7 February 2025

Via email: private.hosptals@health.gov.au

Catholic Health Australia Submission: Private Health Reform Options

Thank you for the opportunity to provide feedback on the Department of Health and Aged Care's (DoHAC's) Private Health Reform Options.

Catholic Health Australia's not-for-profit providers are dedicated to advocating for an equitable, compassionate, best practice, and secure health system that prioritises person-centred care. CHA and its members welcome the government's intent to improve the viability of private hospitals and broadly supports the proposed reforms.

CHA encourages DoHAC to implement immediate financial relief for private hospital providers by establishing regulated minimum sector-wide payment terms and guidelines applicable to all health funders and service providers. This measure would provide timely and effective financial support while enhancing sector productivity and efficiency by standardising health funding contract terms to align with industry-wide standards, similar to other industries such as aged care.

CHA has proposed several additional recommendations aimed at addressing the financial and operational challenges faced by private hospitals in the short-term. These include:

- leveraging private hospital capacity to support public hospitals
- incorporating current and future hospital costs into the private health insurance premium round process, including enterprise agreement wage growth
- adjusting capital reserve requirements for private health insurers
- ensuring the entirety of the private health insurance rebate is allocated to patient benefits.

If you wish to discuss anything further, please contact Dr Katharine Bassett, Director of Health Policy on 0420 727 709 or at katharineb@cha.org.au.

Yours sincerely,

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Catholic Health Australia

Submission: Private Health Reform Options

January 2025

Catholic Health Australia
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Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services accounting for over 15 per cent of hospital-based healthcare in Australia. Our members operate hospitals in each Australian state and in the Australian Capital Territory, providing about 30 per cent of private hospital care and 5 per cent of public hospital care in addition to extensive community and residential aged care. CHA Members also provide approximately 12 per cent of all aged care facilities across Australia, in addition to around 20 per cent of home care provision.

CHA not-for-profit providers are a dedicated voice for the disadvantaged which advocates for an equitable, compassionate, best practice and secure health system that is person-centred in its delivery of care.

Overarching comments

Increasing cost pressures and declining viability has resulted in many hospitals needing to make tough decisions regarding what services are provided. These pressures are more pronounced for for-profit hospital providers who are driven by the interests of private equity investors and shareholders. In the last few years, we have seen for-profit providers increasingly focus on providing high-activity, lower-cost, and low-complexity services to maximise profits, and reduce the availability of high-cost, complex services. Not-for-profit hospitals, particularly those run by faith-based organisations, frequently step in to fill this gap, as these hospitals prioritise patient care over profitability. Additionally, not-for-profit hospitals often serve a higher proportion of uninsured or underinsured patients. These factors have resulted in not-for-profit hospitals facing significant financial strain as they absorb the costs of providing essential services that for-profit hospitals are less inclined to offer. To address these challenges, it is essential the industry establishes more equitable funding models that avoid some hospitals focusing on low cost and high margin services at the exclusion of other essential private health services. Policies should aim to ensure not-for-profit hospitals receive adequate support to continue providing essential, high-cost healthcare services without compromising their financial stability.

Additionally, while CHA welcomes the government's intent to improve the viability of private hospitals, the only proposal that will provide immediate relief to hospitals is the implementation of regulated and standardised sector-wide guidelines for payment terms between private health insurers and private hospitals, providing all outstanding payments not under dispute are promptly paid. CHA has prioritised the proposals based on what will have an immediate impact on viability:

1. Payment terms and administrative costs
2. Mental health
3. Hospital in the home
4. Changes to risk equalisation arrangements
5. Maternity care
6. Second-tier default benefits

The following additional proposals are recommended to improve private hospital viability in the short-term:

- **Leverage latent capacity on private hospitals to support public hospitals:** there is an opportunity to shape the National Health Reform Agreement (NHRA) to support financial sustainability for private hospitals by taking a national approach to incentivise state and territory governments to utilise private hospital capacity for public hospital waiting lists. Currently the individual arrangements are separately negotiated between various states and local health networks with individual hospitals providers/hospitals. This process is inefficient, bureaucratic, short-term focused, and often provided by the private provider at a discount to the state/territory funding. These arrangements could be significantly improved through the development of a national private contracting framework, with states and territories obliged to pass through 100 per cent of existing health funding, with transparent and published performance targets set for all state and territory public health services.
- **Support enterprise agreement (EA) wage growth in private hospitals:** the increasing cost of EA wage growth (in particular nursing) is of significant concern for the private healthcare sector and the ongoing sustainability of the sector. State and territory negotiated EAs typically dictate the market rate for the private sector. The government can support EA wage growth in private hospitals through several mechanisms. These include subsidies under Section 51, grants under Section 96, and tax incentives or rebates under Section 51(ii). Additionally, the government can offset costs by covering superannuation contributions, subsidising utilities and medical consumables, and supporting capital expenditures and compliance costs.
- **Incorporate hospital costs into the annual private health insurance premium round process:** the cost pressures faced by private hospitals must be integrated through an external cost model to ensure

premium increases account for hospital cost pressures. This process must be transparent, with clear agreements on handling commercially sensitive information. The Department of Veterans' Affairs (DVA) Cost Indexation Report could be a useful first tool for this integration, providing an evidence-based overview of cost pressures without additional administrative burden. Funders could reference this report in their applications, explaining how they will ensure adequate reimbursement for health service providers.

- **Adjust the capital reserve requirements for private health insurers:** the Australian Prudential Regulation Authority (APRA) implemented a new capital framework for private health insurers on 1 July 2023, to enhance financial protection for policyholders by better reflecting the risks faced by insurers. Private health insurers argue that these stringent requirements overstate their risks, leading to higher costs and operational challenges. The new standards inadvertently reduce funding to hospitals as insurers must maintain higher reserves, limiting liquidity for immediate expenditures like hospital reimbursements. Additionally, many private health insurers are holding onto more capital than required, resulting in less liquidity available for hospital reimbursement. Adjusting the capital requirements to better align with the unique risk profile of private health insurers and implementing a cap on capital requirements could alleviate these pressures and direct more funding to hospitals. A phased implementation and thorough assessment of financial impacts are necessary to ensure a smooth transition.
- **Allocate the entirety of the private health insurance rebate to patient benefits:** the private health insurance rebate is designed to help Australians afford private health insurance premiums, with higher rebates for older and lower-income individuals. Around 20 per cent of the rebate is currently used for private health insurers administrative and management expenses, reducing its effectiveness in enhancing patient care. To address this, private health insurers should be required to allocate the entire rebate to patient benefits. This should be implemented alongside
- **Pause reforms to the Prescribed List:** the ongoing reforms to the Prescribed List are inadvertently impacting hospital viability. These changes include, but are not limited to, the removal of fibrin sealants from the list, amendments to definitions under the current prescribed list grouping scheme, and the removal of technical support services for cardiac implantable electronic devices from the prescribed list. It is recommended that these reforms be paused until the private hospital viability issues are addressed.

Response

Proposal 1: second-tier default benefits — short-term reform proposal

The proposal aims to enhance negotiations between private hospitals and insurers by updating the calculation methodology for second-tier default benefits. This involves using volume weighting of contracted services to prevent artificially low benefit rates and revising hospital categorisation to increase benefits for non-metropolitan hospitals from 85 per cent to 100 per cent of the insurer's contracted rate. The changes will be implemented by amending Schedule 5 of *the Private Health Insurance (Benefit Requirement) Rules 2011*.

