Australian
Private Hospitals
Association

Federal Budget Submission 2021-22

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Contents

PRIVATE HEALTH – WHAT NEEDS TO BE DONE

Private health remains integral to the Australian health sector

The private hospital sector provides more than 34,300 licensed beds[1], a resource that would cost taxpayers more than $34 billion to replicate in the public sector.

The private hospital sector employs 137,400 people[2]. In ordinary circumstances, the sector has a turnover of $17 billion[3] and operates with an overall profit margin of just 4.5 percent[4]. In 2020, the sector was directly impacted by the COVID-19 pandemic as the Federal Government imposed restrictions on elective surgery and consumers deferred non-emergency services. Private hospital operators worked with government to rapidly divert resources in readiness for forecast scenarios of the pandemic impact 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 beds and the drugs, equipment and personal protective equipment essential to the pandemic response.
- Private hospitals provide 35 percent of Australia's standing intensive care capacity[5] 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 Saturday 28 March 2020 private hospitals in Western Australia responded immediately to an urgent state government request to accept 46 symptomatic patients from the cruise ship Artania.
- At local level private hospitals assisted other services in health, aged care and disability sectors by sharing PPE resources and expertise.
- In Victoria, private hospitals accepted residents transferred from aged-care homes where outbreaks had occurred, treating COVID-19 patients requiring hospitalisation.

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[1] ABS, Private Hospitals, Australia 2016-17, Catalogue 4390.0
[2] People employed as at the end of June ABS, Australian Industry, 2018-19, Friday 29 May 2020.
[3] Sales and service income for 2018-19, ABS, Australian Industry, 2018-19, Friday 29 May 2020.
[4] Ratio of operating profit before tax to Sales and service income for 2018-19.
[5] AIHW, Admitted Patient Care, 2018-19.

Private hospital sector staff and expertise proved essential to the COVID-19 response on multiple levels:

- Long term secondment of staff to contract-tracing teams and other non-clinical facing roles,
- Provision of training to aged care providers in the use of PPE and infection control and specialised training in COVID-safe practices
- Supporting services in the aged care, drug and alcohol and disability sectors with expertise in planning and training and the delivery of services in high risk environments.
- 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 backfill vacancies as the number of cases and requirements for isolation increased within the health and aged-care workforces. Private hospital sector staff were deployed in teams to address COVID-19 outbreaks in several aged care services.

In the second half of 2020, as restrictions on elective surgery in most states were eased, the private hospital sector focussed on ensuring services were delivered to consumers safely and efficiently so backlogs in deferred demand could be addressed. The private hospital sector did 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.

The private hospital sector is and will remain central to meeting Australia's health challenges in 2020-21 and in the years ahead. 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[6].
- The complexity of overnight patients in private hospitals has increased by nine percent[7].
- 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 five of those years[8].

[6] AIHW Admitted Patient Care, 2008-9 and 2017-18.
[7] AIHW Admitted Patient Care, various years.
[8] AIHW Admitted Patient Care, various years, Health Expenditure Australia, 2017-18

- In the year ending Tuesday 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[9].
- 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[10].

Marginal cost increases over the last decade have been outweighed by improved health outcomes for patients.

The outlook ahead for 2021-22 remains dominated by continuing health and economic impacts of the COVID-19 pandemic within Australia and internationally. This challenge on top of the underlying challenges facing the Australian health sector will mean that private hospitals remain crucially important in providing timely access to health services for all Australians.

In surgery, the private hospital sector provides around 60 percent of all services including:

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

Each year, private psychiatric hospitals treat around 42,000 people living with acute mental health conditions[11]. These hospitals provide 38 percent of acute specialist mental health beds and 45 percent of acute adult general psychiatric beds[12].

Private hospitals provide 63 percent of all overnight in-patient rehabilitation admissions in addition to rehabilitation care in day programs.

This capacity and capability will be essential as the Australian health system works to meeting the pent-up demand for health services
In this context, four challenges must be met:

- Consumers and taxpayers need to be assured of value.
- The health sector, public and private, needs a workforce equipped for the future.
- The resilience of the health sector to future shocks must be ensured in response to key learnings out of the COVID-19 pandemic.
- The affordability of private health needs to be improved.

