absence of a private hospital in the same area.

Australian Institute of Health and Welfare (AIHW) data shows default benefits for private patients in public hospitals make only a marginal contribution to the access of consumers in regional areas to private health.



It is notable that many people in regional areas receive care in the private hospital sector availing themselves of support provided by private health insurance to travel to hospitals with the necessary staff, infrastructure and experience to deliver quality care.

The contention that access to the 'right of private practice' is crucial to attracting specialists to regional areas is also debatable as the mal-distribution of the medical workforce remains an entrenched problem with many causes. But to the extent to which this is true it can be addressed by allowing clinicians to work across both public and private facilities.

The following table (most recent data available) shows the number of hospitals in each AIHW group and their distribution across major cities, inner regional and outer regional areas.

[13] National Health Performance Authority (NHPA), 2016, *Costs of acute admitted patients in public hospitals 2013-14 supporting data*, April.

Table 6: The diversity of private overnight medical/surgical hospitals, 2012–13

HOSPITAL TYPE	MAJOR CITIES	INNER REGIONAL	OUTER REGIONAL	TOTAL
Group A	21	1	0	22
Group B	29	6	1	36
Group C	30	15	4	49
Group D	45	19	7	71
Total private acute	**125**	**41**	**12**	**178**
	70%	23%	7%	100%

Data source: AIHW report *Private Hospitals 2012-13* (most recent data available)

In those instances where there is genuine market failure, where private operators cannot establish viable facilities and health insurers cannot find private facilities with which to contract, a more rational solution to both consumer access, and retention of clinicians needs to be found. APHA suggests that allowing public hospitals to contract with health insurers for the provision of private patient services within a framework designed to protect the obligation to provide public hospital services and preserve competitive neutrality would be a better solution.

Contested assumptions – public hospital default benefits provide patients with choice

AIHW data show almost half of all private patients in public hospitals are emergency separations, i.e. circumstances in which there is minimal opportunity, if any, for consumers to exercise choice, for example choice in selecting the medical specialist responsible for their care[14].

Almost half (46 percent) of all public hospital separations funded by private health insurance are same-day separations (AIHW, 2017), a result suggesting that a substantial proportion of this care could have been provided in a non-hospital setting.

Market research conducted by the APHA shows that only 40 percent of private patients in public hospitals had a choice of doctor. The other 60 percent were treated by a doctor allocated to them in the same way as if they had elected to be treated as a public patient. Clearly patient experience of 'election' varies. The impact of doctor choice on subsequent treatment might also vary depending on the doctor's role and level of active involvement during the admission.

A significant proportion of these admissions are likely to have come through emergency departments. It is known that some jurisdictions and hospitals have implemented deliberate campaigns to persuade people to elect to be treated as private patients when they are referred for admission by the emergency department. These campaigns include such questionable tactics as:
failure to provide informed financial consent, including patients not being aware they are signing an election to be treated as a private patient:

[14] Private Patients in Public Hospitals 2015-16: Separations by Urgency and Type of Care. Source AIHW Admitted Patient Care: Hospital Statistics 2017

- ‘Conversion’ of patients from public to private post-admission even though election is supposed to be exercised prior to, at, or as soon as possible after admission.

- Pursuit of patients post-discharge to retrospectively elect to use their private health insurance.

- Lack of, or insufficient provision of, information to enable a patient to consider care options and make an informed choice.

- Denial of a patient’s request to transfer to a private facility.

APHA has received anecdotal accounts of public hospitals appearing to act contrary to the spirit of the 2020-25 National Health Reform Agreement (NHRA):

- Patients pressured to elect for private admission while family members have stepped away from the bedside for a short time.

- Patients emotionally blackmailed with threats that a facility will close if they do not elect to be admitted as a private patient.

- Public hospitals persuading a patient to retrospectively elect to be a private patient.

- Public hospitals writing to patients post-discharge inviting them to retrospectively elect to have the admission recorded as a private patient admission.

- Patients forced to wait for a transfer and/or being told that no private hospital bed is available when this is not the case.

- Patients told the private hospital doctor is on leave-not available when this is not the case.

- Patients being told the private hospital does not admit seriously ill patients when this is not the case.

- Patient preference for a transfer to a private hospital ignored.

- Patients forced to pay the cost of ambulance transfer from a public hospital to a private hospital even though they have private health insurance and ambulance cover.

- Patients persuaded to elect as a private patient and then directed down a public sector care plan without being advised of their alternatives including private sector options through which they could access the required treatment in a significantly shorter timeframe.

- Patients’ requests to be taken to their private emergency department of choice refused by ambulance services, even though the hospital in question is formally recognised as able to take cardiac patients.

Specific accounts of pressure applied to patients have been obtained in a range of circumstances including psychiatric patients, patients admitted through emergency departments and cardiac patients.

Public hospital default benefits lead to practices that are not in the interests of consumers and which place undue pressure on the public hospital system to the detriment of the wider community. The limited benefits that can accrue by enabling the treatment of private patients in public hospitals can be

better achieved through other mechanisms without causing detriment to consumers who depend on the public hospital system.

Recommendation

8) Remove default benefit payment to public hospitals while allowing health insurers to contract with public hospitals.

The case for reform – ensuring default benefit arrangements cover all hospital services provided by private hospitals

Who would benefit from this proposal?

This proposal would most benefit the following people:

- People at high risk of hospital admission for a mental health condition who currently struggle to access the services they need to ensure they avoid hospital admission.
- People who could benefit from shorter hospital admissions if streamlined pathways to coordinated home-based services were available. These people include those living with chronic conditions and people with high risk of relapse or readmission.
- Members of smaller health insurers (that do not have the capacity by themselves to sponsor innovative services) who would otherwise not have access to these services.
- Members of all health insurers by virtue of the fact that programs established at scale, rather than for the exclusive benefit of a single payer, are likely to be more sustainable and hence more consistently available.

How does this proposal deliver value to patients?

- New technologies and contemporary clinical practice mean people can often receive hospital-level care by attending hospital-run day-programs or receiving hospital level care in their own homes. For the purposes of this response these services are termed ‘ambulatory care’.
- When hospitals can provide services to people in their homes, they offer four advantages:
    - Unlike home-based services provided by non-hospitals, hospital-run services are required to meet the same safety and quality accreditation standards as services delivered in a hospital.
    - Consumers have the option of receiving home-based services and hospital-based services from the same provider, thus assuring continuity of care and the ability to quickly escalate if hospital admission is required.
    - Consumers, particularly those living with a mental health or other chronic conditions, value receiving services from providers with whom they are familiar and who can provide integrated services, convenience and confidentiality.

- Private hospitals employ multi-disciplinary teams of clinicians and provide the infrastructure to support career development, clinical governance and job security while at the same time deploying clinical teams in a flexible manner across the 'continuum of care' to target the needs of patients at greatest risk of clinical deterioration and avoidable hospitalisation.

These characteristics set hospital services apart from hospital-substitute services as defined by the PHI Act which are, by definition, provided and managed by non-hospitals.

What are the problems that needs to be addressed?