Issues for stakeholder feedback:

General comments

The proposal aims to enhance the integrity of second-tier default benefit calculations and increase support for established regional hospitals. Currently, the process to calculate second-tier default benefits is *ad hoc* and complex, making it difficult for health funds — particularly those with complex funding models — to calculate default benefits accurately. CHA is supportive of simplifying the calculation methodology and using volume weighting as a mechanism to improve integrity. This could be achieved using Hospital Casemix Protocol and Private Hospital Data Bureau datasets. Currently default benefit rates are not transparent, as hospitals are only able to access the rates if they are unable to negotiate a contract. Hospitals should have the ability to confidentially access rate information from the Department of Health and Aged Care (DoHAC) independent of the private health funders when negotiations stall. Furthermore, private health insurers

should commit to ensuring that no contracted hospital in non-metropolitan areas has rates in place that are less than the second-tier rates to set a floor for private hospital funding.

CHA is also supportive of increasing the second-tier default rate to 100 per cent of the insurer's contracted rate for non-metropolitan hospitals and recommends increasing it to 90 per cent for metropolitan hospitals. There is a risk this policy may create a perverse incentive for hospitals to go out of contract with insurers, particularly when a facility is contracting below the default benefit rate, which would have a significant impact on patients. Additionally, there is a risk that this policy could entice new services to enter the market, potentially disrupting existing services. The policy should therefore only apply to established services.

If the objective is to improve funding models to ensure the sustainability of regional private hospitals long-term, an independent pricing body, such as IHACPA, should be responsible for determining a National Private Price for private health services. This price would consider factors which impact the cost of delivering care, including rurality, as it would be based on cost data provided by private health providers, meaning that price growth would mirror cost growth. The goal of funding reform would be to more adequately and accurately recognise relativities and increases in costs, and remove perverse incentives/disincentives that prevent the sector from responding to the needs of consumers and the health sector.

Whether the proposed changes are implemented on a temporary or permanent basis and the period by which a post implementation review should be undertaken.

It is recommended the proposed changes to the calculation methodology for second-tier default benefits be implemented permanently, with an initial review conducted 12 months after the implementation of the changes and adjustments made if needed.

The commencement of the proposed changes, noting the current annual processes for second-tier audit, categorisation and rate calculation.

As outlined above, this proposal is unlikely to have a significant impact on hospital viability, and therefore the timing of commencement is not critical and can align to the current annual processes for second-tier audit, categorisation, and rate calculation.

The criteria for determining what constitutes an established regional hospital eligible for a higher second-tier default benefit, noting DoHAC regularly makes use of the Modified Monash Model (MMM) for geographic definitions.

The following criteria is recommended:

- geographic location: the hospital must be located in a regional area as defined by the MMM
- accreditation: the hospital must be accredited and meet all relevant standards for private hospitals
- service range: the hospital should offer a wide range of services, demonstrating its capability to provide comprehensive care to the regional population
- volume of services: the hospital must deliver services at a specified volume, ensuring it lays a crucial in the regional healthcare system.

The level of the proposed increase to the second-tier rate for established regional hospitals and estimated impact on private health insurance benefit amounts. There are around 110 hospitals in MMM2 or above areas. The number of separations these hospitals account for approximately 14% of all private hospital separations and approximately 12% of all private hospital revenues. We note that not all of these hospitals accessed second tier benefits.

Many of these hospitals in MMM2 or above areas contract as part of larger hospital groups and are therefore unlikely to access second-tier default benefits. To support the small number of hospitals that would utilise second-tier default benefits, it is recommended that the rate be increased from 85 per cent to 100 per cent of the insurer's contracted rate. While the proposal is unlikely to have a significant impact on private health

insurance benefit amounts as it will only apply to a small number of hospitals, the impact on insurance premiums should be monitored and managed to ensure affordability for consumers.

Any additional arrangements to support the effectiveness of the proposed changes, including audits of calculations and the publication of second-tier rates.

- **Transparency of second-tier default benefit rates:** while transparency of the methodology should be improved, caution should be exercised in publishing second-tier rates. This is because some providers may be contracting below the second-tier rate, which is currently only revealed to a hospital if they go out of contract. Although it is important for hospitals to be paid appropriately, publishing these rates could negatively impact the viability of the private health sector in the short-term. This is because insurers would be required to pay more than originally anticipated, resulting in insurers needing to compensate for the increased costs through other such as tighter contracting with hospitals or increased premiums. It is for this reason that CHA recommends the focus be on non-metropolitan areas.
- **Audits of calculations:** regular audits of calculations should be performed to ensure accuracy and compliance with the established methodologies. These audits will help maintain the integrity of the system, identify any discrepancies, and provide assurance to stakeholders that the calculations are being conducted correctly.
- **Weighted model:** when considering how to aggregate hospital needs using a weighted model, it is essential to ensure that the methodology is both fair and accurate. One effective mechanism to achieve this is by leveraging the Australian Institute of Health and Welfare's (AIHW) peer grouping system. The AIHW's peer grouping system categorises hospitals based on shared characteristics, such as the type and nature of services provided, hospital size, and geographic location. This system allows for meaningful comparisons and ensures that hospitals with similar profiles are grouped together. By using this established framework, the weighted model can more accurately reflect the diverse needs of different hospitals.

Proposal 2: payment terms and administrative costs — short-term reform proposal

The proposal aims to improve private hospital cash flows and reduce administrative costs by implementing sector-wide guidelines. Key measures include a moratorium on unpaid benefit claims exceeding a reasonable payment period, standardising the timeframe for post-payment audits, and standardising administrative, reporting, and compliance terms in Hospital Purchaser Provider Agreements. These changes will be implemented through amendments to these agreements by private health insurers and hospitals.

Issues for stakeholder feedback:

General comments

CHA is strongly supportive of the introduction of payment terms and standardising administrative, reporting, and compliance contract terms. Several private health insurers have existing contract payment terms ranging between 14 and 28 days, however moving to a minimum standard payment terms of 14 days will enable alignment with health provider payment terms and would be an improvement for the sector. Wages are the substantial operating cost of hospital providers and are paid on a fortnightly basis.

CHA members also currently have substantial amounts in unpaid claims, primarily due to issues related to the Prescribed List (and certification requirements). Despite the legal obligation of insurers to pay claims under the *Private Health Insurance Act 2007*, many insurers fail to comply, and DoHAC, which is currently responsible for regulating this act, is not currently utilising its enforcement powers. Additionally, many contracts currently contain payment terms and conditions on audits, however these are typically ignored. In some instances, private health insurers will request clinical notes from hospitals, which may be a risk to patient privacy as the consent on the National Private Patient Claim Form is often insufficient. There is often a reluctancy to enter a formal dispute as this is a costly exercise that often has an impact on broader negotiations and the relationship between hospitals and insurers. Some disputes are brought to the Commonwealth Ombudsman with varying degrees of success and often long timeframes until resolution.

DoHAC also assists in resolving these disputes, however this assistance is advisory rather than regulatory, and the advice provided is unable to be shared with other parties, further complicating the process. This demonstrates there is a need for stronger regulatory measures to ensure compliance and ensure the introduction of payment terms is effective (further detailed below).