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

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[9] APRA, Private Health Insurance Statistics.
[10] AIHW Health Expenditure Australia, 2017-18
[11] PPHDRAS
[12] AIHW, Mental Health Services

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 in five key ways:

- Reform and retention of the Prostheses List to assure consumers of access to proven medical technologies at a transparent and competitive price without the risk of patient out-of-pocket costs.
- Support for innovations to provide patient centred care in flexible environments.
- Enabling private and public sectors to work more closely together to ensure timely access to clinical services.
- Reforms to ensure transparent disclosure to consumers.
- Support for systems that enable continuity of care and administrative efficiency.

Access to proven medical technologies at a transparent and competitive price.

The Federal Government and the Medical Technology Association of Australia (MTAA) agreement outlines a program of reform that will ensure technologies are made available at a transparent and competitive price and the Prostheses List reflects changes in medical technology. Further reforms to be implemented following the end of this agreement should be the result of evidence based co-design processes involving all stakeholders. Implementation timeframes should ensure continued patient access to private hospital services.

Some stakeholders have argued the Prostheses List is too large and complex, and should either be substantially reduced in size or else replaced altogether. APHA advocates the List be retained, but simplified in structure. Benefits should be set in a more transparent manner, using public sector prices as the starting point for a formula that also accounts for how surgical services are delivered in the private sector, and the role of private hospitals in making these technologies available.

Restructuring the Prostheses List and introducing a reference-based approach to setting prostheses benefits is a major reform that will require significant lead time and staged implementation.

It is essential that any reforms to the Prostheses List ensure consumers are not disadvantaged in accessing technology through the imposition of out-of-pocket costs.

Support for innovations to provide patient-centred care in flexible environments

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.

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

- Although it is allowed under the existing regulatory framework, 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.
- The Medicare Benefits Schedule (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 barrier to the provision of innovative community and home-based services using virtual technologies to support consultations and the coordination of team-based care.

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

- A minimum default benefit for the provision of hospital-in-the-home, day programs, and hospital services delivered using both face-to-face services and virtual health technologies – particularly in the areas of mental health, rehabilitation and palliative care (while requiring such services to meet the same safety and quality accreditation requirements as in-hospital services).
- Provision of MBS items for the use of virtual health in delivering consultations and case-conferencing for private hospital in-patients.

Reforms are needed to ensure that private hospitals are enabled to provide comprehensive patient centred care for people living with mental health conditions:

- Amend private health insurance regulations to allow the payment of benefits in circumstances when psychiatric treatment and medical, surgical or rehabilitation services need to be delivered concurrently or on the same day.
- Ensure that private health insurers, private hospitals and non-hospital providers are subject to regulatory frameworks which protect consumers and recognise the primacy of pre-existing therapeutic relationships.

Enabling private and public sectors to work more closely together to ensure timely access to clinical services

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 Addendum should remove the incentive for states to further expand the diversion of public hospital resources to the treatment of privately insured patients but further actions will be needed to realise the spirit of this agreement.

The Addendum reaffirms and strengthens commitment to the provision of informed financial consent, but the performance of the public sector in delivery of informed financial consent is poor and inconsistent. Consumers often find they are liable for out-of-pocket costs they did not expect. They can also find they miss out of treatment options that would otherwise have been available. If electing to use private health insurance, they should be supported in making fully informed choices. Public hospitals should be required to enable consumers to exercise their options including the option to be transferred to a private hospital.

Reforms to ensure transparent disclosure to consumers

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.

Support for systems that enable continuity of care and administrative efficiency

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

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

The health sector needs a workforce equipped for the future

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

The 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[13].

[13] 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 experienced clinicians to positions 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.

Health sector resilience should be assured

The COVID-19 pandemic saw the Australian health sector as a whole put to the test to an extent not seen in more than a century. Moreover, the sector experienced the impact of a truly global event as the pandemic spread rapidly around the world.

In response to this crisis, governments, health care providers, clinicians and scientists in both public and private sectors demonstrated a capacity for agility and collaboration, and discovered new ways of working together.

