New South Wales

Special Commission of Inquiry into Healthcare Funding

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Private Healthcare Australia
Better Cover. Better Access. Better Care.

NSW Special Commission of Inquiry into Healthcare Funding

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About Private Healthcare Australia (PHA)

Private Healthcare Australia (PHA) is the Australian private health insurance industry's peak representative body. We have 24 registered health funds throughout Australia as members and collectively represent 98% of people covered by private health insurance. PHA member funds provide healthcare benefits for 14.6 million Australians.

Response

PHA welcomes the opportunity to contribute to the Special Commission of Inquiry into Healthcare Funding. This Inquiry comes at a critical time for NSW as it emerges from the pandemic during a persistent cost-of-living crisis. The dual public private health system in NSW delivers some of the best health outcomes in the world, but it faces significant challenges, including a shortage of health workers, increasing demand from an ageing population, more chronic disease, and rising costs for new technology. If we are to meet the health needs of NSW residents over the next 40 years, we must introduce more cost-effective ways of delivering healthcare.

Private health insurance (PHI) and the private healthcare system it supports are core pillars of the NSW health system. Every year, the private health system absorbs a substantial amount of demand for essential medical care, taking pressure off the public health system. According to the Australian Institute of Health and Welfare, two out of three elective surgeries were performed in private hospitals nationally last year, along with 81% of admissions for rehabilitation, 62% of admissions for mental health care and 23% of child births. The private system plays a crucial role in surge capacity, too. As the pandemic showed, when public hospitals are overwhelmed, private hospitals can assist with emergency, surgical and intensive care capacity.

In 2022-23, health funds paid more than $7.3 billion in benefits for members in NSW. This included:

- $5.19 billion for hospital treatment – up 8.8 per cent from 2017-18.
- $248 million for state ambulance levies – up 20.8 per cent from 2017-18.
- $1.9 billion for general treatment ('extras' such as dentistry and physiotherapy) and ambulance services – up 15.6 per cent from 2017-18.

A significant proportion of hospital claims are high-cost claims exceeding $10,000 for people needing complex care for conditions such as heart disease, cancer, stroke, and dementia. In 2022, there were 117,096 'high-cost claims' in NSW. Health funds paid more than $2.44 billion for these episodes of care – 15.4% more than five years ago in 2017.

More than half the population of NSW contribute towards their healthcare through private health insurance, and membership is growing. Since 2017-18, there's been a 6.1% increase in PHI members in NSW. On 30 June 2023, 4.79 million people in NSW had some form of private health insurance – 57.6% of the population. Of this number, 3.88 million people had hospital cover – 46.6% of the population. This membership provides consumers with more choice about their healthcare and frees up the public health system for people who rely on Medicare alone.

Most of the population paying for private health insurance in NSW are not rich. According to the latest Australian Taxation Office statistics:

- 12.4% have an annual taxable income of $18,200 or less.
- 22.4% have an annual taxable income ranging from $18,201 to $45,000.
- 45.3% have an annual taxable income ranging from $45,001 to $120,000.
- 11.9% have an annual taxable income ranging from $120,0001 to $180,000; and
- 7.9% have an annual taxable income of $180,001 or more.

About eight out of 10 people with private health insurance in NSW are eligible to receive the Commonwealth Government's rebate for PHI. This subsidy is critical to maintain the affordability of private health insurance, especially during difficult economic conditions. Most Australians have never seen inflation this high and the pressure on household budgets is growing. The most recent Australian Bureau of Statistics data on barriers to use of healthcare showed an increasing number of Australians are delaying or foregoing healthcare, including prescription medicines and hospital care due to cost.

Recent studies commissioned by the Commonwealth Government confirmed the value of the PHI rebate for the Government and taxpayers. It currently delivers savings of about $916 per person with PHI because of savings in the public health system.

Health funds are intensely focussed on keeping premiums low and delivering value to consumers. Since the beginning of the pandemic, health funds have returned more than $3.5 billion to members as part of their promise not to profit from a reduction in claims due to pandemic restrictions. This commitment has since been monitored and reported on by the ACCC.

The effectiveness of Australia's dual public-private system has consistently delivered strong health outcomes, especially when compared to similar economies. The United Kingdom's health system is mostly public funded and the United States' is mostly privately funded. Avoidable mortality in the UK

is 69 per 100,000 people while it is 88 per 100,000 people in the US. In Australia, this figure is just 46 avoidable deaths per 100,000 people.[1]

In response to this Inquiry's Terms of Reference, the following opportunities would allow PHI to more effectively support the safe delivery of high quality, timely, equitable and accessible patient-centred care to the people of NSW, now and into the future.