If payment terms are introduced, CHA recommends that any outstanding payments not under formal dispute should be promptly paid within 14 days. CHA and its members willing to collaborate with DoHAC to develop a solution that minimises the administrative burden for DoHAC, noting that DoHAC can, as the regulator, issue directives to private health insurers to ensure timely payment of outstanding amounts. Implementing this measure would immediately enhance the financial viability of private hospitals, ensuring they can continue to provide essential healthcare services.

While introducing measures to reduce payment delays will be beneficial, the underlying cause of the delays also needs to be addressed:

- There is currently poor understanding of *Private Health Insurance (Reforms) Amendment Rules 2018,* Rule 11F which sets out the coverage of treatment for insurance policies that cover hospital treatment. The new product tiers and clinical categories were intended to give consumers greater certainty about services covered, however private health insurers continue to reject claims where internal rules have been created that limit scope by MBS, DRG, or other factors. Other elements of Rule 11F including associated unplanned treatment and treatment for complications are also poorly understood. An education package for private health insurers and consumers is needed to reinforce the correct interpretation of legislation and rules.
- Advocacy bodies and private health insurance management agents often provide 'guidance' notes to private health insurers, which recommend a particular course of action to reject claims under certain circumstances. This results in private health insurers collectively rejecting claims without necessarily understanding all requirement of a complex rule or the individual variation of a claim. Several of these 'advice notes' include inaccurate information, resulting in payment delays. All advice given by advocacy bodies/management agents to private health insurers should be fact checked by DoHAC and endorsed as correct. The AskMBS Email Advice Service provides this service however responses are not broadly shared or published or publishing it, leads to wasted time and duplication of effort. Departmental advice should be transparent, defensible, and repeatable. A Q&A webpage for access by topic would alleviate DoHAC's workload as often multiple parties are seeking the same information. Additionally, this function should be broader than just the MBS (e.g. ask DoHAC) as this would reduce claim rejection, waste, and costs across the sector in managing mass claim rejection issues.
- Long-term reforms are needed to modernise the Prescribed List and reduce the administrative burden associated with maintaining the list. This includes streamlining the listing pathways and transitioning to a more sustainable funding model that is less susceptible to influence and funds innovation and value-based care.
- Any significant changes to the Prescribed List need careful consideration to ensure patient access is maintained and devices are adequately paid for, and there have already been considerable reforms to the Prescribed List that have negatively impacted access, such as the removal of fibrin sealants. It is crucial that any further changes continue to support access and ensure patients receive the necessary medical devices without financial barriers.

The certification process also creates a significant amount of administrative burden largely because it does not reflect contemporary clinical care, and ageing population, the value proposition of private health insurance, and whether the MBS has been correctly allocated based on majority usage. Type B and Type C certificates in particular are burdensome and more clarity on funding is needed. Certification must consider the policy intent (including MBS Review Taskforce and Medical Services Advisory Committee (MSAC) advice/recommendations), as well as the clinical requirements (including MBS claiming/other usage data for similar items, internal clinical advice, and private health sector consultation).

The requirement for Type B and Type C certification should be paused until a review is conducted to determine whether the requirements are fit for purpose. This review should consider the following recommendations:

- Apply an age-based exemption for Type B and Type C certifications so they are not required for patients over 65 years of age.
- Apply a time-based exemption for Type B and Type C certifications if the operating time commenced after 3pm and greater than 45 minutes.
- Exclude multiday stays (greater than two days) from Type B and Type C certification requirements, as admissions for a medical reason may take multiple days yet only attract an MBS item relating to the doctor's consultation (thereby making it a Type C).
- Align the Therapeutic Goods Association (TGA) and MBS clinical requirements with certification requirements for monoclonal antibody infusions to remove the time restriction.
- Review Type B and Type C procedure allocation to ensure the certification does not unfairly discriminate against those settings who do not provide all services.
- Intensive care unit and neonatal certificates provide no value, and a standardised funding model would resolve this issue.
- Acute care certificates require signatures from both the clinician and the patient, which is unnecessary.
- Anecdotally, CHA members have heard funds do not look at rehabilitation and psychiatric certifications, and that their system is set up to capture the presence of a certification in the ECLIPSE field rather than the content of the certification (as the HCP and claims data provides the information insurers need).
- An age-based exemption should be applied for Type B and Type C certificates, so they are not required for >65+ years.

The extent to which a sector self-regulatory approach is viable, including how consensus arrangements may be identified, maintained and updated.

As outlined above, stronger regulatory measures are needed to ensure compliance, and therefore a self-regulatory approach is unlikely to be viable. In addition to regulatory measures, the following is also required for the proposal to be viable:

- **Industry commitment:** issues persist even under the current regulatory framework, and therefore if new arrangements were developed, all stakeholders, in particular private hospitals and health insurers, must be committed to the process. This includes a willingness to adhere to agreed-upon standards and to participate in the development and enforcement of these standards. Consensus can be achieved by involving all relevant stakeholders in the decision-making process.
- **Clear guidelines and standards:** establishing clear, consistent guidelines and standards will be crucial. These should be developed collaboratively to ensure they are practical and acceptable to all stakeholders involved.
- **Effective monitoring and enforcement:** mechanisms will be required to monitor compliance and enforce the standards. This could include regular audits, reporting requirements, and penalties for non-compliance.
- **Conflict resolution:** clear mechanisms for resolving disputes will be required to maintain consensus. This could include mediation or arbitration processes that are agreed upon by all stakeholders.
- **Flexibility and adaptability:** the regulatory framework should be flexible enough to adapt to changes in the industry and to incorporate feedback from stakeholders. This ensures that the regulations remain relevant and effective over time.
- **Continuous improvement:** the regulatory framework should be subject to regular review and updates. This allows for the incorporation of new information, feedback from stakeholder, and changes in the industry.

The contribution DoHAC or another third party may play in facilitating industry agreement on standardised contractual terms.

DoHAC or another third party will play an essential role:

- **Neutral facilitator:** DoHAC or a third party can act as a neutral facilitator, ensuring all stakeholders have an equal voice in the discussions. This will help build trust and encourage open communication.
- **Expertise and guidance:** DoHAC or third party can provide expertise and guidance on best practices for standardised contractual terms. This includes sharing knowledge on legal requirements, industry standards, and effective contract management processes.
- **Mediation and conflict resolution:** in cases of disagreement, DoHAC or third party can mediate and help resolve conflicts. This ensures discussions remain productive and consensus can be reached more efficiently.
- **Drafting and reviewing contracts:** DoHAC or third party can assist in drafting and reviewing standardised contracts to ensure they are fair and balanced. This will help prevent potential disputes and ensures the interests of all stakeholders are protected.
- **Monitoring and compliance:** DoHAC or third party can also play a role in monitoring compliance with the agreed-upon terms and conditions. This includes conducting audits and providing feedback to ensure continuous improvement.

The potential for regulatory changes to assist in the introduction of standardised arrangements and/or to address issues that give rise to significant disputes about claims for benefits such as hospital certification requirements.

