

Australian  
**Private Hospitals**  
Association



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Australian Private Hospitals Association ABN 82 008 623 809

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# PRIVATE HEALTH – WHAT NEEDS TO BE DONE

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## Private health remains integral to the Australian health sector

The private hospital sector provides more than 34,300 licensed beds<sup>1</sup>, a resource that would cost taxpayers more than \$34 billion to replicate in the public sector.

The private hospital sector employs 137,400 people<sup>2</sup>. In ordinary circumstances the sector has a turn-over of \$17 billion<sup>3</sup> and operates with an overall profit margin of just 4.5%<sup>4</sup>. In 2020, the sector was directly impacted by the COVID-19 pandemic as consumers deferred non-emergency services and operators worked with government to rapidly divert resources in readiness for forecast scenarios and in response to changing clinical priorities.

Throughout 2020, the private hospital sector proved itself ready, willing and able to partner with the Commonwealth and with States and Territories in meeting the challenges posed by the COVID-19 pandemic:

- The private hospital sector responded swiftly reducing volumes of admissions and elective surgeries to reduce demand for intensive care and consumables essential to the pandemic response.
- Private hospitals provide 35% of Australia's standing intensive care capacity<sup>5</sup> and negotiated with States/Territories to contribute additional surge capacity in beds, equipment and clinical personnel.
- Private hospital operators demonstrated agility in responding to specific requests from the Commonwealth and individual States/Territories to assist with the treatment of COVID-patients and non-COVID patients. For example, on 28 March private hospitals in Western Australia responded immediately to an urgent government request to accept 46 symptomatic patients from the cruise ship Artania.
- In Victoria, private hospitals accepted residents transferred from aged-care homes where outbreaks had occurred, treating COVID-19 patients requiring hospitalisation.
- The private hospital sector also made staff available as part of the whole of sector response to the high levels of community transmission and the need to back-fill vacancies as the of cases and requirements for isolation increased within the health and aged-care workforces.

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<sup>1</sup> ABS, Private Hospitals, Australia 2016-17, Catalogue 4390.0

<sup>2</sup> People employed as at the end of June ABS, Australian Industry, 2018-19, Friday 29 May 2020.

<sup>3</sup> Sales and service income for 2018-19, ABS, Australian Industry, 2018-19, Friday 29 May 2020.

<sup>4</sup> Ratio of operating profit before tax to Sales and service income for 2018-19.

<sup>5</sup> AIHW, Admitted Patient Care, 2018-19.

In the second half of 2020 as and when it has been possible to ease restrictions on elective surgery, the private hospital sector has focussed on ensuring that services are delivered to consumers safely and efficiently so that backlogs in deferred demand can be addressed. The private hospital sector is doing this by:

- Implementing additional infection control measures to protect patients, staff and the wider community.
- Bringing capacity for elective surgery back on line as quickly as possible.
- Addressing the surgical and medical care needs of patients whose health conditions were exacerbated as a result of the pandemic.
- Providing acute psychiatric care to patients requiring hospital admission throughout the course of the pandemic.
- Establishing alternative models for the delivery of care including delivery of care in the home and in community settings and using virtual health technology.

During the last decade, private hospitals have driven efficiencies, just at the time when the age and complexity of patients has been increasing. Data prior to the COVID-19 pandemic shows:

- The average length of stay in the private hospital sector has decreased by eight percent<sup>6</sup>
- The complexity of overnight patients in private hospitals has increased by nine percent<sup>7</sup>
- Total expenditure per separation has increased in real terms by less than three percent over the decade as whole and has, in fact, decreased in real terms in five of those years<sup>8</sup>
- In the year ending 31 March 2020, private health insurance benefits paid to private hospitals increased 3.4 percent, but this was entirely due to increased utilisation. The benefit paid per separation actually decreased in real terms<sup>9</sup>
- Expenditure growth in the public hospital system was 4.2 percent in real terms over 2015-16 to 2017-18. In the private hospital system it was only 2.6 percent<sup>10</sup>.

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

The biggest driver of private health insurance outlays is utilisation. Annual utilisation of hospital cover has increased from 312 per 1000 people covered to 420 per 1000 people covered<sup>11</sup>. In summary:

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<sup>6</sup> AIHW Admitted Patient Care, 2008-9 and 2017-18.

<sup>7</sup> AIHW Admitted Patient Care, various years.

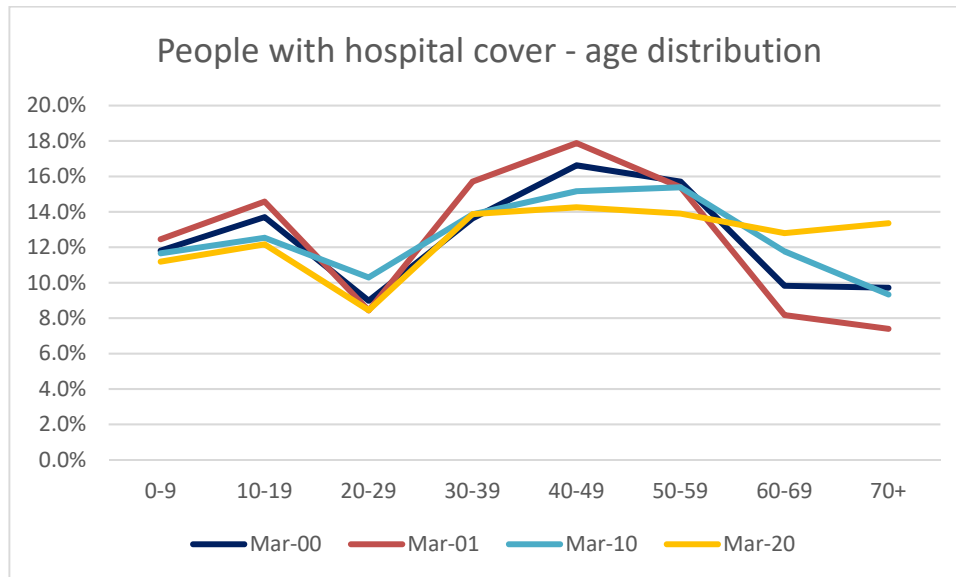
<sup>8</sup> AIHW Admitted Patient Care, various years, Health Expenditure Australia, 2017-18