- Because a number of hospital services are not mentioned in Private Health Insurance (Benefit Requirements) Rules 2011, health insurers have been able to refuse to pay benefits or decline to include benefits within contracts for the following types of service:
    - Psychiatric day programs provided by hospitals and delivered by multi-disciplinary teams.
    - Psychiatric outreach services that provide care in the community and/or people's homes, for example, programs targeting people at high risk of hospital readmission.
    - Rehabilitation day programs provided by hospitals and delivered by multi-disciplinary teams.
    - Rehabilitation services delivered by hospitals in the patient's home.
    - Palliative care delivered on an ambulatory basis (i.e. other than as an overnight hospital admission).
- The Private Health Insurance (Benefit Requirements) Rules are also silent on the issue of "hospital-in-the-home". This term appears nowhere in the Rules. As a result, there is no clear obligation for insurers to provide benefits for services provided in this manner.
- As a consequence:
    - there is no default benefit for these services
    - there is no requirement for these services to be included in contracts or second-tier schedules derived from them.
- When private health insurers do provide support for such programs it is often only on a temporary 'pilot' basis or on terms which tightly limit the conditions under which such options will be funded.
- As a consequence:
    - Private hospitals often struggle to find sufficient payer support to establish new programs on a viable basis. This is because hospitals typically hold contracts with multiple payers, each responsible for only a percentage of patients.
    - Consumers find access to such programs, where they exist, is circumscribed by the insurer they are with. They have no assurance that the program will be available over the long term because its viability is at the discretion of a single payer. If they change insurers in order to access the program, they may have to pay higher premiums and risk losing other benefits of value to them.

- Because there is no requirement for these services to be included in contracts, hospitals holding contracts which exclude these services are just as disadvantaged as hospitals that do not have contracts for services of any kind. This means that for the advantages of reform to be fully realised for consumers, provision would need to be made for hospitals holding contracts that did not include services of this type to also have access to default benefit arrangements.

What would this reform achieve?

- This reform would enhance the value of private health insurance to consumers requiring these services by expanding the range of clinical treatment options available which may more appropriately meet the needs of patients.

- This reform would enable private hospitals to provide models of patient centred care that are common in the public sector and actively promoted in the NHRA.

- A default benefit specified in Commonwealth regulations would enable hospitals to establish innovative programs at a sustainable scale and assure consumers of a basic level of cover for the program of their choice.

- This reform would enable private hospitals to provide, at scale, models of care which deliver value by reducing the risk of relapse and hospital readmission for overnight hospital care.

- Providing a default benefit of this kind would mirror protections that are available for overnight hospital admissions but not for more innovative and contemporary models of care.

Issues that will need to be addressed

- Eligibility for benefits would need to be controlled and targeted to areas of greatest need, specifically those services which cannot be provided in other ways and for which there is an un-met need. This objective could be readily achieved by requiring:

    - Referral by a relevant specialist

    - Compliance with industry agreed guidelines such as already exist in relation to mental health and rehabilitation.

    - Restriction of default benefits to hospital services provided by private hospitals, i.e. facilities accredited and licenced to provide hospital level services. This assuresconsumers of the same levels of safety and quality as are required for hospital services generally and the ability to provide integrated care with the ability to 'step-up' to in-patient services when/if required.

  These criteria would preserve the distinction between these services and those funded by private health insurance as general services or provided by individual clinicians and funded through the MBS.

Recommendations:

9) Expand the scope of default benefits to cover all hospital services provided by private hospitals including psychiatric, rehabilitation and palliative care services provided on an 'ambulatory basis' and hospital in the home.

Responses to questions posed in the EY discussion paper

Q1. What do you see as the current objectives for default benefit arrangements?

The primary objectives of default benefit arrangements are:

- Protecting patients from significant out-of-pocket costs when their health insurer arbitrarily declines to contract with a private hospital or day hospital.
- Giving patients choice and eliminating restrictions on where they can access private health affordably and in a timely manner.
- Preserving the value of private health insurance to consumers.

Default benefits also ensure private hospitals are not forced out of business by arbitrary decisions made by health insurers and that new private hospitals are able to enter the market, increasing the range of services available, ensuring diversity and maintaining competition.

The role and importance of default benefit arrangements is discussed further at pages 5 and following.

Q2. How well do the current arrangements meet these objectives?

Minimum default benefits – private

Minimum default benefits apply in the private hospital sector in three quite different ways.

First there are always a number of hospitals who do not hold eligibility for second tier. This may arise when:

- The hospital is very new and is awaiting second-tier recognition.
- An administrative oversight has resulted in the hospital temporarily losing second-tier eligibility.
- A commercial choice has been made not to seek second-tier eligibility.

Occasionally there may be a more substantive reason why the hospital may have lost second-tier status, but such reasons usually prevent a hospital from retaining its licence and hence providing clinical services of any kind. But if this is not the case, minimum default benefits are the only means by which consumers may derive value from their private health insurance when accessing services at these facilities.

The second way in which minimum default benefits are used is to ensure that second-tier rates are set at or above a specified minimum. Without this provision, there would be nothing to prevent a health insurer manipulating their second-tier schedule to produce rates at an implausibly low level.

The third way in which minimum default benefits are used is when private health insurers use the default as a means of restricting their liabilities by offering 'restricted cover' in a hospital cover policy. Health insurers are only able to provide 'restricted cover' for mental health, rehabilitation and palliative

care. All other hospital service must either be covered or not covered. This type of restricted cover is permitted in Basic, Bronze and Silver policies. Consumers with these policies may find their cover for mental health, rehabilitation and palliative care is restricted even if they are admitted to a hospital with which the insurer has a contract. In these instances, the health insurer policy will stipulate the level of cover, for example:

> "Covered for shared room accommodation in a public hospital. You may face large out-of-pocket costs for this treatment in a private hospital, or for a private room in a public hospital."

In each instance the benefit paid by the private health insurer is very low and consequently the out-of-pocket charge to the patient may be extremely high, but the minimum default ensures the patient receives a small amount of support when accessing services which meet significant health needs. Without these provisions, consumers would not receive benefits.

Defects with these arrangements include:

- Minimum default benefits do not extend to the full range of hospital services.
- Minimum default benefits are only available when a hospital is not in contract with a health insurer. Ambiguity in the Rules mean in practice they are not available for services not included that contract, and health insurers are not obliged to include all hospital services within their contracts.

These defects and improvements that could be made are discussed at pages 27 and following.

Minimum default benefit – public hospital

Minimum default benefits are payable when a patient elects to be treated as a private patient in a public hospital. They may find they have no out-of-pocket expenses at all if these are waived by the hospital and the treating doctor.

The patient may perceive that this arrangement provides them with value, although, in reality, the clinical treatment they receive is no different to the treatment they would have received as a public patient.

The low value delivered to patients in return for around $1 billion in benefit outlays and the associated upwards pressure on private health insurance benefits and the significant public subsidisation of these services makes this policy a poor investment.

For these reasons, APHA is of the view that the minimum default benefit provisions for public hospitals should be removed and that access to private health in locations where there are no private hospitals (i.e. market failure) can be better met through other mechanisms.

This issue is discussed in greater detail at pages 22 and following.

Second-tier – Private hospital

The evidence of use of second-tier benefits demonstrates that when flexibility of choice of provider is required, patients are exercising it and receiving treatment at the hospital that can best meet their needs.

However, second-tier arrangements are limited in their ability to meet the objectives stated above when:

- There is a delay in hospitals being able to access current schedules with the result that they cannot advise patients of out-of-pocket costs.
- Second-tier rates are set at artificially low levels imposing unreasonable pressure on private hospitals and unreasonably high out-of-pocket costs on consumers.
- Second-tier rates are not available for all hospital services.