Regulatory changes can mandate the use of standardised contractual terms across the sector. This would ensure consistency and fairness in agreements between private hospitals and health insurers, reducing the potential for disputes. The following contractual terms should be included:

- **Clear guidelines for payment periods:** regulated payment periods and enforced penalties for non-compliance. A payment period of 14 days is recommended. This would help improve cash flows for private hospitals and reduce administrative burdens.
- **Post payment audit processes:** standardised timeframes for post payment audits that align with existing compliance arrangements like the Medicare Benefits Schedule (MBS). It is recommended this timeframe be two years to align with existing compliance arrangements. This would provide clarity and consistency, reducing disputes related to audit processes.
- **Audit volume cap:** a requirement that no more than two per cent or 250 episodes (PHI members per facility) may be audited in any given year, recognizing that errors can occur in both directions.
- **Resolution of audit queries:** a requirement that audit queries are resolved within 14 days of receiving legitimately requested information. This would require clarification of the information private health insurers are able to request, the minim security specifications required for data sharing, and clear destruction protocols and timeframes for private health insurers to destroy any information requested after it has been used for an audit query.
- **Post-payment audits:** audits of claims can only occur post-payment unless a manifest error in an invoice is identified. For this to be effective, clear definitions would be needed on what information can be requested (as outlined above).
- **Escalation of unresolved claims:** any unresolved audit claims should be escalated internally to a senior executive level for resolution.
- **On-site audits:** whenever possible, audits of clinical notes/medical records should be conducted on-site to reduce the risk associated with the transmission of sensitive information.

- **Reciprocal audit rights:** if a private health insurer chooses to audit a hospital, the hospital should have reciprocal rights to review an equivalent number of episodes within the same annual period where they believe an error resulting in an underpayment may have occurred and resubmit for payment.
- **Payment of resubmitted claims:** any resubmitted claim within the claim submission terms (generally three months to two years) should be paid according to payment terms, regardless of whether it is an initial claim or a correction.
- **Reporting of error rates:** private health insurers and hospitals should be required to report annual error rates (claims not paid in full or amounts/number of claims requiring a refund due to error) for transparency, either to DoHAC, the Commonwealth Ombudsman, or other appropriate tribunal. Private health insurers should also report error rates to the Australian Prudential Regulation Authority (APRA) as part of the quarterly reporting.

In addition to standardising contractual terms, the following regulatory changes should be considered:

- **Hospital certification requirements:** regulatory changes can streamline hospital certification requirements, ensuring that all hospitals meet consistent standards. This would help address issues that give rise to disputes about claims for benefits, as all parties would have a clear understanding of the certification criteria.
- **Independent dispute resolution:** implementing an independent dispute resolution process, similar to the one established by the No Surprises Act, can help resolve payment disputes between providers and private health insurers. This process can provide a fair and transparent mechanism for resolving disputes, reducing the need for lengthy and costly litigation.
- **Monitoring and compliance:** regulations can also establish robust monitoring and compliance mechanisms to ensure that all parties adhere to the standardised arrangements. This includes regular audits, reporting requirements, and penalties for non-compliance.

Proposal 3: hospital-in-the-home — short-term reform proposal

The purpose of this initiative is to enhance patient access to effective hospital-in-the-home (HITH) and ensure funding stability for providers. By early 2025, the sector and the DoHAC will identify an initial set of beneficial programs. Insurers will be mandated to fund these programs for policyholders with appropriate coverage, provided the programs meet accreditation and quality standards. After implementing the first set of programs, DoHAC will work with the sector to consider adding more programs. This will involve amending the *Private Health Insurance (Benefit Requirement) Rules 2011*.

General comments

Expanded out of hospital care and hospital in the home care are powerful opportunities

A default benefit for out-of-hospital (OOH) services, including HITH, is a crucial interim reform to enhance short-term patient access to safe and clinically effective care. This reform will drive productivity in the sector by encouraging insurers to contract with private and not-for-profit hospitals, thereby expanding the delivery of HITH and other OOH services to more patients.

Private hospitals and other facilities currently offer varying types and levels of healthcare outside the hospital. For the purposes of this submission and establishing a default benefit, these types of care have been classified as:

- Tier 1: acute care at home (HITH):
  - high-acuity care that requires admission with medical supervision
  - episodic treatment for an injury, acute illness or medical condition
  - led by hospital-level medical staff with 24/7 access to the multidisciplinary treating team
- Tier 2: post-acute and sub-acute care for ongoing recovery and goal-directed care to support functional capacity at home:

- multidisciplinary care delivered immediately after the acute phase
- reducing patient length of stay in hospital and/or avoiding readmission post discharge
- subacute care can be delivered hospitals or preferably in many instances, the home
- examples include rehabilitation, palliative, geriatric evaluation and management and psychogeriatric care types.

The reason for differentiation is to clarify the scope, complexity, and cost of offering different levels of care outside the hospital.

Despite the enormous opportunity for improved productivity and health outcomes, OOC has been described as the 'missing sector'. It represents 'low-hanging fruit' for a structurally significant improvement in the capacity of the healthcare system to deliver high-quality care to Australians at scale. Compared to traditional inpatient care for medically stable patients, OOH services — including hospital-level acute care (HITH) and subacute care programs (e.g. rehabilitation at home) — are often more efficient and effective, with lower readmission rates, shorter lengths of stay, reduced mortality, and increased patient satisfaction.[1,2] In the United Kingdom, 20 per cent of bed capacity is dedicated to OOH care, while some regions in Canada allocate 10 per cent. In contrast, OOH care in Australia accounts for only five per cent of private hospital care, with HITH representing just a small portion of that 5 per cent. Private health insurers have estimated that expanded HITH could save the private health system $1.3 billion per year.[3]

Challenges in increasing out-of-hospital care

In 2024, CHA conducted in-depth public research which found that 94 per cent of Australians believe patients and their doctors — rather than insurers — should decide whether a patient should access HITH and subacute care, provided it is safe and appropriate. Furthermore, 87 per cent agreed that OOH care should be a mandatory inclusion in insurance policies.[4] Yet despite the evidence, cost savings, and patient demand, the absence of default benefits has meant there is little incentive for insurers to fund OOH services. Some private health insurers refuse to contract with hospitals for these services, citing concerns about benefit outlay, quality,[5] and necessity. Others do not support services outside their own direct or subcontracted care (a model often referred to as 'managed care'), which can inhibit patient choice and clinical autonomy. Concerns raised by CHA members include:

- private health insurers instating on practices which contradict contemporary best practice or are not clinically indicated (for example, requiring medication delivery via a peripherally inserted central catheter line and refusing to fund delivery via a cannula)
- some private health insurers have discontinued funding for HITH services, including chemotherapy at home
- private health insurers can decline to fund HITH referrals directly from a private emergency department, despite direct referrals being common practice in public emergency departments

[1] Out of hospital care in Australia (2021) Catholic Health Australia. Available at: https://www.cha.org.au/wp-content/uploads/2021/03/6- CHA-Report-J170720.pdf

[2] Cross, J., et al (2020). 'Supporting choice: an innovative model of integrated palliative care funded by a private health insurer.' Internal Medicine Journal, 50(8), pp.931-937.

[3] There's no place like home: Reforming out-of-hospital care (2023) Private Healthcare Australia. Available at: https://www.privatehealthcareaustralia.org.au/wp-content/uploads/20230523_PHA-Report_Reforming-out-of-hospital-care.pdf

[4] Note: CHA can make this polling available to DoHAC in greater detail on request.