<sup>9</sup> APRA, Private Health Insurance Statistics

<sup>10</sup> AIHW Health Expenditure Australia, 2017-18

<sup>11</sup> APRA, Private Health Insurance Statistics, 30 March 2020. Note that this analysis does not account for the impact of the COVID-19 pandemic.

- Consumers, particularly younger people, who perceive themselves less likely to need private health insurance are dropping their cover or electing not to take cover.
- Consumers who retain private health insurance are using their cover.
- As shown by the chart below, the insured population is ageing.



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

Recent reforms introducing an age-based discount from 1 April 2019 have not increased youth private health insurance participation<sup>12</sup>. Although more than two thirds of policy holders aged 25-29 are in receipt of a discount, less than 25% of people in this age group are covered for hospital care. Market research by APHA shows that the community in general remains unaware that aged-based discounts are available.

In this context, three challenges must be met:

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

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

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

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

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<sup>12</sup> Department of Health, Private Health Insurance Reform Data

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

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

## **Consumers and taxpayers need to be assured of value**

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

- The Medicare Benefits Schedule (MBS) Review is rightly reforming the benefits schedule and associated rules to reflect contemporary medical practice
- The agreement between the Federal Government and the Medical Technology Association of Australia (MTAA) outlines a program of reform that needs to be followed through to ensure technologies are made available at a realistic price and the Prostheses List reflects changes in medical technology
- The 2020-2025 Addendum to the National Health Reform Agreement commits States, Territories and the Commonwealth to ensuring that there is 'overall parity' in the funding provided to public and private patients. The Addendum also affirms a strengthened requirement that access to public hospital services is to be solely "on the basis of clinical need and within a clinically appropriate period". This agreement should remove the incentive for further upwards pressure on PHI premiums from the public hospital sector.

As the public and private hospitals work together to manage the COVID-19 pandemic and the significant backlog in elective surgery, the Addendum to the National Health Reform Agreement needs to be complemented by a comprehensive policy framework including:

- Removal of the rebate on 'public hospital only' (basic tier) policies as these products only provide access to public hospitals.
- Removal of the obligation for private health insurers to pay for private patients treated in public hospitals so as to reduce the pressure on private health insurance premiums while preserving the value proposition of private health insurance.
- Strengthened patient election provisions including provision of the option to be transferred to a private hospital.

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

- Pharmacy services for consumers during a hospital admission and immediately following discharge.

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

Prior to the onset of the COVID-19 pandemic, private hospitals were already striving to respond to consumers by providing new services. These include services delivered in people's homes and services delivered to people in regional communities.

The onset of the COVID-19 pandemic and associated restrictions made the provision of flexible care options even more important as consumers were obliged to restrict their movements and hospitals modified their services in order to meet physical distancing requirements and other preventative measures. In this context, the ability to provide integrated services delivered both within a hospital facility and in patients' homes using both face-to-face and virtual health technologies has become even more important.

However, two factors have prevented private hospital operators from developing these innovations to the point of scalable viability:

- The MBS specifically precludes payment of benefits for services provided using virtual health technologies for in-patients. Virtual health is an adjunct, not a replacement for face to face consultation. However this preclusion is a fundamental barrier to continuity of care for vulnerable patients. For example, a psychiatrist required to self-isolate is unable to provide continuity of care to their admitted patients. Care cannot readily be delegated to other specialists in the private sector and in some instances, including psychiatry, delegation can be contrary to best practice because of the importance of the therapeutic relationship.
- Health insurers are not obliged to provide benefits for services delivered as day programs, community based programs or home based services including services delivered through virtual health. This means that unless hospitals can persuade multiple payers to contract for the provision of services there is no scope for them to be provided on a sustainable scale. Lack of support from health insurers for innovations of this type has also limited the ability of private hospitals to continue services under COVID-19 restrictions.

Going forward, regulatory change is needed to support the continued development and delivery of adaptive and innovative services. The changes required include:

- Provision of MBS items for the use of virtual health in delivering consultations and case-conferencing for private hospital in-patients.
- A minimum default benefit for the provision of hospital-in-the-home, day programs, and hospital services delivered using virtual health technologies.

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

- Information on medical out-of-pocket costs
- The availability of independent information and advice for consumers.
- Transparency of information for consumers concerning vertical integration and the commercial interests of health insurers in health services.