Pre-existing pandemic plans and sources of expertise provided a valuable starting point for national and local responses, but opportunities to improve the health sector's future resilience were also quickly exposed as the clinical, social and economic dimensions of the pandemic unfolded.

While prospects for reducing the threat posed by COVID-19 through vaccination are promising, the risk of significant outbreaks will remain through 2021. It is essential that the Federal Government and state/territory governments retain the ability to resume contractual arrangements with private hospital sector operators in order to respond effectively should outbreaks on the scale experienced in Victoria and overseas emerge.

Affordability of private health needs to be improved

APHA welcomes the Federal Government's announcement in the October 2020 Budget to commission actuarial research and to consider policy setting changes to:

- Lifetime Health Cover (LHC) Loading, which provides a financial incentive for people to take out private hospital cover before the age of 31 years.
- Risk equalisation, which supports community rating by sharing the cost of certain claims between insurers.

APHA believes it is vital this research addresses the role of the Private Health Insurance Rebate and the Medicare Levy Surcharge (MLS) in influencing participation in private health insurance.

The policy measures introduced 20 years ago to ensure affordability of private health insurance require review.

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.

Key budget measures outlined in this submission

1. **Ensure an evidence based approach to reform of the Prostheses List with adequate implementation lead times that will ensure patient access to access to proven medical technologies at a transparent and competitive price with no patient out-of-pocket costs.**

2. **Remove barriers to hospital providers delivering at scale contemporary models of care including delivery of rehabilitation 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.
   - Introduce and retain MBS items for the use of virtual health in delivering consultations and case-conferencing for private hospital in-patients.

3. **Remove barriers to hospital providers delivering at scale contemporary models of care including delivery of mental health 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.
   - Introduce and retain MBS items for the use of virtual health in delivering consultations and case-conferencing for private hospital in-patients.
   - Amend private health insurance regulations to allow the payment of benefits to circumstances when psychiatric treatment and medical, surgical or rehabilitation services need to be delivered concurrently or on the same day.
   - Ensure that private health insurers, private hospitals and non-hospital providers are subject to regulatory frameworks protect consumers and which recognise the primacy of pre-existing therapeutic relationships

4. **Support Addendum to the 2020-2025 National Health Reform Agreement**
   To realise the full intent of the Addendum, the Federal Government should enjoin states and territory governments to enter into agreed national standards regarding the provision of informed financial consent and the administration of election processes which include the opportunity to elect transfer to a private hospital.
   Saving: up to $380 million.

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

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

7. **Increase funding for clinical placements for university and vocational education and training sector undergraduates.**
   Cost: Dependent upon further analysis by relevant departments.

8. **Reduce the cost and complexity of skilled migration arrangements.**
   Waive the Skilled Migration Levy for the sponsorship of registered nurses and midwives.
   Cost: $2 million in foregone revenue to the Skilling Australia Levy.

9. **Retain ability to rapidly activate contractual arrangements with private hospital sector operators in the event of further COVID-19 outbreaks.**
   The Federal Government and state/territory governments retain the ability to resume contractual arrangements with private hospital sector operators in order to response effectively should outbreaks on the scale experienced in Victoria and overseas emerge.

10. **Support for domestic manufacture of essential medical supplies**
    Federal Government measures to encourage domestic manufacture of essential medical supplies should be continued and supported through government purchasing policies.

11. **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'.

12. **Maintain the effective Private Health Insurance Rebate at Wednesday 1 April 2020 levels.**
    Maintaining the Rebate at the effective levels applicable on Wednesday 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.

13. **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

14. **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.

15. **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.

16. **Reform to the LHC Loading**
    Reform the 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.

17. Increase the MLS
    Doubling the MLS will provide a more realistic incentive to higher income households to invest in private health insurance. Estimated Revenue: up to $355 million.

ENSURING PRIVATE HEALTH DELIVERS VALUE

Access to proven medical technologies at a transparent and competitive price

Since 2005, the Prostheses List has provided a basis for determining the benefits payable for implantable medical devices used in surgery where the treatment is covered by private health insurance. This mechanism has protected consumers from out-of-pocket costs, while ensuring they have access to technologies recommended by their treating surgeon. The List has also provided stability within the sector allowing insurers, hospitals and medical technology manufacturers to manage their respective financial risks. At the same time this approach has a number of limitations, particularly with respect to assuring consumers these technologies are available at a transparent and competitive price.