[5] Concerns regarding quality are unfounded, as hospital-delivered HITH and other OOH services must comply with the same processes for quality measurement and care delivery as the hospital and be accredited against the National Safety and Quality Healthcare Standards.

- private health insurers declining to contract directly and insisting hospitals contract with their own OOH care/HITH vertically integrated subsidiary, at reduced rates
- for palliative care at home (detailed further below), it is common for a patient's ability to access this service to be dependent on their local government area, even with major insurers.[6]

Sporadic and intermittent funding of OOH care, and in particularly HITH, has created uncertainty, resulted in expansion of insurer-delivered HITH, prevented hospital providers from investing at scale, and ultimately contributed to Australia's low uptake of OOH care and HITH. For these reasons, adopting default benefit arrangements for Tier 1 and Tier 2 services is time sensitive.

Health insurance premiums

Some stakeholders have erroneously suggested that clinician-led HITH services would lead to higher health insurance premiums. This claim is not supported by evidence or basic economic principles.

The insurance peak body's report[7] estimated the savings of HITH at $1.3 billion annually (11 per cent of baseline spend in 2023 when the report was released). These savings can only be realised if HITH services are scaled up, and after two decades, it is evident that insurers will not make these investments without the incentive of a default benefit. To suggest shifting more Australians into typically lower-cost care environments would result in higher premiums is unsubstantiated. Furthermore, the underlying implication of this suggestion — that insurers, rather than patients and clinicians, should control access to OOH care/HITH — is not evidence-based and is contradicted by the savings achieved by hospital, public health, and aged care models of HITH currently operating across Australia. The largest market for HITH is the United States (US), with these HITH models funded and delivered by private health insurers (managed care). The government is unlikely to emulate the US health system's cost and equity model, however without a default benefit, it is possible this model will be adopted in Australia before broader private health reforms can be considered.

There are also significant workforce constraints. Despite efforts by both Commonwealth and state/territory governments to expand the health workforce, a dramatic shortage persists, with 82 per cent of health occupations are reportedly in shortage.[8] With a growing and ageing population, it is unlikely Australia will overcome these shortages anytime soon. Private hospitals are therefore unlikely to be able to staff a separate HITH workforce in addition to the existing inpatient workforce. Instead, a default benefit for HITH will enable more productive allocation of funding to areas of clinical need, resulting in efficiencies that will help drive down premiums, avoid continued development of expensive inpatient hospital facilities and ensure patients receive more appropriate care in the correct setting at a lower cost to the community.

The need for long-term reform

Long-term reform should aim to transition Australia's private health system toward a clinically needs-based approach to care settings, which cannot be fully realised under current funding models. For example, the Pricing Framework for Australian Public Hospital Services includes a key pricing principle: *"Promoting harmonisation: Pricing should facilitate best practice provision of appropriate site of care".*[9] In the public hospital system, an ever-expanding list of treatment types utilise HITH as a matter of routine, not exception. If implemented effectively, this transition could lead to significant savings for the private hospital system by

[6] CHA member reports

[7] There's no place like home: Reforming out-of-hospital care (2023) Private Healthcare Australia. Available at: https://www.privatehealthcareaustralia.org.au/wp-content/uploads/20230523_PHA-Report_Reforming-out-of-hospital-care.pdf

[8] https://www.jobsandskills.gov.au/sites/default/files/2023-09/2023%20SPL%20Key%20Findings%20Report_0.pdf

[9] https://www.ihacpa.gov.au/sites/default/files/2024-12/pricing_framework_for_australian_public_hospital_services_2025-26.pdf

reducing the need for additional brick-and-mortar hospitals. It would also preserve the essential role of existing overnight acute hospitals, which remain crucial to Australia's healthcare needs.[10]

What priority conditions, if any, should the mandated HITH programs focus on and why?

The default benefit should cover all inpatient treatments for which there is strong clinical evidence supporting the safe and effective delivery of care at home. A broad range of treatments should be available to ensure the program's success, enabling providers to scale and invest in services. The immediate focus should be on services already offered in Australia (either in the public or private hospital sector) to allow for rapid implementation, with additional services added over time and reviewed annually. Table 1 includes a list of appropriate services, including designating those most appropriate for immediate adoption.

Table 1 - List of appropriate Tier 1 and Tier 2 OOH services for a default benefit - by priority

Service type	Priority	Typical tier (HITH – 1 or Sub-acute – 2)
Cellulitis	1	1
Respiratory disorders	1	1
Bone and joint infections	1	1
Heart failure	1	1 and 2
Septicaemia	1	1
Complex medical	1	1
Palliative Care	1	*own tier
Acute nursing	1	1
Anticoagulant therapy	1	1
Intravenous therapy	1	1 and 2 (for chronic disease management)
Stoma / PEG / catheter management	2	3* – basic nursing by non-hospital provider
Complex Wound management	1	1
Pain management	1	1 and 2
Dialysis	2	2
Chemotherapy	1	1
Rehabilitation	1	2
Basic wound care	1	3* – basic nursing by non-hospital provider
Geriatric evaluation and management	2	2

The focus should be on patient choice and clinical autonomy, allowing patients to opt for OOH care/HITH when it is clinically appropriate. Services already offered by insurer-owned OOH care/HITH programs should be included as a minimum, with a further focus on OOH care/HITH services currently delivered in Australia by private hospitals.

What evidence should be required to demonstrate that a specific HITH program is well established *and* clinically beneficial?

The evidence required for Tier 1 (HITH) programs should demonstrate clinical outcomes and patient experience metrics that are equivalent to or exceed those achieved in inpatient settings. This may include metrics such as Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures

[10] Pandit, J.A., Pawelek, J.B., Leff, B. *et al.* The hospital at home in the USA: current status and future prospects. *npj Digit. Med.* **7**, 48 (2024). https://doi.org/10.1038/s41746-024-01040-9

(PREMs). All providers should be held to the same standards of quality care, ensuring that HITH services are both clinically beneficial and patient centred.

What are the appropriate arrangements for determining and requiring service providers to meet appropriate accreditation and service quality standards?

Tier 1 and 2 programs should adhere to the National Safety and Quality in Health Care Standards (NSQHS), with care delivered by or on behalf of a registered private overnight hospital. Each provider should be accredited by a registered body (for example, the Australian Council on Healthcare Standards as having met the NSQHS).

There may be differences in requirements for specific services, however to qualify as an OOH care/HITH service for the purposes of receiving a default benefit, both Tier 1 and Tier 2 services should include:

- a daily nurse visit (noting that this may be virtual where appropriate, for example a negative pressure wound dressing)
- access to allied health
- medical oversight and access to medical care
- 24-hour care escalation pathways
- the capacity to deliver telehealth
- the ability to provide access to face-to-face medical consultations.

Tier 1 services must have access to the full range of hospital interventions and diagnostics appropriate for treatment, including allied health, pathology, pharmacy, and radiology. Only programs operated by or on behalf of a registered private hospital should qualify for the default benefit.

Should the provision of the mandated Hospital in the Home programs be limited to any particular type of healthcare providers/facilities?