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

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

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

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

As was acknowledged in the National Principles for Clinical Education During the COVID-19 Pandemic<sup>13</sup>, access to clinical placements was directly impacted by the pandemic, particularly nationally in the period March-May 2020 and in more recently in Victoria, when levels of hospital activity in both public and private sectors was significantly lower than normal. It is imperative that the Australian Government resource additional clinical placement opportunities and positions for early career clinicians so that students and recent graduates can resume their career pathways.

The independent review of nursing education conducted in 2019 by Emeritus Professor Steven Schwartz AM for the Federal Government has strongly recommended a greater emphasis and more funding, for clinical placements in nursing education<sup>14</sup>.

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<sup>13</sup> National Principles for Clinical Education During the COVID-19 Pandemic was released by the Australian Government's Department of Health and Department of Education, Skills and Employment, the Australian Health Professionals Regulatory Authority and National Boards and the Health Professions Accreditation Collaborative Forum.

<sup>14</sup> Department of Health, 'Educating the Nurse of the Future—Report of the Independent Review into Nursing Education' Author: Emeritus Professor Steven Schwartz, Commonwealth of Australia 2019.



Work on the National Medical Workforce Strategy was suspended in March 2020 due to the COVID-19 pandemic. This Strategy needs to be completed as soon as possible and consideration of the recommendations to be prioritised.

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

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

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

- 1. Index income thresholds used to calculate the Private Health Insurance Rebate**  
Indexation of income thresholds used to calculate the Rebate will protect policy holders who would otherwise be effected by 'bracket creep'.
- 2. Maintain the effective Private Health Insurance Rebate at 1 April 2020 levels.**  
Maintaining the Rebate at the effective levels applicable on 1 April 2020 will protect policy holders eligible for the rebate from the double effect of an increase in premiums and a decrease in the effective value of the Rebate.
- 3. Restore the Private Health Insurance Rebate to 30 percent for households in the lowest income tier.**  
Restoring the rebate for households in the lowest income tier to 2013-14 levels: 30 percent for under 65 year olds; 35 percent for 65-69 year olds and 40 percent for 70 year olds, providing a reduction in premiums
- 4. Fund a government communications campaign to promote awareness of government measures to improve the value of private health insurance within the general community.**  
Addressing the lack of general awareness in the community of discounts available to young people and the availability of an opportunity to immediately upgrade health cover to access mental health care will assist in improving the participation of young people in private health insurance.
- 5. Increase the age to which a young adult can be considered a dependent for the purpose of private health insurance.**  
Increasing the age to which a young adult can be considered a dependent will improve access to private health insurance for young people directly affected by the economic impact of the COVID-19 pandemic, particularly those retraining for new employment opportunities.
- 6. Reform to the Lifetime Health Cover Loading**  
Reform the Lifetime Health Cover (LHC) loading to reduce the deterrent to the growing number of people who have health insurance by the age of 31 from taking out health insurance.
- 7. Increase the Medicare Surcharge Levy**  
Doubling the Medicare Surcharge Levy will provide a more realistic incentive to higher income households to invest in private health insurance. Estimated Revenue: up to \$355 million.
- 8. Curb claims to private health insurance for private patients in public hospitals as a result of the Addendum to the 2020-2025 National Health Reform Agreement**  
Reduced private health insurance benefits for private patients in public hospitals would reduce health insurer outlays immediately, reducing upwards pressure on private health

insurance premiums and the Private Health Insurance Rebate.  
Saving: up to \$380 million.

**9. Remove barriers to hospital providers delivering at scale contemporary models of care including delivery of care in the community and in the home and through virtual health**

- Introduce a minimum default benefit for day programs and services delivered in the home/community in mental health, rehabilitation and palliative care.
- In response to the COVID-19 pandemic, introduce and retain MBS items for the use of virtual health in delivering consultations and case-conferencing for private hospital in-patients.

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

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

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

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

Cost: Dependent upon further analysis by relevant departments.

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

Waive the Skilled Migration Levy for the sponsorship of registered nurses and midwives.

Cost: \$2 million in foregone revenue to the Skilling Australia Levy.

# IMPROVING ACCESS TO AFFORDABLE HEALTHCARE

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

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

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

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

Year 1 April - 30 March	Base tier rebate	Industry average increase	Premium before rebate	Premium after rebate	Increased cost to the consumer
2013–14	30.000%	5.60%	\$3,892.90	\$2,725.03	5.60%
2014–15	29.040%	6.20%	\$4,134.26	\$2,933.67	7.66%
2015–16	27.820%	6.18%	\$4,389.76	\$3,168.53	8.01%
2016–17	26.791%	5.59%	\$4,635.14	\$3,393.34	7.10%
2017–18	25.934%	4.84%	\$4,859.49	\$3,599.23	6.07%
2018–19	25.415%	3.95%	\$5,051.44	\$3,767.62	4.68%
2019–20*	25.059%	3.25%	\$5,215.61	\$3,908.63	3.74%
2020(A)	25.059%	0.00%	\$5,215.61	\$3,908.63	0.00%
2020(B)	25.059%	2.92%	\$5,367.91	\$4,022.76	2.92%
2021-22 est	24.559%	2.92%	\$5,524.65	\$4,167.85	3.61%

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

\* The rebate did not change on 1 April 2020. It remained at this level for the period 1 April 2020-1 March 2021<sup>15</sup>.

2020 (A) Many health insurers have deferred the increase in premiums for at least some members for a period of time.

2020 (B) Most health insurers will apply the increase approved for 2020-21 at some point during the year.