These problems are exacerbated by the lack of visibility of health insurers' implementation of second-tier benefit schedules and the lack of scrutiny applied by the Department. These issues are discussed further in the main body of this submission at pages 18 and following and pages 27 and following.

Q3. What other objectives should default benefit arrangements be aiming to achieve?

- Enabling patient access to the full range of contemporary hospital services including:
    - Psychiatrist referred day programs for acute mental health care
    - Psychiatrists led out-reach/home based multidisciplinary care
    - Specialist rehabilitation day programs
    - Specialist rehabilitation in the home
    - Palliative care
    - Hospital in the home.

This issue is discussed further at pages 27 and following.

Q4. Do the current default benefit arrangements disincentivise contracting at all?

Default benefit arrangements do not disincentivise contracting to any extent. Instead, they facilitate meaningful contract negotiations by providing a balance of power between insurers and hospitals in the negotiation of contract rates.

- Default arrangements provide hospitals with an alternative to a negotiated agreement, without which they have no power to seek favourable rates which allow them to operate sustainably.
- Without default benefit arrangements hospitals would risk having no access to any benefit at all or being offered unacceptably low contracts. Currently is it common for new entrants, particularly smaller facilities, to wait several years before even receiving the opportunity to contract with an insurer. Without default benefits a significant proportion of market participants would exit the market through mergers and acquisitions, leading to consolidation of the sector, reduced competition and the loss of consumer choice.
- Default arrangements maximise consumer choice and hence promote competition among private hospitals to minimise out-of-pocket costs to consumers and optimise their service offering.
- Default arrangements enable new entrants to bring innovative services and business models to the market to better support clinicians in meeting consumer needs.

Q5. Should contracting between hospitals and insurers be the preferred model?

In the private hospital sector, a hybrid of default benefits and contracted rates is the preferred model as it:

- Ensures that consumers have maximum opportunity to derive value from their investment in private health insurance.
- Promotes market efficiency by allowing the price of services to converge to their equilibrium values across the market.
- Prevents oligopoly by minimising anti-competitive policy settings such as constraining affordable supply to contracted hospitals.

In the public sector, the viability of public hospitals and the availability of public hospital services (in accordance with clinical prioritisation of need) is underpinned by Medicare. Consequently there is no need for a default benefit and contracting, within a framework of competitive neutrality, should be the preferred model for the provision of private patient services in the public sector.

Q6. Currently, the only formal data collection that we are aware of relating to the usage of default benefit arrangements is the "Hospital Contract Status" data item in the Private Health Industry data collections (Hospital Casemix Protocol 1 and Hospital Casemix Protocol 2) submitted to the Department collections under the Private Health Insurance Act 2007. What, if anything, should be done to improve the ease of data submission and the clarity and usefulness of these data collections to reflect possible payment arrangements between hospitals and insurers?

The Department may be able to create a policy and economic environmentpromoting the commercial development of claims processing IT platforms with a commonly readable output processed in real time by the Department. Such an environment already exists in the provision of pharmaceutical benefits, whereby pharmacies submit Pharmaceutical Benefits Schedule (PBS) claims and dispensing records to Medicare, in real time, using the pharmacy dispensing systems of their choice.

The ECLIPSE system is widely utilised and while further investment would be required to support the extraction of data the benefits to the sector in increased efficiency and timeliness of reporting could be significant.

Q7. Do you have any comments or reflections on the data presented in this section?

- There is over $1 billion in minimum benefits flowing annually to public hospitals for patients that are entitled to receive free care. These benefits are not providing improved outcomes for these patients, while unnecessarily utilising public capacity. The paper has overlooked this information.
- In 2020- 21, there were about five million separations in private hospitals. One-to-two percent, as indicated in the annotations to Figure 4, represents 50,000 to 100,000 separations. There is no stratification of these separations to identify which patient groups or treatment categories are represented in the figures. Therefore, the impact on the most vulnerable patients of changes to the default benefit arrangements has not been adequately explored.
- The report appears to have made no attempt to validate the accuracy of reported default benefit payments. This problem is discussed further at pages 5 and following.

Throughout the report there is no account taken of the potential impact of COVID-19 on the data presented.

See also comments on pages 48 and following.

Q8. How effective are default benefit arrangements at improving PHI consumers' access to and choice of services? What other mechanisms/arrangements have an impact?

The effectiveness of default benefits in improving consumer access and choice is based on how second-tier benefits underpin the sustainability, spread and diversity of the private hospital sector and the services that it provides.

This issue is discussed further at pages 8 and following.

Q9. In your experience, what health services/providers are the most reliant on default benefit arrangements?

a. *How critical are these health services/ providers to the consumer? For example, rural/remote providers, new providers, specialised/ innovative services, providers that are unable to reach any negotiated contract agreements*
b. *Does reliance on default benefits arrangements change over time for these providers?*

Although some types of private hospitals (overnight and day) appear to be more commonly associated with the use of default benefit arrangements than others, it is important not to make generalisations.

As discussed in pages 5 and following.

Q10. Option for Change | Do you think default benefit arrangements should be specifically targeted exclusively for the services/providers that you identified in Q9?

No, they should be available to any licenced private hospital that meets the eligibility requirements.

The central purpose of default benefit arrangements is the protection of consumers interests. Their interests are best service by ensuring access to the full range of providers meeting the requirements of declaration as a private hospital under the Act. These arrangements:

- Provide the flexibility for consumers ensuring access to facility which is most appropriately equipped to meet their specific needs.
- Reduce the ability of insurers to erode of value in private health insurance by selective contracting.

Moreover, there is no significant difference in the burden involved in providing default benefit arrangements for one group of private providers over retaining provision for all private providers

Q11. Option for Change | Should future options for change have two different tiers (minimum and second)? If so, what is the benefit and/or cost associated with a two-tier scheme?

As already detailed above, the minimum default benefit performs a number of distinct functions with reference to the private hospital sector. These functions are essential to the overall policy objective.

Minimum default benefits should be removed in the public sector. Should genuine instances of market failure be identified, this should be addressed through a competitive neutrality framework which enables private health insurers to contract with public hospitals in instances where this is necessitated

by market failure, and where such contracting can be undertaken without prejudice to Medicare obligations.

Q12. How are default benefit arrangements important for hospitals that do have contracts with private health insurers, and how is this beneficial to insured patients at those hospitals?

Private Hospitals

As at 14 September 2022, there were 640 hospitals declared by the Commonwealth to be private hospitals. Of these, 511 (79.8%) have voluntarily invested in, and been granted, second-tier eligibility[15]. This statistic underscores the importance of default benefit arrangements to the vast majority of private hospitals in Australia.

APHA represents about 300 private hospitals nationally including large groups which have contracts with health insurers. Despite the contracts they have in place, private hospital operators consistently support the continued existence of default benefits in the interest of a sustainable sector. The following issues underpin the importance of default benefits to contracted hospitals:

- It is unlikely that a given hospital has a contract with every insurer whose patient seeks treatment at that hospital.
- Private hospitals seek to operate sustainably by maximising the number of privately insured patients they treat. Default benefits give private hospitals market access to the entire insured population.
- Default benefits facilitate the market growth strategies of contracted hospitals by allowing them access to non-contracted patients at close-to-market prices.