APHA supports fully implementing the agreement between the Federal Government and the MTAA signed in 2017 (the Agreement). APHA in the process of responding to a consultation paper released by the Department of Health on Friday 18 December 2020 inviting response to two broad options for reform.

APHA is of the view that the best way forward should be based on a the recognition of the following principles

- Retaining the ability of clinicians, in partnership with consumers to select the most appropriate technology for each patient.
- Ensuring that the Prostheses List delivers certainty to consumers by minimising patient out-of-pocket costs.
- Ensuring that the process used to set benefits is transparent.
- Ensuring that the Prostheses List is responsive to chances in service delivery and changes in technology.
- Ensuring that the process of benefit setting delivers fair value to all stakeholders.
- Ensuring that this reform protects the financial sustainability of the private health sector.

Management of the Prostheses List must be robust, efficient and transparent. Some stakeholders have argued the Prostheses List is too large and that a significant number of items should be removed from the list. A report prepared for the Department of Health by EY Consulting recommends the majority of the General Miscellaneous category should be removed from the Prostheses List. However, EY Consulting notes that this move, a cost shift to the private hospital sector of up to $250 million, should only be made once alternative funding mechanisms have been put in place.

APHA contends that while the EY Consulting report highlights a number of challenges in managing the Prostheses List, it fails to make the case for the removal of the General Miscellaneous category from the Prostheses List. On the contrary, concerns about ensuring

technologies are made available at a transparent and competitive price; are used appropriately and as clinically intended; and clinicians can make evidence based cost-effective choices in medical technology can only be achieved by retaining a Prostheses List covering the full range of technologies used in contemporary surgical practice and investment in systems to support the utilisation of the List to achieve these objectives.

The central problem a reformed Prostheses List seeks to solve, is the delivery of value to the consumer – access to contemporary technologies without out-of-pocket costs. The challenge is the management of risk across four stakeholders:

- The surgeons must be able to access a range of technology to deliver an acceptable outcome for each specific patient.
- The private hospitals and day hospitals must be able to cover the costs of purchasing the required technology and the costs, additional to the purchase price, of making technology available in theatre.
- The manufacturer must be able to provide the technology within the Australian market while recognising that their volume of sales cannot be assured.
- The private health insurers must be able to forecast outlays and set premiums at a level that is acceptable to Australian consumers.

In the public sector, this challenge is met by states/territories constraining the range of technologies available, and rationing the available resources to patients on the basis of clinical urgency. Patients and surgeons in the public sector consequently have less choice in the selection of the technologies available to them. Patients deemed less urgent wait longer when they fall outside the available budget envelope.

In the private sector, it is recognised that patients expect a premium service in terms of access to and choice, of technology, timely treatment and protection from out-of-pocket costs. The individual requirements of each case mean cost of prostheses can vary significantly from one patient to another. Consequently, financial risk must be controlled in other ways.

The Prostheses List protects the viability of private health insurers by limiting their liability for each product on the List. In doing so, the Prostheses List also assures hospitals of the benefit received for purchasing the technology chosen by the surgeon and making it available in theatre. The Prostheses List also indirectly signals an acceptable price to the manufacturer without intervening to set the price at which the technology must be sold.

Over time it has become obvious the Prostheses List requires reform so the process of benefit setting is more transparent and competitive. Although pricing information provided by sponsors is taken into account when listing technologies, in most instances there is no explicit mechanism for externally confirming that benefits are competitive and appropriate to the Australian market.

The solution to this problem must be both robust and efficient. APHA believes the most practical solution would be to implement a new benefit setting mechanism which would use reference pricing against the Australian public sector as a starting point. This approach would meet all six principles detailed above. Other alternatives are either prohibitively expensive to

implement (full health technology assessment reviews across all items) or inadequate as mechanisms to manage financial risk across both private health insurers and private hospitals (use of a DRG-based approach to set a prostheses benefit).