Only programs operated by or on behalf of registered overnight private hospitals should qualify for the default benefit.

What is the appropriate mechanism for determining the minimum contribution that insurers will be required to pay to the service provider for delivering the mandated HITH programs?

In the public sector, price harmonisation between inpatient and Tier 1 (HITH) services ensures hospitals are incentivised to offer the most appropriate care setting for each patient. This should be the intended goal of long-term reforms (nothing this is not the intent of this short-term policy initiative or the function of a default benefit). Cost savings however will only be achieved if the default benefit that incentivises the delivery of care at home while ensuring the sustainability of private hospitals.

DoHAC should develop a small set of default benefits to reflect different types of treatment. Broadly these should cover Tier 1 and Tier 2, while also covering additional high priority care types:

- Tier 1, for example cellulitis, acute nursing, chemotherapy
- Tier 2, for example, dialysis, post-surgical nursing.

Other treatments will likely require their own specific default benefit due to their different cost base. A key example is palliative care, for which there is strong evidence of cost savings from treatment at home,[11] but will require a higher default benefit than some other treatment types to be effective. Evidence compiled by Palliative Care Australia and other researchers has demonstrated further savings resulting from reduced ED presentations, a reduction in hospital days in the final year of an individual's life, and patients being twice as

[11] . Productivity Commission (2017) 'Introducing competition and informed user choice into human services: Reforms to human services', Report No. 85, Canberra

likely to die at home when receiving palliative care at home.[12,13] These advantages are in addition to the evidence that people overwhelmingly prefer to die at home with appropriate supports in place.[14]

CHA can facilitate access to cost information for programs run by our members to support the calculation of default benefits. CHA has also previously developed cost methodologies that may be useful to DoHAC, which can be made available on request.

What factors should be taken into account in determining the number of HITH programs included in the first tranche and what if any conditions should be placed on the period of time these programs will be mandated?

The first tranche of Tier 1 and Tier 2 OOH care programs should include clinically appropriate inpatient treatments with strong evidence for home-based care. Table 1 outlines a suitable order for implementation. Excessively limiting the scope of eligible treatments would hinder the program's stated goal of improving patient access by preventing providers from scaling and investing in services. Concerns regarding premium growth should be firmly rejected, as expanding OOH care/HITH will lead to substantial cost savings over time. Given the current workforce constraints, it is expected that even with broad default benefits, the expansion of OOH care, and in particular HITH will be limited in the first few years.

There should be no fixed end date for the mandate, except in the event of broader reforms that recognise HITH equally alongside inpatient care. A review period to assess the implementation and impact of OOH care/HITH services is appropriate, but the mandate should continue as long as the program is delivering the expected benefits.

What if any other regulatory arrangements may need to be changed to support the implementation, operation and financial sustainability of this reform option?

Existing hospital and clinician regulators are well-equipped to oversee the implementation, operation, and financial sustainability of HITH programs, and therefore there is no need to establish new regulatory bodies. The focus should be on the current regulators monitoring and adapting existing regulations to ensure consistency and support the scaling of HITH services.

A key consideration for DoHAC is ensuring MBS items typically applicable for in-patient care and necessary to provide HITH are available for this purpose. Several of these items have already been made available as a result of reforms during the COVID-19 pandemic. The items however should be reviewed to ensure they will appropriately support HITH. For example, certain items may allow a doctor to conduct a telehealth appointment, but not if the patient is admitted to a hospital. It should be clarified that a HITH admission qualifies for a telehealth appointment. Finally, as the proportion of care delivered via HITH increases, it can be assumed that MBS costs will be lower at a systemic level.

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[12] https://treasury.gov.au/sites/default/files/2020-09/115786_PALLIATIVE_CARE_AUSTRALIA_-_SUBMISSION_2_-_SUPPORTING_DOCUMENT.pdf

[13] May P, Garrido MM, Cassel JB, Kelley AS, Meier, DE, Normand C, Smith TJ, Stefanis L and Morrison RS, 2015. *Prospective cohort study of hospital palliative care teams for inpatients with advanced care: earlier consultation is associated with larger cost-saving effect* Journal of Clinical Oncology, 33(25): p2745

[14] Best Australian and international evidence is that around 90% of people would prefer to receive palliative care & end-of-life care at home – with appropriate support in place. Around 50% of people in Australia would prefer to die at home *Agar M, Currow D, Shelby-James T, Plummer J, Sanderson C and Abernethy A (2008) Preference for place of care and place of death in palliative care: are these different questions? Palliative Medicine 2(7): 787-795*

Pinto, S, S Lopes, A de Sousa, M Delalibera and B Gomes, 2024, Patient and Family Preferences about place of end-of-life care and death: an umbrella review, Journal of pin and symptom management 67(5), May 2024, https://doi.org/10.1016/j.jpainsymman.2024.01.014

Proposal 4: mental health

The proposal aims to improve access to mental health care by increasing the supply of internationally educated psychiatrists who can admit patients to private mental health hospitals. The Private Hospital Sector Financial Health Check found that private mental health services are under pressure due to difficulties in attracting and retaining psychiatrists in an inpatient setting. Currently, overseas trained psychiatrists must work in a District of Workforce Shortage (DWS) for 10 years before accessing Medicare rebates, which are essential for admitting patients to private hospitals. The proposal suggests amending this 10-year moratorium to ensure appropriate patient care and enhance the provision of acute mental health services through resource sharing between private and public hospitals.

Issues for stakeholder feedback:

General comments

While increasing the supply of internationally educated psychiatrists able to admit patients in private mental health hospitals may benefit some areas in the short term, it is unlikely to be a sustainable solution as it will not address the root cause of the issue. In recent years there has been a notable increase in the diagnosis and treatment of attention-deficit hyperactivity disorder (ADHD) and autism spectrum disorder (ASD). This is due to several factors, including increased awareness, patient expectations, improved diagnostic practices, and unfortunately, financial incentives for outpatient psychiatrists/healthcare providers to focus on diagnoses that are more easily managed through outpatient care and telehealth as opposed to intensive inpatient care. Specifically, psychiatrists in an outpatient setting can earn higher incomes (an estimate of four to six times those working in an inpatient setting) by accessing funding through the National Disability Insurance Scheme (NDIS) and the MBS. They can also charge patients higher out-of-pocket costs due to increased demand for their services. Additionally, the ability to diagnose via telehealth (which became more prevalent during the COVID-19 pandemic) allows them to work remotely. Due to these financial and lifestyle incentives, many psychiatrists are choosing to focus primarily on outpatient services instead of inpatient care, leading to a shortage of psychiatrists in inpatient facilities.

For this issue to be addressed, the ability for psychiatrists to diagnose and prescribe via telehealth needs to be reviewed to ensure there is a balance between ensuring patients can access psychiatric care while also aligning to the government's directive that telehealth should complement, not replace, face-to-face services. Additionally, the guidelines on accessing NDIS funding need to be strengthened, and limits on the out-of-pocket costs psychiatrists can charge for (including but not limited to ADHD and ASD diagnoses) could be implemented. Finally, there are opportunities to increase the scope of practice for general practitioners with mental health qualifications, nurse practitioners, and psychologists to support the diagnosis and treatment of low complexity mental health disorders, as well as admit patients to day programs and inpatient services, under the clinical governance of psychiatrists. An example of a model for general practitioner inpatient mental health care is the Cabrini Health Women's Mental Health inpatient unit.