Patients

- Default benefit arrangements protect patients from large out-of-pocket costs in the event that an insurer refuses to renew a contract. For example, if the recent contract dispute between BUPA and Ramsay Health Care was not able to be resolved, it would have impacted 3.5 million consumers and dramatically increased the number of patients requiring the protection provided by second tier default benefits.
- Due to the existence of default benefits arrangements, insured patients can currently move freely within the private hospital system without the restrictions imposed by the individual contractual arrangements between hospitals and insurers. This results in:
  - Increased access, choice and cost reduction.
  - Continuity of care for insured patients treated in any private hospital.

[15] Current Listing of Commonwealth declared hospitals, 14 September 2022, https://www1.health.gov.au/internet/main/publishing.nsf/Content/hospitals2.htm

Q13. Are you aware of examples where hospitals go from in contract to out of contract (and thus have to rely on default benefits)?

Yes, hospitals go from being in contract to being out of contract. In fact, a large private hospital provider, accounting for around 18 percent of private hospital services and operating in WA, SA, VIC, NSW and QLD, recently faced non-renewal of contract with a large health fund.

Data held by the Commonwealth Ombudsman shows changes in contractual arrangements occur continuously. This data is updated on monthly basis and shows changes over time[16].

Q14. How effective are default benefit arrangements at impacting the predictability of and reducing hospital and medical out-of-pocket costs for consumers?

Minimum default benefits provided a basic level of cover, but much more effective protection from out-of-pocket costs is provided by second tier arrangements – to the extent that out-of-pocket costs while not eliminated (as they usually are under contractual arrangements) are usually lower than they would be under minimum default benefits.

It is important to note that other patient out-of-pocket charges such as excess payments and co-payments are not affected by minimum default benefits. Doctors fees and out-of-pockets are not directly affected although some insurers may pay higher medical benefits if a patient is treated at a contracted hospital.

Predictability is dependent on the availability of information in advance of an admission. Predictability is impaired when:

- There is a delay in health insurers disclosing second-tier schedules meaning patients cannot provide fully informed financial consent prior to admission.
- There is an extreme degree of variance between second-tier rates and contracted rates due to manipulation by health insurers.
- Second-tier rules give rise to anomalous results.

This predictability could be further enhanced as explained below.

Q15. Option for Change | What mechanisms could be introduced to impact the predictability of and reduce hospital and medical out-of-pocket costs for consumers?

- Remove separate qualification requirements so all declared private hospitals meeting the requirements for recognition as private hospitals automatically qualify for second-tier arrangements.
- Calculate second-tier benefits based on benefits paid (to eliminate health insurers gaming the calculation of schedules).

[16] The data underpinning the website privatehealth.gov.au is available through open access arrangements https://data.gov.au/data/dataset/private-health-insurance

- Increase the Department's oversight of implementation of default benefits arrangements by health insurers to ensure accuracy.

- Publish the schedules to avoid delay in hospitals accessing them for the purpose of ensuring informed financial consent.

- Publish the schedules to support transparency and motivate insurers and private hospitals to negotiate the best outcome in the interests of consumers. Aware of the differential, private hospitals would be better placed to weigh up the benefits of accepting a contract versus the impact of second tier default benefits on their competitiveness in the eyes of clinicians and their patients – particularly in relation to out-of-pocket costs.

These recommendations are further discussed at pages 18 and following

Q16. How do default benefit arrangements impact on agreed contract rates?

Due to the confidential nature of negotiations and terms of contracts between hospitals and insurers, the impact of default benefit arrangements on agreed contract rates are not directly observable.

In the absence of research on this matter, applying the principles of negotiation would lead to the conclusion that default benefits prevent unbalanced downward pressure on agreed contract rates. The following rationale can be applied to the effect of default benefits on agreed contract rates:

- Insurers acting in their best interests seek to minimise agreed contract rates and hospitals, acting in theirs, seek to maximise them.
- Porter's five force analysis of the purchaser-provider contract market would establish that private health insurers are powerful buyers, due to their small number relative to private hospitals who are the sellers in this relationship and the fact that as purchasers, smaller insurers are able to negotiate on a group basis through either the Australian Health Service Alliance or Australian Regional Health Group.
- Private health insurers' power is further enhanced by the fact that they fund the overwhelming majority of private hospital separations. Without access to private health insurance most consumers would find private hospital care unaffordable. The alternatives to reliance on private health insurance are few and restricted in scope (specific forms of insurance, government benefits for veterans), underdeveloped (short term financing/payment plans) or associated with significant disadvantages (use of savings and superannuation).
- Default benefit arrangements are the only Best Alternative to a Negotiated Agreement (BATNA) available to private hospitals in the negotiations with their powerful buyers, insurers.
- In the absence of a BATNA, private hospitals are forced to:
    - remain uncontracted in an environment that would have few private funding sources or
    - accept unsustainably low contract rates.

- The BATNA carries with it three powerful disincentives:
    - It decreases a hospital's competitiveness in the eyes of consumers – because of the high out-of-pocket costs incurred.
    - It decreases a hospital's competitiveness in the eyes of doctors – again because of high out-of-pocket costs incurred and, in some instances, because the health insurer benefits payable to the doctor may also be reduced.

- The hospital has no option but to accept terms and conditions (business rules) imposed by the health insurer because there is no contractual opportunity to negotiate alternatives.
- It leaves the hospital no opportunity to negotiate for increased compensation in recognition of increased costs. At best there is a substantial lag of several years before second-tier rates reflect broader increases in contractual rates.
- It leaves the hospital no opportunity to negotiate special rates to specific services. At best second-tier rates reflect average rates for standard services and funding models which may be quite different from those available under a negotiated contract.

Default benefit arrangements therefore provide the essential balance of power in purchaser-provider negotiations, positioning private hospital operators to seek and obtain contract rates that enable them to operate, innovate and grow.

Q17. How does variation in contract structures and in prices agreed for similar treatments impact on prices paid for private health insuranceby consumers?

As in question 16 above, due to the commercial confidentiality of purchaser-provider contracts, the structures, price agreements, and the variations thereof cannot be easily observed.

Health insurers tend to adopt structures and business rules that are then rolled out across their portfolio of contracts. There is therefore, likely to be less variation within a health insurer than there is across the industry as a whole, although such variations are likely to persist for a long time. In some instances it may be important for either or both parties to retain legacy arrangements. There are costs and risks for both health insurers and hospitals in changing the structure of contracts in a significant way and timelines are not aligned across contracts so for this reason changes are generally gradual rather than radical.

Variability within a fund can make the calculation of second-tier rates complex. It also means these rates are unlikely to reflect recent innovations or changes in funding models.

Q18. Option for Change | What would be the implications of a published set of independently produced minimum or second-tier default benefits, from which insurers/hospitals could agree loadings/discounts in contracts? How feasible is this option and what data could be used to inform the published benefits?

APHA advocates for the publication of second-tier rates as a measure to improve transparency and efficiency, particularly in the provision of informed financial consent but introduction of a standardised schedule of rates across the industry raising issues well beyond the scope of this project. As already noted above there are risks for all stakeholders in implementing substantial change. The costs and benefits would need to be well understood before any such proposal could be considered.

This option is not feasible without visibility of benefits paid to the independent agency. The consultation paper offers no detail of how this option for change would be implemented or what it would be intended to achieve.

Q19. What impact do other policies or institutional frameworks have on default benefits and contracting? E.g., the National Procedure Banding Committee.