An approach based on reference pricing to public sector prices within Australia produces a result relevant to the Australian market and reflective of market forces. Analysis by the Independent Hospital Pricing Authority has already shown there are many devices sold to the public sector at a price suggesting there is scope to reduce Prostheses List benefits. A reference-based approach, which also recognises valid differences in the way the private sector delivers services, is the most direct way in which to increase value to consumers while at the same time retaining a robust tool for managing risk across the sector.

Investment in systems aligning information about the intended purpose (as specified in the Australian Registry of Therapeutic Goods) and performance (as indicated by clinical registries) with the Prostheses List would enable clinicians to access the information needed to make cost-effective choices.

Support for innovations to private patient-centred care in flexible environment

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 82,373 separations involving a charge for hospital-in-the-home care were delivered in 2019-20 up from 74,209 separations in 2017-18. According to the same source, these separations account for two percent of all those delivered in 2019-20. According to the Department of Health's Hospital Casemix Protocol Annual Report for 2019-20 only, 12,789 private sector hospital-in-the-home separations were funded (benefit reported) through private health insurance compared with 25,565 in 2017-18.

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 and falling. 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 for providing continuity of care for vulnerable patients. Virtual health technologies also assist hospitals to deliver 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, previously group therapy rooms in psychiatric and rehabilitation hospitals were large enough to accommodate standard group sizes. Now, 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 are not restricted by choice of insurer and mean consumers can access the most efficient and clinically appropriate care pathway.

Providing default benefits for community-based and home-based programs would enable private 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 should remove barriers to private 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 services are provided to the same level of safety and quality required of hospitals.

All 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 choses 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 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[14]. 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 acuity 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.

[14] 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.

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.
- 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 health care 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 health care.

Enabling private and public sector to work more closely together to ensure timely access to clinical service

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 Wednesday 1 April until Friday 15 May 2020, all but the most urgent surgeries were deferred nation-wide and restrictions remained in place in Victoria into the December quarter. Restrictions resulted in a 9.2 percent decrease, or 69,834 fewer admissions for elective surgery in public hospitals between 2018-19 and 2019-20, compared to the five years prior to the pandemic when elective surgery admissions were increasing 2.1 percent per year[15,16]. 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

[15] AIHW. Elective surgery activity 2019-20. Canberra; AIHW. https://www.aihw.gov.au/reports-data/myhospitals/intersection/activity/eswt Accessed 26 January 2021.
[16] AIHW. Elective surgery waiting times 2019-20. Canberra; AIHW. https://www.aihw.gov.au/getmedia/f72949da-cba8-4f36-a47d-2c5bbcccd55a/Elective-surgery-waiting-times-2019-20.xlsx.aspx. Accessed 26 January 2021.

government resources allocated to public hospitals are used in accordance with clinical need alone.

For many years, state/territory 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 a public patient. States/territories also use this practice to cost shift to the Commonwealth by claiming Medicare rebates for the medical services provided to patients.

This practice is a waste of private health insurance benefits – waste that has not delivered any benefits to patients. It is also a waste of government resources, diverting them away from patient care to revenue generation. In 2019 the Victorian Auditor-General found public hospitals did not know the cost of this activity and could not accurately measure the net financial result[17]. Public sector revenue chasing has put competition ahead of collaboration and prevented public and private hospitals from working together to meet patient needs.

In the current environment, it is not appropriate to divert government resources away from clinical services to drive generation of revenue. It is also 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 there is 'overall parity' in funding provided to public and private patients. The Addendum should remove the incentive for further upwards pressure on private health insurance premiums from the public hospital sector. However, implementing changes to private patient pricing 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 Addendum 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 strengthened patient election provisions, including the option to transfer to a private hospital. This will expand the options available to consumers and facilitate efficient management of pent up demand for hospital services. The Federal Government should work with states and territories to establish agreed national standards for the provision of informed financial consent and the administration of election processes, including the opportunity to elect transfer to a private hospital.

[17] Victorian Auditor General, Managing Private Medical Practice in Public Hospitals, 2019

Additional reforms would not only reduce the trend of public hospitals diverting resources away from public patients but also reduce upward pressure on private health insurance premiums:

- 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.

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[18].