Funding mechanisms that incentivise out-of-hospital care

With health expenditure rising unsustainably and waiting lists for care growing, there is an urgent need to disinvest in low value care and incentivise high value care, including out of hospital services that are safe and convenient for consumers and make the most of our available health budget and workforce.

Australia is lagging the world in out of hospital care which is rapidly being rolled out in other countries due to new technology, consumer demand and medical evidence supporting it. Globally, there is a strong trend towards minimising length of stay in overnight hospitals, increasing the use of 'short stay' or 'day surgery', and in some cases eliminating the need for hospital admissions all together. These changes are for the most part strongly supported and driven by clinicians in the interests of consumer affordability, and quality and safety, and are unlikely to change.

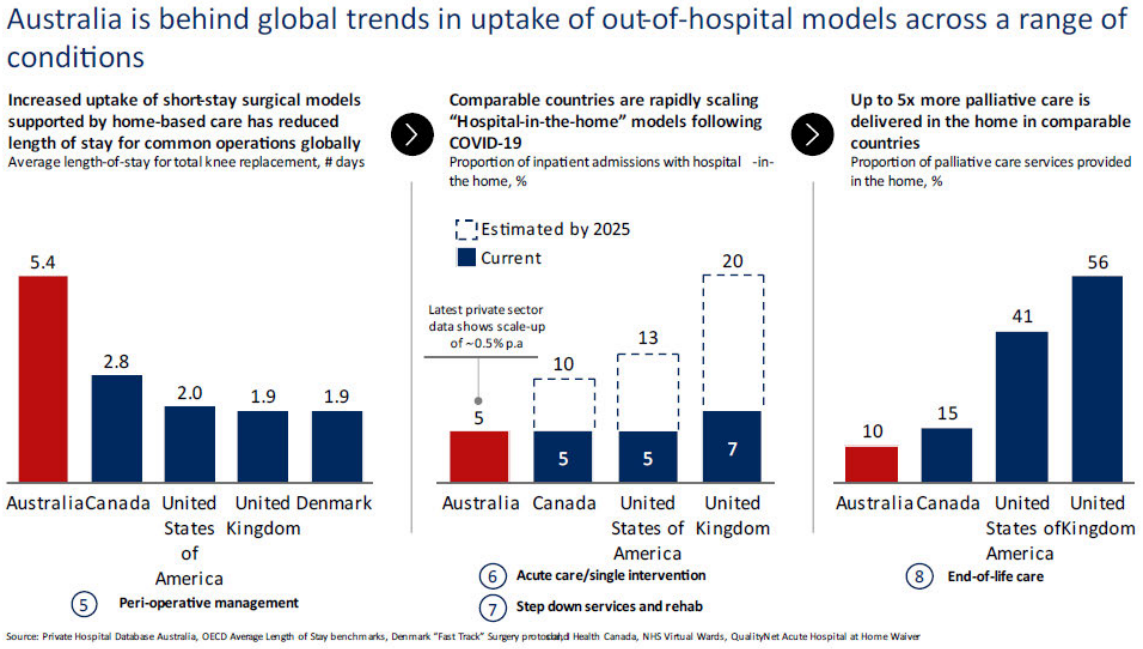
Australian governments must embrace and help facilitate this shift to maximise health funding into the future. PHA's 2023 report 'There's no place like home: reforming out-of-hospital care' outlines a range of reforms that will improve access to out of hospital care, reduce demand for the public health system, and deliver savings of $1.8 billion that will ultimately take pressure off health insurance premiums.

To reduce incentives for in-hospital care and encourage more out-of-hospital models, PHA has recommended the Commonwealth Government:

- Amend the Private Health Insurance Act 2007 to release the restrictions on health funds insuring out-of-hospital care for forms of care that have been demonstrated to deliver patients improved choice and outcomes. This amendment to the Private Health Insurance Act 2007 could be readily achieved without impacting the overall regulatory environment for private health insurance.
- Amend legislation governing the default benefits system that incentivises private hospitals to create more inpatient services in areas of over-supply. The default benefits system incentivises in-hospital care over some out-of-hospital models of care that produce better outcomes for consumers at lower costs, leading to upward pressure on health insurance

[1] The Kings Fund 2023, How does the NHS compare to the health care systems of other countries?

premiums. This, in turn, makes private health insurance more expensive, undermining its sustainability over time.