The following two processes provide outputs which are variously and voluntarily used by industry participants in the negotiation of contracts. As such, they have an indirect impact on second-tier default benefits.

- The National Procedure Banding Schedule (NPBS) allows a mechanism for the indirect assignment of relative fair value for procedural services provided by private hospitals. It does this by assigning procedural MBS items to one of 15 cost bands. The costs that can be taken into account are an agreed set of variable costs. In some instances, cost data provided by private hospitals is independently evaluated, but in most instances historical decisions and assessments of broad equivalence are relied upon to achieve a consensus decision. It does not determine the full costs of providing the service and it does not determine the benefit paid. Rather it provides an independent schedule of relativities which can be variously used by industry participants as an input to contractual negotiations.
- The Independent Hospital and Aged Care Pricing Authority manages the private sector National Hospital Cost Data Collection (NHCDC), a voluntary collection that produces a range of hospital cost and activity information by the AR-DRG. An annual report is published on the findings of each collection round. The coverage of this collection is acute admitted care provided by overnight private hospitals.

Q20. To what extent do you think the current arrangements support the safety and quality of health services?

When the second-tier default benefit arrangements were first established, safety and quality accreditation of hospitals was voluntary and a set of quality requirements for second-tier eligibility was established. With the implementation of mandatory accreditation and subsequent iterations of the NSQHC Standards, all of the previous "additional" requirements for second-tier eligibility have been incorporated into the mandatory standards against which all declared private hospitals must be accredited.

Q21. What role does legislation and/or contracts play in ensuring quality and safety of service?

The NSQHS is administered by the Australian Commission on Safety and Quality in Health Care (ACSQHC). The Commission is established under section 8 of the National Health Reform Act 2011.

The requirement for second-tier eligibility to be dependent on NSQHS accreditation is made in the Private Health Insurance (Health Insurance Business) Rules 2018 which have statutory authority under section 333-20 of the PHI Act 2007. However, this same accreditation requirement is also enforced through other regulations.

Accreditation is a prerequisite for a hospital to be declared by the Minister for Health pursuant to section 121-5(6) of the PHI Act. The PHI Act specifies several matters to which the Minister must have regard in granting or revoking a hospital declaration. Section 121-7(f) of the PHI Act provides that hospital declarations are subject to conditions specified in the Private Health Insurance (Health Insurance Business) Rules 2018. The Rules additional matters to which the Minister must have regard in granting hospital declarations. A facility (public or private) must obtain a declaration that it is a hospital when it commences or when two hospitals amalgamate in order to receive payments of health benefits from health insurers, following treatment of insured patients.

Both public and private hospitals must provide either an accreditation certificate against the NSQHC or evidence that accreditation has commenced[17]. Private hospitals must provide a copy of their state/territory hospital licence.

The PHI Act also gives statutory authority to the Private Health Insurance (Accreditation) Rules 2011. Under these rules, the standard for treatment provided by a hospital is that the hospital has the permission, approval or registration to operate as hospital, as required by the state or territory law of the jurisdiction in which it seeks to operate. In most instances, state and territory law in the hospital's jurisdiction also requires accreditation against the NSQHS.

When insurers try to impose their own quality standards through contracting arrangements, this results in the imposition of differing requirements within the one hospital as the hospital is held accountable to multiple insurers/payers. This is inefficient and counterproductive. Safety and quality requirements should be determine independently as provided for under the Australian Health Service Safety and Quality Accreditation Scheme (the AHSSQA Scheme).

Q22. Option for Change | Should quality requirements for hospitals be broadly comparable regardless of contract status? If so, how should this be achieved?

The NSQHS already allows broad comparability of hospitals' quality, via the existence of a core set of standards, within the NSQHS, which must all be fulfilled by any hospital seeking accreditation.

It should also be noted that the ACSQHC has been tasked with working with the public and private health sectors to identify options to align public reporting standards for safety and quality across public and private hospitals nationally.

APHA advocates that health insurers should support and encourage private hospitals to participate in nationally recognised quality and safety programs rather than imposing their own payer-specific requirements. To do soimposes additional administrative burdens on hospitals and results in their being accountable against multiple, often contradictory frameworks.

Q23. Please explain any impact the current default benefit arrangements may have on the supply or demand of private hospital accommodation services.

The majority (63 percent) of private hospitals hold contracts covering in excess of 90 percent of the insured population in the jurisdictions in which they operate, so default benefit arrangements play no part in enabling them to viable – in these instances, the beneficiaries of default benefit arrangements are consumers.

As discussed on pages 5 and following, hospitals with low contractual coverage account for only a small percentage of the sectors overall capacity. Many of those with the lowest rates of contracting provide services which are funded by sources other than private health insurance. Many of these facilities are highly specialised. APHA estimates that those hospitals with contracts covering less than 60 percent of the insured population account for only around 7.6 percent of private hospital sector activity, demonstrating that default benefit arrangements have only a marginal impact on overall supply. Rather the default benefit arrangements increase consumer access to these specialised providers for private health insurance funded services.

[17] The Act, 121-5, (7) (d) The Minister must have regard to:… whether the accreditation requirements of an appropriate accrediting body have been met"

Public hospitals are not dependent on default benefit arrangements. Government funding is adjusted to take account of any private patient revenue to there should be not financial benefit to the hospital. The consumer benefit provided by default benefit arrangements is negligible for privately insured consumers because these consumers are by definition entitled to treatment as public patients. Rather public hospital default benefits create a detriment for non-insured consumers because they divert public hospital resources away from consumers who have no alternative other than to rely on the public hospital system.

The most recent data available indicates that Australia had at most an availability of 2.7 overnight beds per 1,000 of population. For comparison, the Canada has 2.5 and the United States has 2.8 beds per 1,000 of population. The OECD average is 4.4 beds per 1000[18]. These figures show that the supply of private hospital services underpins Australia's ability to maintain a similar level of service to comparable nations. The importance of the private hospital sector capacity and workforce was demonstrated during the height of the COVID-19 pandemic further demonstrating not only an appropriate level of supply, but also the importance of ensuring the viability of the sector.

The consultation paper raises the possibility of possibility of 'supplier-induced demand' – an assertion that default benefits has enabled more operators to enter the market than is justified by natural or underlying demand, and that this has in itself generated additional demand.

However, this argument is contradicted by the following facts.

- Decisions to admit patients for inpatient service are not made by hospitals. These decisions are made by specialist clinicians operating independently of the private hospitals to which they admit patients. It is illegal for private hospitals to induce clinicians to admit patients.
- Decisions to admit patients are made by doctors acting in the best interest of the patients and within the professional standards of their fields of practice. Such standards are set by regulatory authorities such as the Medical Board of Australia.[19]
- The MBS has in-built mechanisms that mitigate the risk of inappropriate use of inpatient Medicare benefits.
- The Private Health Insurance (Benefits Requirements) Rules 2011 require the treating specialists to certify when a procedure which can normally be performed outside a hospital environment requires admission or when a day procedure requires and overnight admission.

Clinicians must complete certification documents as set out in the rules, and private health insurers must check that certification documents meet the requirements.[20]

[18] OECD (2021), Health at a Glance 2021: OECD Indicators, OECD Publishing, Paris, https://doi.org/10.1787/ae3016b9-en.
[19] Good medical practice: a code of conduct for doctors in Australia, October 2022, https://www.medicalboard.gov.au/codes-guidelines-policies/code-of-conduct.aspx
[20] Type C hospital certification, 5 January 2022, https://www.health.gov.au/health-topics/private-health-insurance/private-health-insurance-reforms/type-c-hospital-certification

Q24. How do the current default benefit arrangements and contracting impact the supply of other private health services, and their alignment with demand for those services? Please consider the development and provision of innovative private health services, such as HITH services, hospital-substitute treatment, and preventative care.