Should an amendment to the 10-year moratorium include provisions requiring that overseas trained psychiatrists dedicate time in both public and private hospital settings? If yes, what is the ideal balance of clinical work hours that should be performed in public hospital roles and in private hospitals?

The current mental health crisis and the pressure on private mental health hospitals necessitates a re-evaluation of the 10-year moratorium to allow overseas trained psychiatrists to dedicate time in both public and private hospital settings. Determining the ideal balance of clinical work hours between public and private hospital roles requires careful consideration of several factors:

- **Workforce needs:** the balance should reflect the current workforce needs in both sectors.
- **Training and development:** the balance should also consider the training and development needs of psychiatrists. A mix of, for example, 50 per cent public and 50 per cent private hospital work could provide a well-rounded experience while addressing workforce shortages.

- **Flexibility and individual preferences:** flexibility should be built into the policy to accommodate individual preferences and career goals. Allowing psychiatrists to choose their preferred balance within a specified range (e.g. 50-60 per cent public and 40-50 per cent private) could help maintain job satisfaction and retention.

In addition to alleviating pressure on private mental health hospitals, enabling overseas trained psychiatrists to work in both public and private hospitals will provide a more comprehensive training experience. Public hospitals often deal with more severe and complex cases, while private hospitals may offer more specialised and elective treatments. This dual exposure can enhance the skills and expertise of overseas trained psychiatrists. There is however often greater oversight of overseas-trained psychiatrists in public hospitals. It is therefore important to consider how the quality of their work is assessed and determine the appropriate point at which they can divide their time between public and private hospitals.

If the proposed amendment to the 10-year moratorium were implemented, should it apply to overseas trained psychiatrists currently practicing in Australia, or be limited to cohorts entering Australia following the amendment?

Implementing the proposed amendment to the 10-year moratorium raises important considerations regarding its application to current and future overseas trained psychiatrists. The advantages of applying the amendment to current and future practitioners is it would have an immediate effect on alleviating workforce shortages. It would also promote fairness as all overseas trained psychiatrists, regardless of when they arrived, will be subject to the same regulations. The disadvantages however are that current practitioners may have already made long-term plans based on the existing moratorium, and changing the rules mid-way could disrupt their professional and personal lives. Additionally, implementing the amendment retroactively could create administrative complexities and resistance from those already practicing under the old rules.

In light of this, a phased approach should be considered. For example, the amendment could apply to new entrants immediately, while current practitioners could be given a transition period to adapt to the new requirements. This phased approach would minimise disruption while gradually addressing workforce shortages.

Should the proposed amendment of the moratorium operate for a time-limited basis? If yes, for what time period should the amendment to the moratorium operate?

Implementing the proposed amendment to the 10-year moratorium on a time-limited basis could offer several advantages:

- **Evaluation and adjustment:** a time-limited amendment allows for an evaluation period to assess its effectiveness in addressing workforce shortages and improving access to mental health care. This period can provide valuable data to make necessary adjustments.
- **Flexibility:** it offers flexibility to policymakers to adapt to changing circumstances and needs in the healthcare sector. If the amendment proves successful, it can be extended or made permanent.
- **Minimising resistance:** a temporary measure might face less resistance from stakeholders compared to a permanent change, as it allows for a trial period to demonstrate benefits.

It is important however to recognise that a time-limited amendment might create uncertainty for overseas trained psychiatrists planning their careers in Australia, and they may be hesitant to commit to positions without knowing the long-term implications. Additionally, it takes more than a decade to train a psychiatrist (including medical school, internship, fellowship training, and subspecialty training), and therefore the shortage is likely to continue for many years. Therefore, it is recommended the policy be implemented indefinitely, with an independent post-implementation review after three years as this will:

- allow for the collection of meaningful data on the amendment's impact on workforce distribution, patient care, and collaboration between public and private hospitals.
- provide enough time to identify any unintended consequences and make necessary policy adjustments

- provide a defined timeframe which will build confidence among stakeholders, including overseas trained psychiatrists and healthcare providers.

Are there any potential risks or unintended consequences associated with the introduction of the proposed reform option? If so, do you have any suggestions to reduce or limit the impact?

- **Workforce distribution imbalance:** the amendment might lead to an uneven distribution of psychiatrists, with some regions potentially experiencing shortages if practitioners prefer working in areas where they can work across public and private hospitals. Additionally, the public sector may lose psychiatrists to the private sector. Incentives could be provided in underserved regions or public hospitals, such as financial bonuses, housing assistance, or professional development.
- **Administrative burden:** the amendments could create additional administrative challenges for overseas trained doctors, adding to an already administratively burdensome process. These amendments should therefore be implemented alongside mechanism to reduce the overall administrative burden associated with the pathway for overseas trained doctors.
- **Impact on current practitioners:** if the amendment applies to current overseas trained psychiatrists, it could disrupt their established career plans and lead to dissatisfaction or attrition. A phased implementation approach would provide a transition period and help minimise disruptions. Allowing overseas trained psychiatrists to choose their preferred balance of work hours between public and private hospitals within a specified range could also minimise disruption.
- **Potential impact on patient care:** if the overseas-trained doctors do not have the same level of training as their locally trained counterparts, there could be an impact on patient care. To mitigate this, level of training could be regularly assessed, and additional training and support programs could be implemented to ensure all psychiatrists meet the required standards before splitting their time between public and private hospitals.

Proposal 5: maternity care

The proposal aims to make privately insured maternity care more accessible and affordable by including maternity cover as a standard inclusion across more insurance policies, not just 'Gold' level policies. Currently, 'Pregnancy and birth' and 'Assisted reproductive services' are only mandated for Gold tier, while 'Miscarriage and termination of pregnancy' are covered in Bronze, Silver, and Gold tiers. Policies that exceed minimum requirements can be labelled as 'Plus' policies (e.g., Bronze Plus, Silver Plus). The government sets a maximum waiting period of up to 12 months for pregnancy and birth coverage. Implementation would require amending the *Private Health Insurance (Complying Product) Rules 2015*.

Issues for stakeholder feedback:

General comments

A key issue with private maternity care is the out-of-pocket costs associated with a pregnancy journey. In particular, the pregnancy management fee often ranges between $5,000–10,000 (sometimes considerably more) and the MBS rebate is only $335, which is on top of the out-of-pocket costs associated with the regular visits with the private obstetrician and diagnostic tests. There are many patients who have Gold private health insurance cover that choose to deliver in a public hospital because of these out-of-pocket costs. The risk with this proposal is that including maternity care in more policies may increase the cost of those policies while not addressing the root cause of the issue — the out-of-pocket costs associated with the obstetrician. For this proposal to be successful in making private maternity care more accessible and affordable, government would need to look at ways to reduce these out-of-pocket costs. This could include:

- increasing the MBS rebate, with a condition that the medical practitioner does not charge an out-of-pocket cost (i.e. the medical practitioner only gains access to the higher MBS rebate if they do not charge an out-of-pocket cost)

- explore and incentivise models of care where private health insurers fund a bundle of care (prenatal, delivery, and postnatal care) across the entire pregnancy journey, with no or a smaller known out-of-pocket cost.