Removal of barriers to full scope of practice

The pandemic put a spotlight on the potential flexibility of our health workforce, and showed how rapidly governments could innovate and change scope of practice in a crisis. When we needed to vaccinate millions of Australians quickly, we saw pharmacy students trained to assist.[2] When hospitals were overwhelmed with emergency patients, we saw physiotherapists and occupational therapists trained to do the work of nurses and doctors to discharge patients and free up hospital beds.[3] There were many other examples from around the world that demonstrated the great potential for health professionals to work smarter, not harder, to deliver more affordable, quality healthcare.

[2] https://www.medicalrepublic.com.au/vic-pharmacy-students-to-join-vaccine-efforts/40724

[3] https://www.abc.net.au/news/2021-10-07/covid-navigator-pilot-cuts-emergency-admission-time/100517492

A barrier to some professional groups working to their full scope of practice is regulation of Chronic Disease Management Plans (CDMPs) funded by private health insurance. Health funds across Australia offer CDMPs to assist people living with chronic conditions including diabetes, heart disease and mental health disorders. The objective of these programs is to return our members to a productive life as fast as possible, and to reduce preventable hospitalisations.

CDMPs are governed by the Private Health Insurance (Health Insurance Business) Rules 2018 (the Business Rules). These Rules currently prohibit health funds from providing CDMP services involving, among others, mental health peer support workers, nurses, and nurse practitioners. The defined list of health professionals listed in the Rules as eligible to provide these services is out of step with current best practice and should be removed altogether.

PHA has engaged with Mental Health Australia and Mind Australia on improving the services available to Australians with a mental health condition, and these organisations advise that a range of practitioners should be employed to provide care. Mental health peer support workers are a clear example of a profession where the evidence base has increased significantly in recent years, yet the current Rules prohibit health funds from providing support to these services.

PHA has also spoken with the Australian College of Nurse Practitioners, who highlight the role that nurse practitioners can play in supporting people with chronic disease. Along with a developing academic literature base supporting the use of a wider range of practitioners in CDMPs for people with chronic health conditions, the Australian Government has several policy positions that support the advocated changes, including:

The Productivity Commission Mental Health Inquiry (November 2020) which recommended the Australian Government "review the regulations that prevent private health insurers from funding community-based mental healthcare with a view to increasing the scope for private health insurers to fund programs that would prevent avoidable mental health-related hospital admissions."

- The Nurse Practitioner Workforce Plan (2023) has a goal "to remove barriers affecting the [nurse practitioner] workforce."
- The Strengthening Medicare Taskforce Report (2023) articulates a vision where "health care professionals work to their full scope of practice."
- The Unleashing the Potential of our Health Workforce – Scope of Practice Review (2023) currently examining barriers and enablers for workforce reform.

Removing the out-of-date definitions for CDMPs within the Rules would address the Commonwealth Government's goals and provide more flexibility to funds to undertake chronic disease programs. This announcement would then provide incentives for the sector to participate in more detailed discussions of specific models using the best available workforce.

PHA has recommended the Commonwealth Government remove the prescriptive list in the Private Health Insurance (Health Insurance Business) Rules 2018 that prohibit nurses, nurse practitioners, and other health workers from being funded to provide services under a Chronic Disease Management Plan.

Mechanisms to reduce low value care

It is estimated that up to 30%[4] [5] of healthcare is 'low value' because it is either ineffective, harmful or confers marginal benefit at disproportionately high cost. Common examples of low value care include unnecessary antibiotics, surgery that does more harm than good, duplication of invasive tests and futile care at the end of life.

Low value care also includes paying too much for goods and services when lower prices are available. This is a problem in Australia where consumers pay much higher prices for medical devices and equipment in the private health system due to the Commonwealth Government's Prescribed List (PL)[6] for private healthcare. The PL sets prices higher than international benchmarks because prices are negotiated between the federal government and medical device manufacturers without input from payers such as private health insurers and the Department of Veterans' Affairs.