The current default benefit arrangements do not apply to all services provided by private hospitals. Specifically they do not apply to:

- Psychiatric day programs
- Rehabilitation day programs
- Psychiatric outreach/home-based services
- Rehabilitation home based services.

These services often do not involve claiming of an MBS item even though, in the hospital context, the service is delivered by a multidisciplinary team and led by a relevant specialist and patients have been referred for these treatment options by a relevant specialist. Health insurers have the discretion not to recognise these in services in contracts. Support can be withheld even when there is a contract in place for other services (e.g. overnight psychiatric admissions, overnight rehabilitation admissions, medical admissions or surgical admissions). Consequently, hospitals confront a high barrier to establishing these services on a sustainable basis because to do so requires the support of multiple payers. With a few exceptions[21], growth of these services has been low and intermittent.

It is important to note that consumers wanting to access mental health, rehabilitation and palliative care in private hospitals are predominantly dependent on private health insurance. Access to these services, where they exist in the public sector is inadequate to meet demand and waiting lists are long. In mental health there is no public sector alternative for most patients treated in the private sector because stretched public sector resources are rationed to those most immediately at risk of harming either themselves or others.

This barrier is evidenced by the low volume of these services, even though services of this type are common in the public sector, where public hospitals are able to provide seamless transitions, stepping up and down the level of care provided by close coordination of admitted inpatient and 'ambulatory services'.

Hospital in the home is another service which has failed to thrive because of the limitations of the default benefit system. In this case, the reasons are more to do with the constraints of the contracting environment. Sometimes health insurers have objected that there is nothing to prevent a hospital providing a contracted service in the home under standard contract arrangements, while hospitals have objected that standard contracts do not make hospital in the home viable. In other instances, an insurer may have refused to recognise a hospital in the home service within a contract. In either case, the hospital is left with no alternative. If they have been successful in winning support for a hospital in the

[21] The limited exceptions have been cases were hospital providers secured contractual support for these programs and they have managed to retain them. Sometimes local market considerations have contributed to the continuance of unusual arrangements. Examples include Ramsay Clinic Adelaide which because of a unique capitated funding model has been able to develop a comprehensive multi-stepped portfolio of psychiatric services.

home service from one payer, they cannot offer it to the clients of other payers and they cannot offer it on an out-of-pocket basis because this is also precluded from contractual arrangements.

It must be noted that innovative services, by definition, are new relative to the existence of second-tier benefits. Second-tier benefits are reflective of established contractual practices because rates are generated from existing contracts. Where contractual conventions have expanded to encompass new services, these services have ultimately been reflected in second-tier rates – this has happened most typically where new MBS items have been recognised for treatments requiring a hospital admission. It is much harder to win recognition of new models of care which do not entail a relevant MBS item even if such models are commonplace in the public hospital sector.

Hospital substitute services and preventative services are funded by private health insurance as general services. By definition, they are not hospital services. Many of these services align closely with services funded by the MBS. Whether any kind a default minimum benefit arrangement should apply to these services is a much wider question, beyond the scope of the issues that can be addressed within this response.

The distinction between hospital substitute services and hospital services and the case for reform is discussed at greater depth on pages 27 and following.

Q25. How can government support the sector in ensuring that evolving consumer health needs are continued to be met by the best health services and technology available at the time?

The government can support the sector in meeting consumer needs by ensuring default benefit arrangements apply to the full scope of hospital services and ensuring that these default benefits are available for services that are not included in contracts, even if a contract between the health insurer and hospital is in place.

These measures will ensure that hospitals are able to introduce new services at scale providing choice and access to consumers, particularly those with specific needs.

In the interests and quality and safety and to maintain the affordability of private health insurance, default benefit arrangements should only be available for hospital services.

The case for reform is discussed at greater depth on pages 27 and following

Q26. Option for Change | Does legislation relating to contracting have a role in promoting innovative health services such as HITH and how can the current legislation be improved to support innovation?

The Private Health Insurance (Benefit Requirements) Rules 2011 makes no reference to hospital in the home creating uncertainty about the legal requirements for funding. In the absence of such clarity hospital providers lack the confidence to heavily invest in and scale up the provision of innovative solutions, particularly in rehabilitation mental health and palliative care but also in services including cancer care, post-surgical care and dialysis.

Insurers have been selective in contracting arrangements, and some have privileged services in which they have a financial interest and imposed contractual arrangements which give them, or their subsidiaries, control of service provision and referral pathways

The scope of default benefits should be expanded so that there is provision of an appropriate form of default benefit for all services which meet the definition of a hospital service.

The case for reform is discussed at greater depth on pages 27 and following.

Q27. Which consumer groups need additional support to access private hospitals?

Within the scope of this consultation, the consumer groups which stand to benefit from reform to default benefit mechanisms include:

- People requiring palliative care
- People requiring psychiatric care
- People requiring rehabilitation services
- People who could benefit from shorter hospital admissions if streamlined pathways to coordinated home based services were available. These people include those living with chronic conditions and people with high risk of relapse or readmission.

Access is currently constrained by the lack of availability of such services.

It is sometimes argued that people in regional and remote locations would particularly benefit from default benefits, but this is not borne out consistently in the data. Analysis by APHA shows that in most states private hospitals in regional areas are more likely to have a good coverage of the insured population (in terms of the contracts held) than private hospitals in metropolitan cities. Although it is true that a third of privately insured patients from regional/remote locations are treated in public hospitals, it is essential to recognise that these people did not need to use their private health insurance to access these services as they were already eligible for treatment as public patients. It is also important to note the majority of these regional private-in-public patients were emergency admissions. People from regional areas electing to be treated as a private patient for non-emergency admissions are much more likely to be admitted to a private hospital.

The other advantage sometimes cited in support of public hospital default benefits is faster access to elective surgery. AIHW data shows patients on elective surgery waiting lists have much shorter wait times when they are treated as private patients in public hospitals. However, this means the availability of default benefits for treatment in public hospitals undermines the principle of Medicare, that access to public hospital services should be based on clinical need, not the capacity to pay. It is not acceptable that these patients should be able to 'jump the queue' at the expense of others who have not option other than wait for the opportunity to be treated as a public patient.

This issue is discussed further at pages 22 and following

Q28. To what extent do default benefit arrangements support consumers to access private hospitals? Is it reasonable to expect default benefits could give more support to consumers given other limiting factors?

See above.

To be clear, the reform of default benefit arrangements is not the only way in which more support could be given to consumers, but the reforms proposed in this submission target specific flaws in current arrangements and barriers to services where the expertise, systems and infrastructure of private hospitals together with the regulatory frameworks within which they operate provide a unique contribution which cannot be provided in other ways.

This issue is discussed further at pages 27 and following.

Q29. Option for Change | What more could/should default benefit arrangements do to support equitable access to privately insured services, or are there more appropriate arrangements to promote equity? If so, what are these arrangements?

See above and pages 18 and following.