2021-22 estimate. This estimate has been calculated by APHA assuming that a further increase in premiums will be approved and that the rebate adjustments will be similar to previous years.

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

<sup>15</sup> PHI 24/20 - Private Health Insurance Rebate Adjustment Factor Effective 1 April 2020

Although the Australian Government approved a premium increase of 2.92% from 1 April 2020, many health insurers deferred their 2020 premium changes on some or all of their products for periods from three to twelve months. The Commonwealth Government also ensured that the effective Private Health Insurance Rebate remained unchanged for the period 1 April 2020 to 30 March 2021. These arrangements have provided important relief to policy holders affected by loss of income as a result of the COVID-19 pandemic.

However, during 2020/2021, PHI policy holders will be asked to accept:

- deferred 1 April 2020 premium increases (with application and timing varying across health insurers)
- additional premium increases effective 1 April 2021, and
- a reduction in the effective PHI rebate from 1 April 2021.

The cumulative effect of these factors could be an effective increase of 6.6% on 1 April 2021 compared with 1 April 2020 for households on the lowest income tier.

This means that there is a heightened risk that policy holders will elect to drop their health insurance, particularly where households have subject to continuing economic stress. A reduced level of private health insurance participation will be particularly deleterious at a time when waiting lists for public hospitals will be under additional pressure as a result of the medium and longer term impacts of the COVID-19 pandemic.

The COVID-19 pandemic has had a substantial impact on jobs over the quarter to May 2020, with employment falling by 838,300 (or 6.5 per cent) between February 2020 and May 2020, in seasonally adjusted terms<sup>16</sup>. Retirees have seen the value of their superannuation and savings eroded. Nearly one in five Australians (19%) reported their household finances had worsened due to COVID-19 in the four weeks to mid-June<sup>17</sup>. These figures do not reflect the further impact of COVID-19 and associated restrictions since May 2020.

The Australian Government will need to ensure that premium increases are managed responsibly and clearly communicated to consumers. It will also need to minimise the impact on households most at risk of dropping their private health insurance.

Seventy-two percent of private health insurance policy holders are in the base tier households<sup>18</sup>. This tier has the greatest influence on private health insurance participation; shaping the trends that determine the sustainability of private health insurance. Yet current policy settings mean these households are the most affected by increases on health insurance premiums, even though they are the least able to absorb them.

Further-more the income thresholds used to calculate the private health insurance rebate have remain unchanged for six years from 2015–16 to 2020–21.. As a result the number of

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<sup>16</sup> Data source: ABS, Labour Force, Australia, cat. no. 6202.0, May 2020, seasonally adjusted

<sup>17</sup> Household Impacts of COVID-19 Survey, 10-15 June 2020 , cat no 4940.0

<sup>18</sup> Australian Taxation Office, Statistics 2017-18.

households subject to reduced private health insurance rebates has increased due to bracket creep.

These inequities should be addressed by the following steps:

1. Indexing the income levels used to calculate entitlement to the Private Health Insurance Rebate.
2. Restoring the rebate for households in the lowest income tier to 30 percent for under 65 year olds; 35 percent for 65-69 year olds and 40 percent for 70 year olds would effectively reduce average premiums for these households by between two percent and four percent.
3. Retaining the Private Health Insurance Rebate at the 1 April 2020 effective level for income levels 1 and 2. This would protect these households from the 'double whammy' of a premium increase and a decrease in the value of the rebate.

Expenditure on these measures would be partially offset by removing the application of the rebate on "Basic" level products (see page 16-17)

- **Promote awareness of government measures to improve the value of private health insurance within the general community.**

Reforms introduced over the last two years to improve the value of private health insurance, particularly for young people have been effective for individual consumers but they are not widely understood across the general community.

As at 30 March 2020, more than two thirds of 25 to 29 year olds covered for private health insurance were in receipt of a discounted premium. Thirty percent of all people benefiting from the opportunity to access an immediate upgrade in order to access urgent mental health care during the year ending 30 March 2020 were aged under 30.

Research commissioned by APHA shows:

- 80% of Australians are unaware of the availability of discounts for young people.
- Australians are also unaware of the opportunity to obtain an instant upgrade to full-cover for mental health.

This lack of awareness has limited the reforms' effectiveness in increasing the participation of younger people in private health insurance.

Notwithstanding the Australian Government's reforms, the number of 25-29 year olds covered for hospital care has fallen from a peak in June 2014 of 555,240 people to 427,495 people as at March 2020.

The immediate and longer term implications of investing in private health insurance before the age of 30 are both complex and significant. The Australian Government needs to invest

in a targeted communication campaign to ensure that people who are not covered by private health insurance are aware of government measures which improve the affordability of value of private health insurance, particularly for young people including the availability of discounts, the future implications of tapered discounts and avoidance of the Lifetime Health Cover loading.

- **Support continuity of coverage for young adult dependents**

Young adults over the age of 18 can be covered by their parent's/guardian's policy up until the age of 25, provided they meet conditions required by the health insurer, for example, the person may have to be a full-time student. These conditions can vary between insurers. This provision is a significant contributor to participation rates for people aged 20-24 being higher than for those aged 25-29.

Young people have been disproportionately affected by the economic impact of COVID-19. Many of them are at risk of long-term unemployment and will need to retrain in order to regain employment. For these reasons the age limit for young adult dependents should be extended to 30.