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)[19]. 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) 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

[18] AIHW, Health Expenditure, APRA Private Health Insurance Statistics
[19] AIHW, Admitted Patient Care, 2018-19

these patients to private hospitals can provide a greater range of choices including choice of environment, doctor and access to timely care.

Reforms to ensure transparent disclosure to consumers

- **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 argues that 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 insurer, 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.

Support for systems that enable continuity of care and administrative efficiency

- **Reduce the administrative burden associated with implementation of the Monday 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 Monday 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 Monday 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 ECPLISE 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. When combined with consumer specific information already provided through ECLIPSE, this single change would ensure 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 there-by relieve upwards pressure on health insurance premiums.

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

As at the end of November 2019, 94 percent of public hospital beds were registered to use My Health Record. These facilities are viewing an average of 80,000 records per month and

uploading up to a million documents every month. No recent data has been reported by the Australian Digital Health Agency in respect of the private hospital sector[20].

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 fewer than 70 percent of overnight private hospital beds and fewer 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[21].

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

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[20] 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

[21] Ibid.

Accountability and Reporting

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

Health insurers have the right to audit claims for benefits to ensure protection from fraud or inappropriate claiming. However, in recent years health insurers have adopted audit practices that are excessive and onerous. Frequently, health insurers demand retrospective audits over several years and may even seek to apply rules and criteria to claims that pre-date these 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/territory 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 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

- **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 Professor Steven Schwartz 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[22].

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 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[23].

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[24].

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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[22] 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.

[23] Australian Private Hospitals Association and Catholic Health Australia, Education and training the private hospital sector, Canberra 2017

[24] 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 New South Wales Department of Employment found nearly 80 percent of all qualified registered nurse applicants were considered by employers (all sectors) as either lacking the minimum level of experience required or lacking experience in the modality required[25].

The Federal Department of Education, Skills and Employment (formerly Department of Jobs and Small Business) has said employment in the health care 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[26]. 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[27]

	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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[25] Department of Employment – Registered Nursing June 2017 (https://docs. jobs. gov. au/system/files/doc/other/2544registerednursesnsw_2. pdf

[26] Labour Market Research, Health Professions, Australia, 2017–18, September 2018 https://docs. jobs. gov. au/documents/health-professions-australia

[27] 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 does not provide any 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 train 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 the increased costs to employers has sharply reduced sponsorship of skilled nurses into Australia.

The cost to an employer (annual turnover of $10 million of 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.

ENSURING HEALTH SECTOR RESILIANCE

The impacts of the COVID-19 pandemic on private hospitals

The National Partnership Agreement on COVID-19 Response signed by the Australian Government and all states/territories ensured the resources, facilities and staff of the private hospital sector were available to assist in the national response to the COVID-19 pandemic. Hospitals and day hospitals contracted by states/territories were supported by Commonwealth funding which enabled them to retain clinical staff and operational readiness.

The impact of the COVID-19 pandemic on private hospitals was nevertheless dramatic and immediate as elective surgery admissions were compulsorily curtailed and consumers chose to avoid hospital admission.

- Private health insurance episodes in private hospitals for the June 2020 quarter were down 21.4 percent on the same quarter in 2019. In the September 2020 quarter episodes were down only 5.4 percent nationally on the same quarter for 2019, but 19.7 percent down in Victoria.
- Private health insurance benefits paid to private hospitals for the year ending Wednesday 30 September 2020, decreased 3.1 percent in real terms, indicating the impact of the pandemic on the private hospital sector is significant[28]. This was driven by a large decrease in private health insurance utilisation from 418 per 1000 to 389 per 1000[29].

Operational costs increased as the price of items essential to the COVID-19 response suddenly increased and international supply chains came under pressure. These cost pressures have remained as the pandemic continues to escalate globally.

It is unknown how the private health sector will emerge from the pandemic. The medium and longer-term outlook is likely to be impacted by a range of factors including economic policy, economic recovery, vaccine efficacy and consumer confidence. Although there are positive signs of recovery of the sector there are also some potential headwinds.