Q30. Please comment on whether and how default benefit arrangements impact the public health system considering:

a. *its role in the funding of private patients in public hospitals*
b. *the extent by which it supports patients to access private healthcare services rather than public healthcare services.*

Default benefit arrangements deliver around $1 billion in revenue to public hospitals but in doing so they also reduce the capacity of the public sector to fulfil its obligation to treat public patients based onclinical need.

Default benefit arrangements maximise the extent to which consumers maintain choice in receiving treatment but in practice, patients are not provided with a full range of options, they are rarely for example, assisted in transferring to a private hospital. Rather public hospital sectors often actively 'harvest' private patient elections in order to attain revenue targets. These practices put the interest of the hospital ahead of consumers.

Many public hospitals substantially subsidise the treatment of private patients and thus reduce the out-of-pocket costs that would otherwise apply. This means price signals to consumers are distorted in favour of consumers preferring treatment as a private patient in a public hospital even though this results in an adverse public policy outcome by increasing demand pressures on the public hospital system.

These issues are discussed further at pages 22 and following

Q31. Please detail any ambiguities or other consequences that arise from the legislation in its current state that have not been described above.

These issues are detailed in the body of APHA's submission particularly pages 18 and following.

Q32. Option for Change | In calculating the average charge for the equivalent episode of hospital treatment for second-tier default benefits, what are your thoughts on taking a volume-weighted approach?

APHA is of the view that second -tier benefits should reflect benefits paid rather than contract prices.

In a weighted average calculation, the expected value is dependent not only on each contract price but on the frequency at which it occurs in the distribution of prices. The weighted average is therefore more representative of the market price for an equivalent episode of hospital treatment.

Q33. Option for Change | What are your views on the current second-tier benefit hospital categories? Are there definitional issues created by these definitions – such as potential interpretations for 'rehabilitation care' in the definition of hospital category (b), and how the categories should apply to 'campuses' that are in different locations to a main facility?

Broadly speaking the existing categories are suitable. However, some hospitals are difficult to categorise because they have services mixes that are not typical of their assigned category. For example, they may have been assigned to Category B – Rehabilitation but also provide services in mental health. One consequence is that the second-tier schedules calculated for Category B may not include rates for mental health services. One solution for this anomaly would be to require the use of rates from the next most applicable category, for example Category A – Mental Health.

The diversity within the day hospital sector makes it particularly complex to calculate second tier schedules that appropriately and accurately recognise all services.

There is ambiguity in the meaning of "rehabilitation care" due to its potential application to drug and alcohol rehabilitation treatment. This would be easily addressed by inserting a note within the Rules. Facilities which provide drug rehabilitation should be categorised with psychiatric facilities. It should be noted that in at least one state, Victoria, some drug and alcohol treatments can only be provided in a hospital setting. For this reason it is particularly important that such treatment options be appropriately recognised in default benefit arrangements.

Q34. Option for Change | What changes would you make to these categories?

See above.

Rather than making major changes to the categories themselves, APHA would advocate improvements to the way in which second-tier schedules are calculated, audited, and monitored by the Department.

This issue is discussed further at pages 18 and following

Q35. Option for Change | Please provide details on the administrative costs associated with operationalising minimum and second-tier default benefits, highlighting any areas which are potentially inefficient.

There administrative costs associated with minimum default benefits for private hospitals are negligible. The cost to government of maintaining the relevant regulation is minimal. However, it should be noted that there are substantial additional costs to government in maintaining the public hospital minimum default benefit and associated measures within the NHRA to ensure there is not financial benefit for states in providing services to private patients. This cost includes work conducted by the Independent Hospital and Aged Care Pricing Authority and the National Funding Pool Administrator. Public hospitals and state governments must also devote resources to gathering and accounting for private patient revenue. These resources are diverted from the provision of public patient services. In addition, there is the significant level of subsidisation provided by Commonwealth and state governments for the treatment of private patients in public hospitals.

The current administrative costs associated with second-tier default benefits are minor:

- For health insurers they entail calculation and audit of the second-tier schedule once per year. The administrative costs borne by health insurers are offset by the fact they are paying second-tier hospitals less than contracted hospitals.
- For hospitals they entail the cost of applying for and demonstrating eligibility for second-tier status.
- For government they entail the cost of maintaining relevant regulation, accessing hospital eligibility and receiving audits of schedules. These costs are off set by cost recovery.

The administration of the second-tier benefits could be improved. The increased costs to government involved in this improvement could be offset by abolishing the need for private hospitals to separately qualify for second-tier status. This proposal is discussed in further detail at pages 18 and following.

Q36. Option for Change | What options are available to improve administrative efficiency? Please consider:
a. prescribed contract templates - applicable regardless of whether default benefit arrangements apply

The administrative efficiencies related to contracting are a function of the administrative operations and resources at the disposal of the negotiating parties. Some insurers already use their own standardised templates.

Any case for standardisation across the sector would have to be established separately. The issues that would need to be addressed go well beyond the scope of a review of default benefit arrangements.

Separate to this, use of a prescribed template against which to prepare second tier schedules might potentially offer some benefit in ensuring compliance with the Rules and monitoring by the Department. However, this would require significant further consultation across the sector and a collaborative design process.

b. standardised terms and conditions, including in relation to quality and safety (see Section 3.3)

See answer to question 22.

Q37. Option for Change | What specific changes would you like to see made to default benefit arrangements and what would be the benefits of these changes in relation to the assessment criteria?

See body of the report.

Q38. Option for Change | What are the other key considerations associated with these potential changes to default benefit arrangements, including:
a. the impacts for consumers
b. financial and non-financial cost considerations related to implementation and ongoing administration?

See body of the report.

Errors and comments on statements in the consultation paper

Page 1 "State and territory governments oversee the licensing of hospitals and ensure the relevant accreditation requirements are implemented, in support of the Australian Commission on Safety and Quality in Health Care (ACSQHC), which defines these accreditation requirements nationally."

Section 81-1 The PHI Act states that: 'an insurance policy meets the quality assurance requirement in this Division if the policy prohibits the payment of benefits for a treatment that does not meet the standards of the Private Health Insurance (Accreditation) Rules.'

The standards of the Private Health Insurance (Accreditation) Rules are made by the Minister under section 333-20. Under this rule, hospitals and organisations providing services on behalf of hospitals must meet state and territory law requirements referred to in subrule 6. These requirements may include the NSQHSS.

However, declaring a facility to be a hospital, the Minister must have regard to whether the accreditation requirements of an appropriate accrediting body have been met (Section 121-5).

Under the National Health Reform Act 2011, the Commission is responsible for the formulation of standards relating to health care safety and quality matters. This includes formulating and coordinating the Australian Health Service Safety and Quality Accreditation Scheme (the AHSSQA Scheme), which provides for the national coordination of accreditation processes.

The AHSSQA Scheme provides for the national coordination of accreditation processes. Awarding accreditation is intended to provide assurance to the community that an accredited health service organisation meets expected patient safety and quality standards and the necessary systems and processes are in place to reduce the risk of harm to patients.

All public and private hospitals and day procedure services are required to be accredited to the NSQHS Standards.

Page 6 "Contractual arrangements provide an opportunity for private health insurers and private hospitals to establish a mutually agreeable arrangement."

This statement assumes mutual agreement. It overlooks the fact that often insurers will adopt a 'take it or leave it' approach, particularly when contracting with smaller organisations or organisations that provide standard services.

Page 6: This may occur due to imbalances in the negotiations process, asymmetry of information, and disagreement on maintaining contractual funding rates within industry benchmarks.