This measure will also increase the likelihood that young adults will purchase their own coverage when they become liable to the Lifetime Health Cover Loading in their thirty-first year.

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

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

At the end of the March 2020 quarter, there were 882,791 people with a certified age of entry of more than 30 and subject to a LHC loading; a net decrease in people paying a penalty over the preceding 12 months of 50,484<sup>19</sup>. The number of people aged between 30 and 49 who have private health insurance has also been decreasing since mid 2016.

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

Potential reform options for consideration include:

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<sup>19</sup> APRA Quarterly Statistics March Quarter AHRA

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

- **Reform to the Medicare Levy Surcharge**

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

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

In 2017-18, this surcharge levy was paid by 274,844 people; an increase of 40 percent in one year. The average levy paid was \$1,290 and the median was \$1,027<sup>20</sup>. This is less than the annual premium for a bronze level of cover for a single person, the minimum level of cover required to provide access to a private hospital.

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

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

Doubling of the levy would increase the average amount paid to \$2,580, still less than the median premium available in most states for a single adult. This measure could initially generate additional revenue of \$355 million. Revenue would be reduced if the reform achieved its intended effect of increasing participation in private health insurance.

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<sup>20</sup> Australian Taxation Office, Statistics 2016-17 and 2017-18



# ENSURING THAT PRIVATE HEALTH DELIVERS VALUE

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## Appropriate claiming

- **Curb claims to private health insurance for private patients in public hospitals within the 2020-2025 National Health Reform Agreement.**

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

Stopping public hospitals from ‘harvesting’ private patient revenue could save health insurers \$1.5 billion each year that would result in a six percent reduction in premiums<sup>21</sup>.

Ten percent of the total inflation-adjusted increase in private health insurance benefits outlaid for hospital care over the decade to 2017-18 is due to public hospitals chasing private health insurance revenue. During the decade, growth in private patients in public hospitals averaged 6.3 percent per annum, a rate of growth that exceeded the growth in number people covered by private health insurance and a rate that is only explicable by the aggressive and deliberate policies adopted by State governments<sup>22</sup>.

During the same period the increase in private patients in private hospitals and day surgeries averaged just 3.6 percent<sup>23</sup>. State governments have set revenue targets for public hospitals and allocated resources to the collection of private health insurance revenue even when the clinical care provided to the patient is identical to that which they would have received as a public patient.

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

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

This practice is also a waste of government resources, diverting them away from patient care to revenue generation. The Victorian Auditor-General found in 2019 that public hospitals did not know the cost of this activity and could not accurately measure the net financial result<sup>24</sup>.

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<sup>21</sup> AIHW, Health Expenditure, APRA Private Health Insurance Statistics

<sup>22</sup> AIHW Admitted Patient Care, various years.

<sup>23</sup> AIHW Admitted Patient Care, various years

<sup>24</sup> Victorian Auditor General, Managing Private Medical Practice in Public Hospitals, 2019

The 2020-2025 Addendum to the National Health Reform Agreement (the Addendum) affirms a strengthened requirement that access to public hospital services is to be solely “on the basis of clinical need and within a clinically appropriate period”. This principle is of particular significance as the health system works to provide timely health services in the wake of the COVID-19 pandemic. During the first half of 2020, both public and private hospitals noted a dramatic reduction in hospital admissions and consumers withdrew from seeking treatment. From 1 April until 15 May, all but the most urgent surgeries were deferred nation-wide and restrictions remain in place in Victoria. Even after mandatory restrictions hospitals were lifted in most jurisdictions, implementation of additional precautionary measures meant most hospitals did not return to full capacity.

It is therefore imperative that government resources allocated to public hospitals are used in accordance with clinical need alone. It is not appropriate to divert government resources away from clinical services to drive generation of revenue. It is not appropriate to give private patients preferential access to public hospital services. Efficient management across both private and public hospital sectors will be required to address pent up demand as a result of deferred services on-top of ongoing requirements for hospital services. In this context, government policy needs to strengthen and reinforce the ability of private health insurance to provide consumers with choices that take pressure off the already over-burdened public hospital sector.

The Addendum commits states and territories and the Commonwealth to ensuring that there is ‘overall parity’ in the funding provided to public and private patients. This agreement should remove the incentive for further upwards pressure on PHI premiums from the public hospital sector. However the implementation of changes to the pricing of private patient activity will not occur until 2021/22. Furthermore the application of ‘back-casting’ means that States/Territories will only be penalised if they increase their private patient activity above levels attained in 2020/21.

While the Agreement is an important statement of principle, the immediate challenges of an overburdened public hospital sector, lengthening public waiting lists and upwards pressure on private health insurance premiums will require a more comprehensive policy framework. APHA advocates:

- A removal of the Private Health Insurance Rebate on ‘public hospital only’ (basic tier) policies as these products only provide access to public hospitals
- Removal of the obligation for private health insurers to pay for private patients treated in public hospitals, relieving pressure on health insurance premiums at no detriment to consumers.
- Strengthened patient election provisions including provision of the option to be transferred to a private hospital to expand the options available to consumers and facilitate efficient management of pent up demand for hospital services.