The biggest threat is a re-emergence of community-spread of infections within Australia forcing further closure of hospital services either compulsorily or in response to consumer reticence. It is essential that Federal and state/territory governments establish and retain the ability to respond quickly. As part of this response, the ability to activiate agreements with the private sector must be maintained

The protracted nature of the negotiations in some jurisdictions with some segments of the private hospital sector needs to be addressed for the future. Such delays would have seriously hampered effective clinical responses had worst case scenarios been realised. These delays also

[28] APRA, Private Health Insurance Statistics

[29] APRA, Private Health Insurance Statistics, September 2020-September 2020

compromised some operators who were left without financial support for an extended period and also precluded them from accessing supports available to the general business sector.

Australia's lack of on-shore manufacturing capacity in essential medical supplies quickly became apparent as overseas manufacturers were subject to emergency shut-downs, surges in demand and disrupted transportation. While Australian manufacturers and government were quick to respond, it is essential that the learnings from this experience as used to improve future responsiveness and address underlying points of vulnerability.

Federal and state/territory governments moved quickly to establish stockpiles of essential supplies, however, the bidding wars which quickly broke out exposed the necessity of a more co-ordinated response.

To address these issues and ensure future health sector resilience, the Federal Government should work with states/territories to ensure:

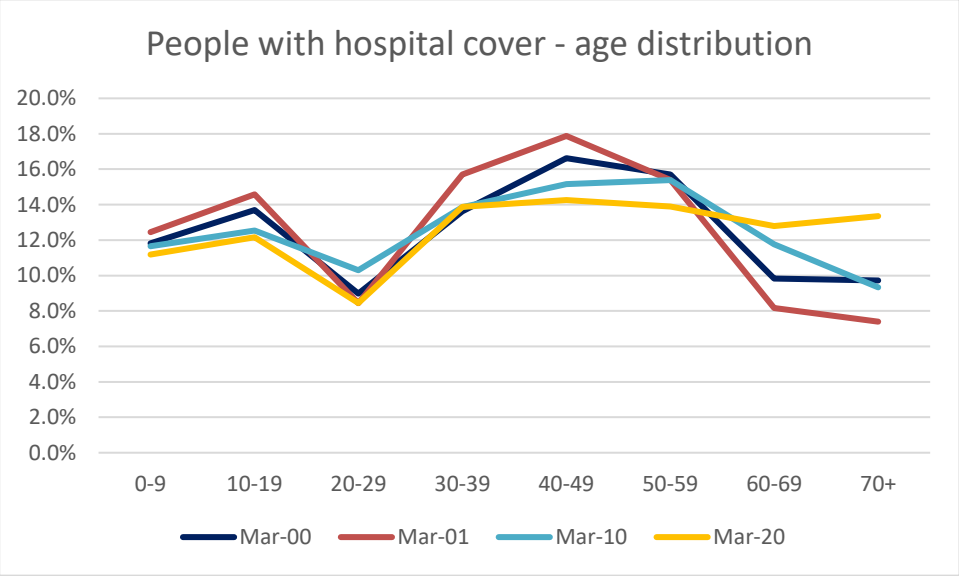
- The national pandemic response plan includes, and maintains, an overview of the resources and capabilities of the private hospital sector.
- The national pandemic response plan includes a standard heads of agreement that could be used by states/territories in the event of future emergencies where it is necessary to quickly harness the private hospital sector.
- Measures to support domestic manufacture of essential medical supplies should be continued and supported through government purchasing policies at all levels.
- A coordinated approach to stockpiling of essential supplies in order to eliminate domestic bidding wars and reduce mismatches in supply and demand across health and other sectors, both public and private, essential to a pandemic or other health emergency response.

IMPROVING ACCESS TO AFFORDABLE HEALTHCARE

Access to affordable health care in Australia is underpinned by two key policy areas, Medicare and private health insurance. For many years shifts in the demographic profile of people covered by private health insurance and the falling percentage of the population covered for hospital care has been a cause for concern.

In summary:

- Consumers, particularly younger people, who perceive themselves less likely to need private health insurance are dropping their cover or electing not to take cover.
- Prior to the pandemic, consumers who retained private health insurance were 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.