Another example is unnecessary use of day hospitals for procedures that can be safely done in a lower cost setting, or use of overnight care when day procedures are more appropriate. For example, Intravitreal eye injections are an outpatient procedure that rarely requires hospital admission. While an MBS Review found up to 3% of patients need it done in hospital, 18% are currently done in hospital, attracting a higher fee from health funds. A small number of doctor-owned ophthalmology clinics have the highest rates, with 10 facilities accounting for more than half of the in-hospital services.

The Royal Australian and New Zealand College of Ophthalmologists (RANZCO) supports greater use of out of hospital settings.[7] Savings to private health funds will be $75m p.a. and $15m p.a. to the Commonwealth Government through the PHI Rebate. This is an existing MBS review recommendation which was not implemented by the previous Commonwealth Government.

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[4] Evidence for overuse of medical services around the world - The Lancet

[5] The three numbers you need to know about healthcare: the 60-30-10 Challenge | BMC Medicine | Full Text (biomedcentral.com)

[6] The Prescribed List was formerly named the Prostheses List.

[7] https://www.choosingwisely.org.au/recommendations/ranzco4

In addition to harming consumers physically and psychologically, low value care is harming our health system. It is wasting scarce resources that should be used for more timely and effective healthcare, it is driving higher out of pocket costs for consumers, and it is deflecting investments in public health and social spending, both of which are known to contribute to better health and wellbeing.[8]

To start reducing low value care, PHA wants to see:

More options for payers to disincentivise and disinvest from low value care

Australia requires more agile mechanisms to detect low value care through independent registries and studies of variation, and these should be used to adjust payment paths, including the Medicare Benefits Schedule, Pharmaceutical Benefits Scheme, Prescribed List, and private health insurance funding, so taxpayers are not paying for low value care. Critical independent adjudicators such as the MBS Review Advisory Committee (MRAC) and the Australian Commission for Quality and Safety in Healthcare (ACQSHC) should also be given more funding to assist with this, so emerging problems can be addressed quickly. The cost of this would be easily recovered by savings derived from deterring and disinvesting in low vale care.

Greater dissemination of evidence and best practice

Australia is well positioned to improve identification of low value care and to communicate best practice to clinicians so they can alter their practice. Australian researchers have published widely on low value care in the academic literature and their work features prominently in initiatives such as the Cochrane Collaboration. However, more needs to be done to support and harness their work for meaningful change. In 2015, the Choosing Wisely Australia initiative was launched to encourage conversations between clinicians and consumers about the harms of unnecessary tests, treatments and procedures. However, Choosing Wisely was defunded in 2022 when the Commonwealth Government stopped funding its host, NPS MedicineWise, as part of a redesign of the Quality Use of Diagnostics, Therapeutics and Pathology Program. The NPS MedicineWise website is now hosted by the Australian Commission on Safety and Quality in Health Care. There is a need to keep investing in the work to help clinicians change their practice and to educate consumers.

Investment in health literacy

Australian consumers need help to understand healthcare and protect themselves from the potential harms of low value care. While campaigns such as the Royal Australasian College of Physicians EVOLVE program have successfully alerted clinicians to low value care, there is evidence to support strategies directed more towards consumers. As Professor Ian Scott and colleagues wrote

[8] Evidence for overuse of medical services around the world - The Lancet

in the Medical Journal of Australia in 2021, reframing low value care as having negative consequences and not just 'worth a go' or 'better safe than sorry' may incentivise patients, clinicians, and policymakers to engage more in mitigation.[9] Many consumers may not realise that negative consequences of low value care include physical, psychological, social, and financial costs.

Conclusion

More than 4.7 million people in NSW are contributing to their own healthcare through PHI so they have more choice in how and when they receive health services. This reduces demand for the NSW public health system, which is still feeling the effects of the pandemic, including delayed care and workforce shortages. It also provides savings for the Commonwealth and taxpayers which can be invested in the public health system.

Australia's health system guarantees access to timely, affordable healthcare through PHI and Medicare. But there are major challenges to confront. Our health financing system was designed in the 20th century and is no longer fit for purpose. If we want a sustainable health system, we must find ways to disinvest from low value care and incentivise new models that deliver equal or better outcomes at a lower cost.

The private health insurance industry stands ready to work with the NSW and Commonwealth Governments on new ways to fund and provide health care, so more people in NSW get faster access to cost-effective treatment in the private and public health systems they rely on.

[9] Low value care is a health hazard that calls for patient empowerment | The Medical Journal of Australia (mja.com.au)