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

Key facts:

- Private patients took up over three million days of care in public hospitals, an estimated 14.9 percent of all public hospital days of care in 2018–19, more than 1.4 times the share from a decade ago. This equates to more than 8,000 public hospital beds.
  - In 2018/19, 881,547 Australians used private health insurance in public hospitals, according to the Australian Institute of Health and Welfare (AIHW)<sup>25</sup>. This was 12.7 percent of all public hospital admissions.
  - In many individual public hospitals, the proportion of patients admitted privately is far higher – over 40 percent.
  - Transferring the more than 100,000 surgeries (elective and emergency) currently performed on private patients in public hospitals to private hospitals, would increase the number of public patient elective surgeries by 16 percent.
  - Half of all private patient admissions in public hospitals are for emergency care, and in some states these percentages are much higher. However, many of those privately insured emergency patients could have been transferred and treated in a private hospital, freeing up beds, reducing ambulance ramping and lessening pressure on public emergency departments. Public hospitals do nothing to facilitate such transfers.
  - Choice for private patients is limited when admitted through a public emergency department. Patients are treated by the available clinicians, so there is no real choice of doctor for the privately insured. Where clinically appropriate, transfer of these patients to private hospitals can provide a greater range of choices including choice of environment, doctor and access to timely care.
- **Implement evidence-based reform of the Prostheses List to ensure technologies are made available at a realistic price and the Prostheses List reflects changes in medical technology.**

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

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

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

When announced, the Agreement was forecast to deliver a reduction in projected private health insurance benefit outlays \$1.1 billion over four years<sup>26</sup>. Savings were the result of

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<sup>25</sup> AIHW, Admitted Patient Care, 2018-19

<sup>26</sup> Total savings from reductions made in the period 2018 to 2021. Department of Health website accessed on 19 December 2019. <https://www1.health.gov>.

reduction in benefits in February 2018, August 2018, February 2019 and February 2020 and were in addition to reductions implemented in 2017. As a consequence of the Agreement total benefit outlays reduced in the years ending 31 March 2018, 31 March 2019 and 30 June 2019. Outlays increased in the year ending 31 March 2020 due to the addition of valuable life-saving technologies to the Prostheses List including high cost cardiology and orthopaedic devices, even so growth in outlays remained below levels for years prior to the Agreement<sup>27</sup>.

Year Ending	Total Prostheses Benefits Paid	Annual Growth
Mar-16	\$1,967,277,000.68	6.7%
Mar-17	\$2,090,886,035.97	6.3%
Mar-18	\$2,084,149,258.70	-0.3%
Mar-19	\$2,077,873,732.61	-0.3%
Jun-19	\$2,081,485,131.89	-0.6%
Sep-19	\$2,123,428,464.93	1.5%
Dec-19	\$2,173,790,192.35	5.1%
Mar-20	\$2,198,592,767.99	5.8%

## Reduction in avoidable hospital admissions

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

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

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

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

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[au/internet/main/publishing.nsf/Content/private-health-insurance-reforms-fact-sheet-prostheses-list-benefit-reductions](http://au/internet/main/publishing.nsf/Content/private-health-insurance-reforms-fact-sheet-prostheses-list-benefit-reductions)

<sup>27</sup> APRA, Private Health Insurance Statistics

The sustainability of hospital-based pharmacy services was placed under further pressure when the 2019-20 Federal Budget reduced the wholesale mark-up payable to Section 94 pharmacies for Section 85 drugs. On top of this, the Seventh Community Pharmacy Agreement has exacerbated the impact of this decision by introducing substantial additional changes to remuneration. The impact of these changes is varied across the private hospital sector because of the different ways pharmacy services are structured. Many pharmacy services are provided through Section 90 arrangements, but some, including major private hospitals, are reliant on Section 94 arrangements.

The impact of these changes has been most severe on hospitals dispensing significant quantities of high cost Section 85 drugs under Section 94 licences. Section 94 pharmacies receive none of the compensatory benefits provided to community based pharmacies by the Administration, Handling and Infrastructure fee. The drugs most impacted by these changes include therapies used to treat cancer patients. The unintended consequence of this change has been to force highly specialised pharmacy services treating complex patients to reduce their level of professional staffing.

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

- Extension to private hospital sector Section 94 pharmacies of the Administration, Handling and Infrastructure fees that are available to Section 90 community pharmacies.
  - Permission for Section 94 pharmacies to dispense to non-inpatients, thereby supporting continuity of care and reducing risk of readmission.
  - Provision of access to provision of medication review funding so that specialised hospital pharmacies can provide reviews to consumers at high risk of hospital readmission.
  - Provision of incentives to pharmacists to promote the uptake of bio-similars recognising the role that pharmacists play in educating clinicians and patients on the benefits of using these cost-effective alternatives.
- **Reduce avoidable hospital readmissions by providing insurance cover for patients admitted for day procedures, but not stable enough for same-day discharge because of travel distance or lack of home/medical support.**

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

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

Amendment of the Rules to allow for overnight admission of these cases would reduce the risk of readmissions and improve patient safety particularly for people living in regional and rural locations.

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

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

The Department of Health's Private Hospital Data Bureau (PHDB) reports that only 25,423 separations involving a charge for hospital-in-the-home care were delivered in 2017-18. According to the same source, these separations account for 10.6 percent of all those delivered that year. According to the Department of Health's Hospital Casemix Protocol Annual Report for 2017-18, 21,285 private sector hospital-in-the-home separations were funded through private health insurance.