This statement implies there are industry benchmarks set by some accepted and independent authority. There are no such industry benchmarks. Health insurers and hospitals may have expectations based on their experience across the market, but this is not the same thing.

Figure 5:

This figure is based on FY20 data which included a substantial impact from COVID-19. During March quarter there were fewer episodes of care than would normally have been expected as consumers and clinicians because aware of the emerging pandemic. During the June quarter of FY20, non-urgent elective surgeries were banned across all states. These events impacted the private hospital sector significantly, but these impacts were different across different segments. Consequently comparisons should be treated with caution.

Page 15 Private hospitals arguably are also incentivised to limit out-of-pocket costs so that potential patients are not deterred (to the extent that potential patients are aware in advance of treatment and that this has an influence on their choice of provider).

Consumers with the opportunity, time and skills to do so may research out-of-pocket costs associated with hospital care. Health insurers often make lists of contracted providers available online and the government website privatehealth.gov.au also provides this information. However, the extent to which this factor influenced consumers is uncertain.

This statement overlooks the role of doctors in determining the facility selected for admission. Clinicians commonly hold admission rights to multiple facilities. They may have a financial interest (e.g. shares in ownership, or they may stand to receive a higher benefit from the health insurer if they select one facility rather than another). Even though it is the hospital's responsibility to provide for informed financial consent in relation to hospital out-of-pockets, it would not be unusual for the admitting doctor (or their staff) to be aware of whether contracted, second-tier or default benefits would apply and this could be one of the factors influencing their recommendation.

Similarly, the existence of contracts with a significant share of the market could be one of the factors attracting doctors to seek admitting rights at one hospital over others. Consequently private hospitals are very aware impacts on their ability to attract and retain relationships with admitting specialists.

Figure 10

This chart compares hospital gaps in contracted and second-tier episodes. The results are not surprising given that contracts preclude hospitals from charging out-of-pocket costs. A more pertinent analysis would have been to compare second-tier hospital gaps with minimum default benefit hospital gaps in order to assess the value provided to consumers.

This chart shows that in major cities, competition exerts downwards pressure on overnight hospitals propensity to charge out-of-pocket costs for second-tier patients. The fact that day hospitals in major cities have not followed the same trend suggests two possible explanations:

- Out-of-pocket costs may be more prevalent amounts day hospitals decreasing competitive pressures.

- Cost pressures and a lack of opportunity to negotiated rates, are leaving day hospitals with no alternative but to increase out-of-pocket costs.

In non-major cities, overnight hospitals are likely to face less competition from other overnight facilities while day hospitals may be under more pressure to compete in a small market competing against both day and overnight facilities.

Figure 11

Medical gaps are not directly impacted by default benefit arrangements although some insurers have attempted to incentivise doctors to preferentially admit to contracted hospitals by offering a higher medical benefit. Differences in case mix between contracted and non-contracting hospitals is another likely contributing factor.

It is also important to note that during this period other measures including a government website have been in place to increase awareness of medical out-of-pocket costs and empower consumers to 'shop-around' and negotiate.

Page 20 "It has been suggested by stakeholders that the presence of default benefit arrangements influences contract negotiations as it both provides information to private hospitals on amounts that have been agreed with other hospitals, as well as giving confidence in the minimum amount that will be agreed. To the extent that this leads to inefficiencies it may result in insurers passing on the cost to their policy holders. However, stakeholders have noted other complexities in contract negotiations that may ultimately result in higher premiums for policy holders and or higher out-of-pockets costs."

Under current arrangements hospitals only have access to second-tier rates when they are not in contract. This means most hospitals have no visibility of second-tier rates for the majority of insurers.

Secondly, the information provided by second-tier rates is indirect. They allow the hospital to infer an average rate for similar services at similar hospitals within that jurisdiction, but this not compel the fund to meet this level in a negotiation. A hospital with this knowledge is, by definition, out of contract, they are at a substantial disadvantage to the fund.

Thirdly, if regulations were to change giving fore-knowledge of second-tier benefits, this would give knowledge of the rates to be paid if negotiations failed but at 15 percent below the average, this still leaves substantial incentive for negotiation.

In referring to "other complexities in contract negotiations that may ultimately result in higher premiums for policy holders and/or high out-of-pockets.", the report provides no examples.

It could also be argued that visibility of second-tier rates would actually provide a powerful incentive for hospitals to attempt to secure a more favourable outcome and/or one more tailored to their specific services and the current environment (rather than an average drawing on contracts negotiated in different circumstances). On their part, insurers could use second-tier rates to drive convergence about a normative level, so it should not be assumed the impact would necessarily be inflationary.

There are many factors influencing benefit outlays, negotiation of hospital benefits is only one factor. Historically, upward trends in utilisation and an increasing complexity in case mix have been the dominant factors. Countering this are:

- Reforms to the Prostheses List which will produce significant reductions in benefits paid for prostheses.

- Trends in favour of short stay admissions.

- MBS reforms introducing constraints on 'low value' care.

- The ability of the private hospital sector to drive efficiencies over time even though the acuity of patients has increased.

In the current environment, the overriding concerns for private hospitals are heightened cost pressures on multiple fronts and the need for evolved business models and models of care that are sustainable. These drivers are likely to made them both tough and persistent negotiators.

Page 22 "However, there are notable examples where contracts between HITH providers and insurers have been agreed; implying that there may be sufficient support for innovation between contracted private health insurers and private hospitals."

The consultation paper provides no examples. APHA's observations are that while promoted heavily in the media, such announcements have yet to produce a significant change in the availability of service options for consumers. This is because announcements by single funders are usually heavily circumscribed and without default benefit arrangements there is no opportunity for hospitals to provide these services at scale. These problems are demonstrated in the low numbers of episodes reported.

Page 22 "There are also other innovative services to consider in developing a funding solution, including hospital-substitute treatment and preventative care."

Hospital substitute and preventative services are funded by health insurers are general services. They are, by definition, services provided by non-hospitals. Many of these services are substantially similar to those funded through MBS and state and Commonwealth governments and they are fundamentally different, in funding, clinical governance and focus, from "ambulatory services" provided by hospitals.

The Australian Private Hospitals Association

- The Australian Private Hospitals Association (APHA) is the largest peak industry body representing the private hospital and day surgery sector.
- APHA members provide services in all states and territories.
- APHA members operate 160 overnight hospitals and 151 day hospitals across Australia.
- Major operators within the membership include:
    - Adventist HealthCare Limited
    - Aurora Healthcare
    - Cura Day Hospitals Group
    - Dental Corporation Pty Ltd
    - Eastern Heart Clinic Group
    - Epworth HealthCare
    - Evolution Healthcare Pty Ltd
    - Genea Limited
    - GenesisCare
    - Healthe Care Surgical Pty Ltd
    - Icon Pty Ltd
    - MSI Australia
    - Nexus Day Hospitals Pty Ltd
    - PresMed Australia
    - Queensland Eye Institute
    - Ramsay Health Care Australia Pty Ltd
    - Royal Rehab Group
    - The Park Private Hospital & Walcott Street Surgical Centre
    - Unitas HealthCare Pty Ltd
    - UnitingCare Health Group
    - Vision Eye Institute
    - Wesley Hospital Ashfield & Kogarah.

In addition to these corporate groups, APHA represents more than 90 independent stand-alone facilities.