In response to the COVID-19 pandemic, the Australian Government maintained the private health insurance rebate at Monday 1 April 2019 levels and health insurers provided a range of relief measures to members. As a result overall participation rates dipped in the June quarter to a low of 43.5 percent but then recovered to the March 2020 level of 43.8 percent. The number of people covered for hospital treatment as at Wednesday 30 September 2020 was 11,301,501, the highest number since March 2018.

However, there is significant uncertainty ahead as relief measures available to Australian households from private health insurers and other avenues wind back. Setting June 2020 aside, the private health insurance participation rate for hospital cover remains at a low not seen since 2007.

This challenge can be addressed by the Federal Government though a number of mechanisms detailed below.

- **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-Mar	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	24.415%	3. 95%	$ 5,051.44	$ 3,818.13	6.08%
2019–20*	25.059%	3. 25%	$ 5,213.61	$ 3,907.13	2.33%
2020(A)	25.059%	0. 00%	$ 5,212.61	$ 3,906.38	0.00%
2020(B)	25.059%	2. 92%	$ 5,367.91	$ 4,022.77	2.98%
2021-22	24.559%	2.74%	$ 5,514.99	$ 4,160.56	3.43%

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[30].
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 ahead of confirmation of the Private Health Insurance rebate adjustment factor for 2021/22

[30] PHI 24/20 - Private Health Insurance Rebate Adjustment Factor Effective 1 April 2020

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.

Although the Australian Government approved a premium increase of 2.92 percent from Wednesday 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 Wednesday 1 April 2020 to Tuesday 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, private health insurance policy holders will be asked to accept:

- Deferred Wednesday 1 April 2020 premium increases (with application and timing varying across health insurers).
- Additional premium increases effective Thursday 1 April 2021 of 2.74 percent.
- A reduction in the effective private health insurance rebate from Thursday 1 April 2021.

The cumulative effect of these factors will be an effective increase of 6.5 percent on Thursday 1 April 2021 compared with Wednesday 1 April 2020 for households on the lowest income tier.

This creates a heightened risk 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 in Australia. Between February 2020 and May 2020 there was a decrease in employment of 6.5 percent. This has somewhat recovered to a reduction in employment of 143,000 people (or 1.1 percent) between February 2020 and November 2020, in seasonally adjusted terms[31]. Retirees have seen the value of their superannuation and savings eroded. Nearly one in five Australians (19 percent) reported their household finances had worsened due to COVID-19 in the four weeks to mid-June[32]. By October 2020, five percent reported problems paying their home or investment property mortgage compared with two percent in June[33] 2020.

[31] Data source: ABS, Labour Force, Australia, cat. no. 6202.0, December 2020, seasonally adjusted

[32] Household Impacts of COVID-19 Survey, June 2020 , cat no 4940.0

[33] Household Impacts of COVID-19 Survey, October 2020 , cat no 4940.0

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[34]. 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.

Furthermore, 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 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 Wednesday 1 April 2020 effective level for income levels one and two. 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 17-17).

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

  Reforms introduced in 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 Monday 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 Monday 30 March 2020 were aged under 30.

[34] Australian Taxation Office, Statistics 2017-18.

Research commissioned by APHA shows:

- 80 percent 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 429,444 people as at September 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 LHC loading.

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

  In December 2020, the Department of Health released a consultation paper exploring a proposal to increase the continuity of coverage for young adult dependents. APHA is supportive of this proposal.

  Young adults over the age of 18 years old can be covered by their parent's/guardian's policy up until the age of 25 years old, provided their 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 years old being higher than for those aged 25-29 years old.

  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 LHC Loading when they turn 31 years old.

- **Reform to the LHC Loading**

  The 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 31 years old.

At the end of the September 2020 quarter, there were 878,665 people with a certified age of entry of more than 30 years old and subject to a LHC loading; a net decrease in people paying a penalty over the preceding 12 months of 30,929 [35]. The number of people aged between 30-49 years old 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:

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

- **Reform to the Medicare Levy Surcharge (MLS)**

The 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 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[36]. 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.

[35] APRA Quarterly Statistics September Quarter AHRA

[36] Australian Taxation Office, Statistics 2016-17 and 2017-18

APHA believes 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.

PRIVATE HOSPITALS IN AUSTRALIA

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

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

- Almost half (49 percent) 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.