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

The onset of the COVID-19 pandemic and associated restrictions has made the provision of flexible care options even more important as consumers have been obliged to restrict their movements and hospitals have sought to modify their services in order to meet physical distancing requirements and other preventative measures. In this context, the ability to provide integrated services delivered both within a hospital facility and in patients homes using both face-to-face and virtual health technologies has become even more important.

Virtual health is an adjunct, not a replacement for face to face consultation but it is an essential tool in providing continuity of care for vulnerable patients. For example, a psychiatrist required to self-isolate due to COVID-19 is unable to provide continuity of care to their admitted patients. Care cannot readily be delegated to other specialists in the private sector and in some instances, including psychiatry, delegation can be contrary to best practice because of the importance of continuity in the therapeutic relationship. Virtual health technologies also assist hospitals in delivering care to vulnerable patients by facilitating care in their own homes and by enabling the use of hospital facilities in a safe way. For example, where as previously group therapy rooms in psychiatric and rehabilitation hospitals were large enough to accommodate standard group sizes, some facilities cannot provide recommended COVID-19 physical distancing requirements without video-conferencing to enable standard groups to be split between more than one room (with clinical staff in each room).

Going forward, once COVID-19 restrictions ease, face to face consultations will likely remain the norm within hospitals but there will still be value in exploring the scope to use virtual health technologies to assist in providing services to people in their homes and to people living in remote and regional communities.

Unlike admitted hospital care, there is no provision for minimum default benefits for day programs or home-based services in mental health, rehabilitation and palliative care. Consequently, consumers can only access these programs if their insurer has contracted with the hospital to cover them. The reluctance of insurers to support home-based services provided by private hospitals has retarded their growth.

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

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

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

The Australian Government needs to remove barriers to hospital providers delivering at scale contemporary models of care including delivery of care in the community and in the home and through virtual health by:

- Introducing a minimum default benefit for day programs and services delivered by hospitals in the home/community in mental health, rehabilitation and palliative care
  - Introducing and retaining provision of MBS items for the use of virtual health in delivering consultations and case-conferencing for private hospital in-patients.
- **Create a level and well regulated playing field for hospital and non-hospital providers – i.e. government endorsed guidelines assuring minimum quality standards.**

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

Hospitals must meet the National Safety and Quality Health Service Standards. Hospitals providing mental health and rehabilitation services are also obliged to meet the requirements of industry-agreed guidelines. These guidelines were originally developed with the involvement and endorsement of the Federal Government. The Improved Models of Care Working Group of the Private Health Ministerial Advisory Committee recognised

these guidelines provided a logical starting point for a common framework applicable for both hospital and non-hospital services.

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

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

The National Mental Health Commission's Equally Well consensus statement aims to reduce the life expectancy gap that exists between people living with a mental illness and the general population by championing the importance of the physical health of people living with a mental health condition<sup>28</sup>. This aim is reflected in the Fifth Mental Health Agreement.

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

The Federal Government's Private Health Insurance Rules assume a patient is either a psychiatric patient or not a psychiatric patient. The regulations do not admit the possibility that a patient might require both medical and psychiatric treatment. For example, a patient may require urgent medical or surgical treatment that cannot be deferred until their acute psychiatric condition has abated. As a consequence, health insurers refuse to cover the provision of medical treatment if, in their view, the patient is a psychiatric patient.

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

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

- There are circumstances where a patient admitted for mental health treatment may also require cover to medical and/or surgical treatment, including the provision of mental health treatment and medical and/or surgical treatment on the same day

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<sup>28</sup> National Mental Health Commission, Equally Well Equally Well Consensus Statement: Improving the physical health and wellbeing of people living with mental illness in Australia. Sydney NMHC, 2016.



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

## Evidence-based Care

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

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

Thus far, MBS Review reforms have led to restrictions on the frequency with which colonoscopies can be performed. Recommendations relating to cardiology, urology, neurology and neurosurgery have been scheduled for implementation before the end of 2020 and other will follow in 2021. Ultimately every aspect of the services provided by the private hospital sector will be subject recommendations arising from the MBS Review.

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

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

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

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

## Consumer Experience

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

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

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

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

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

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

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

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

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

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

## Administrative Efficiency

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

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

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

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

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

Several problems need to be addressed:

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

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

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

This enhancement would improve the experience of consumers by ensuring the provision of efficient and consistent advice. It would also support the administrative efficiency in hospitals and health insurers and thereby relieve upwards pressure on health insurance premiums.

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

As at the end of November 2019, 94 percent of public hospital beds were registered to use My Health Record. These facilities are viewing an average of 80,000 records per month and uploading up to a million documents every month. No recent data has been reported by the Australian Digital Health Agency in respect of the private hospital sector<sup>29</sup>.

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

- 300 overnight hospitals
- 357 day hospitals

On this basis, APHA estimates less than 70 percent of overnight private hospital beds and less than 20 percent of day hospital beds are registered. This level of registration must be significantly increased to realise the benefits to the health system as a whole.

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

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

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

The benefit of hospitals registering with My Health Record is realised outside the hospital, not inside. This challenge is reflected in data produced by the Australian Digital Health Agency that demonstrates that public hospitals upload 12 documents for every one view accessed within the hospital<sup>30</sup>.

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<sup>29</sup> Australian Digital Health Agency, My Health Record Statistics and Insights, March 2019 to November 2019  
[https://www.myhealthrecord.gov.au/sites/default/files/mhr\\_stats\\_marchnovember2019.pdf?v=1576471841](https://www.myhealthrecord.gov.au/sites/default/files/mhr_stats_marchnovember2019.pdf?v=1576471841)

<sup>30</sup> Ibid.

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

## **Accountability and Reporting**

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

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

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

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

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

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

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

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

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

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

APHA advocates that continued work towards a single reporting platform, auspiced by government, would provide a useful service to consumers and reduce the waste and duplication of resources which arises from the diverse and duplicative demands of individual health insurers and government agencies.

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

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

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

# EQUIPPING THE HEALTH SECTOR FOR THE FUTURE

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

Government support for training opportunities should be expanded, including:

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

Australia's future medical workforce faces four challenges:

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

University and vocational education and training enrolments are at an all-time high for medical, nursing and allied health professions. However, these graduates will be unable to enter their intended professions without adequate access to clinical placements. On top of these demands, additional resources are required to enable students and early career clinicians to complete placements and early career opportunities (graduate placements, internships, etc) that were disrupted as a result of COVID-19.

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

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

- Recommendation Ten: To ensure that all nurses are adequately prepared, ANMAC and the NMBA should increase the minimum number of placement hours required for the Bachelor of Nursing degree to 1,000 hours. ANMAC/NMBA should also increase the minimum number of placement hours required for Enrolled Nursing diplomas and graduate-entry master's degree programs proportionately<sup>31</sup>.

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

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

- 40,400 days of clinical placement for medical students
- 304,800 days of clinical placement of nursing and midwifery students
- 28,900 days of clinical placement for allied health students<sup>32</sup>.

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

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

In 2015, the private hospital sector spent an estimated \$167 million on training medical, nursing, midwifery and allied health staff. In fact, the private sector plays a particular role in providing training in health areas not readily available in the public sector, including many areas of surgery, mental health and rehabilitation<sup>33</sup>.

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

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<sup>31</sup> Department of Health, 'Educating the Nurse of the Future—Report of the Independent Review into Nursing Education' Author: Emeritus Professor Steven Schwartz, Commonwealth of Australia 2019.

<sup>32</sup> Australian Private Hospitals Association and Catholic Health Australia, Education and training the private hospital sector, Canberra 2017

<sup>33</sup> Ibid.



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

The COVID-19 pandemic has had a profound impact the labour market including:

- An increase in unemployment in Australia and an increase in the number of Australians seeking to move into new careers including careers in healthcare
- barriers to the international mobility of labour,

Nevertheless skilled migration will continue to be of significant importance to the Australian hospital sector in both the short and longer term.

International health care workers and international students who have remained in Australia have played an integral part in the response to COVID-19 pandemic. Highly skilled health care workers on skilled migration visas bring capabilities and experience that cannot be provided by new graduates. They are essential to the depth of skill and expertise required for the provision of hospital services and for the training the future workforce.

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

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

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

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

The Department of Employment found nearly 80 percent of all qualified registered nurse applicants in New South Wales were considered by employers (all sectors) as either lacking the minimum level of experience required or lacking experience in the modality required<sup>34</sup>.

The Department of Jobs and Small Business has said employment in the healthcare and social assistance industry (a major employer of health professions) will expand at double the pace of all industries over the five years to May 2023<sup>35</sup>. The Royal Commission into Aged Care is likely to highlight the need to address skill shortages in the aged care sector creating further demand for skilled and experienced clinicians, particularly nurses, across both sectors.

Migration remains an essential strategy for employers in recruiting to roles that require specialised skills and experience, particularly registered nurses and midwives. As at 30 September 2019 there were 2,225 registered nurses on skilled worker visas. They included 1,431 working in specialist areas relevant to private hospitals as summarised in the following table.

**Registered nurses in selected areas relevant to the private hospital sector<sup>36</sup>**

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

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

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

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

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<sup>34</sup> Department of Employment – Registered Nursing June 2017 ([https://docs.jobs.gov.au/system/files/doc/other/2544registerednursesnsw\\_2.pdf](https://docs.jobs.gov.au/system/files/doc/other/2544registerednursesnsw_2.pdf))

<sup>35</sup> Labour Market Research, Health Professions, Australia, 2017–18, September 2018 <https://docs.jobs.gov.au/documents/health-professions-australia>

<sup>36</sup> Department of Home Affairs: Temporary resident (skilled) visa holders <https://data.gov.au/dataset/ds-dga-2515b21d-0dba-4810-afd4-ac8dd92e873e/details?q=>

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

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

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

The cost to an employer (annual turnover of \$10 million or more) includes a skill levy of \$7,200. This levy does nothing to reduce the reliance of the Australian health sector on immigration. If this levy was abolished, skilled migration sponsorship would once again be a viable option for employers. Sponsorship of skilled registered nurses would benefit Australia in two ways:

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

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

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

# PRIVATE HOSPITALS IN AUSTRALIA

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

The private hospital sector treats:

- 4.6 million hospitalisations a year.

In 2018–19 it delivered:

- 59% of all surgery
- 71% of eye procedures
- Almost half of all heart procedures
- 74% of procedures on the brain, spine and nerves.
- 60% of all musculoskeletal procedures
- At least 30% of all chemotherapy

Australian private hospitals by the numbers (2016–17, most recent data available):

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

## **The Australian Private Hospitals Association**

The Australian Private Hospitals Association (APHA) is the largest peak industry body representing the private hospital and day surgery sector.