The other issue with private maternity is workforce shortages. Workforce shortages (in particular, shortages of obstetricians, anaesthetists, paediatricians, and midwives) are placing significant strain on private maternity service supply and viability. These workforce shortages have been the driving force behind many maternity units closing or diverting cases and demand to the public sector. This in term creates a vicious cycle, as it makes the private sector less attractive to obstetricians and midwives due to the absence of practices and impact on job security. While this proposal is welcome, it is unlikely to significantly impact the viability of private maternity services unless out-of-pocket costs and workforce shortages are also addressed.

Which private health insurance product tier(s) should provide coverage for the 'Pregnancy and birth' clinical category to enable improved access and affordability for policyholders?

As outlined above, the risk with including maternity care in a greater number of policies is that it will likely the cost of these policies. As a priority, government should perform economic modelling on the impact of including maternity cover in more policies, with the goal of making these services accessible to as many policyholders while also keeping the costs of premiums low.

What are the implications for policyholders and the health system in retaining the current arrangements and the implications associated with a change, including the impact on premiums and the value proposition of private health insurance.

If the current arrangements are maintained, we will likely continue to see further closures of private maternity services, which will:

- reduce the value proposition of private health insurance, as those with maternity cover will be unable to use it
- reduced access to private maternity services and broader gynaecological services, as typically maternity care is provided alongside gynaecological health services
- transfer births from the private to the public sector, which will increase the strain on public sector capacity, as well as increase costs for governments
- have an impact on workforce, particularly in regional, rural, and remote communities where it is more challenging for existing workers to find alternative roles in the same location.

Any change that genuinely reduces costs across the entire pregnancy journey will help address these issues and enhance the value of private health insurance.

If you consider the clinical category of 'Pregnancy and birth' should be a mandatory inclusion in another product tier(s), do you consider the related clinical categories of 'Assisted reproductive services' and 'Miscarriage and termination of pregnancy' should be included in the same product tier(s) as 'Pregnancy and birth' or remain in the currently assigned product tier?

When considering the clinical category of 'Pregnancy and birth' as a mandatory inclusion in another product tiers, it is essential to ensure that patients have access to all services associated with the pregnancy journey. 'Miscarriage of pregnancy' should remain in all product tiers.

What other changes, if any, to existing private health insurance product rules and regulatory arrangements may be required to make the addition of cover for maternity care in lower product tiers provide value to the patient and be sustainable for the sector?

In addition to those outlined previously, the 12-month waiting period for private maternity services should also be reviewed. While this waiting period is primarily designed to prevent individuals purchasing insurance solely to claim benefits for an impending maternity expense, it also disadvantages those who may not have planned their pregnancies and were unable to purchase or upgrade their cover. An alternative policy could involve a more flexible approach that encourages long-term retention of health insurance, such as

incentivising policyholders to maintain their health insurance for a certain period after the birth by providing comprehensive coverage for the newborn. Depending on which policies contain maternity if this proposal is implemented, another option could be allowing policyholders to automatically upgrade their policy without needing to serve the mandatory waiting period. There is however a risk that patients who upgrade their policy will downgrade it after the birth with the knowledge they can upgrade it again. To partially mitigate this, the patient upgrading could be asked to pay a lump sum payment of the higher premiums they did not pay for the previous year to deter them from gaming the system.

Additionally, any changes to maternity care should also be implemented alongside changes to risk equalisation to better compensate private health insurers for the higher costs associated with maternity care (discussed further below).

Proposal 6: changes to risk equalisation arrangements to support improved access to mental health and maternity care

The proposal aims to improve access to more affordable private health insurance coverage for mental health and maternity care by amending the risk equalisation regime. Risk equalisation supports the community rating principle, preventing insurers from risk rating premiums. It compensates insurers with riskier demographics by redistributing funds from insurers with lower average benefits to those with higher average benefits. Current regulations include an age-based pool for participants over 55 and a high-cost claims pool for claims exceeding $50,000 annually. Maternity and psychiatric care claims are generally not subject to risk equalisation unless costs exceed $50,000 per year.

Issues for stakeholder feedback:

General comments

This proposal is unlikely to improve access to more affordable private health insurance coverage for mental health and maternity care if it is not implemented alongside other policies (outlined in Proposal 4 and Proposal 5).

In-principle, do you support changes to the risk equalisation regime to equalise some or all of the benefits insurers pay for mental health and maternity care?

CHA is supportive of the changes to risk equalisation to equalise all the benefits insurers pay for mental health and maternity care. Mental health and maternity care are critical areas of healthcare that often incur significant costs. By including these services in the risk equalisation framework, insurers can be partially compensated for the higher costs associated with these claims. This compensation will prevent insurers from passing these costs onto consumers in the form of higher premiums and pricing products that offer maternity services out of the market — a behaviour which is currently occurring. This change will also promote market stability, as it will reduce the financial strain on those insurers with a higher proportion of members requiring mental health and maternity services maintaining a stable and competitive market.

Based on your experience and/or understanding of private health insurance claims for mental health and maternity care, what risk equalisation parameters should be considered or further examined (for example, patient age, benefit amount(s), types of treatment)?

Several key parameters should be considered to ensure the settings effectively support access to these services, including:

- **Patient age:** currently the risk equalisation framework includes an age-based pool that primarily benefits individuals over the age of 55. This approach reflects the higher healthcare costs typically associated with older age groups. Mental health and maternity care however often involve younger individuals. For instance, maternity care is predominantly required by women of childbearing age, typically between 20 and 40 years old. Similarly, mental health issues can affect individuals across all age groups, including younger populations. The risk equalisation framework should be adjusted to include younger age groups specifically for mental health and maternity care claims.

- **Benefit amount:** the current risk equalisation framework includes a high-cost claims pool for claims that exceed $50,000 annually. While this provision helps manage extremely high-cost claims, it rarely addresses the costs associated with mental health and maternity care which often do not reach the threshold. The threshold for high-cost claims should be adjusted specifically for mental health and maternity care claims.
- **Types of treatment:** mental health and maternity care encompasses a wide range of treatments and services. For the policy to be effective, the risk equalisation framework should include all services that a patient may require.
- **Geographic location:** healthcare costs can vary significantly based on geographic location, with rural and remote areas often facing higher costs. Including geographic location as a parameter could help ensure that insurers serving these areas are not impacted by covering these patients, promoting equitable access to mental health and maternity care in these areas.
- **Chronic conditions:** mental health and maternity care often intersect with chronic conditions, such as diabetes or hypertension, which can complicate treatment and increase costs. Including chronic conditions as a parameter could help ensure that insurers share the risks associated with funding these complex cases.

What information, data or modelling does the private health sector require to assess the impact of amendments to the risk equalisation arrangements on private health insurance premiums, product offerings and to inform government on the timeframe for implementing the proposed changes?

The following is required to understand the impact of including mental health and maternity care in the risk equalisation framework:

- **Claims data:** detailed claims data for mental health and maternity care is required, including data on the frequency, cost, and types of claims made for these services. This will enable government to identify patterns and trends in service utilisation, which can help predict future costs associated with the proposal. Claims data can also help identify high-cost cases and the factors contributing to these costs, which will be essential for setting appropriate thresholds for high-costs claims and determining the proportion of costs that should be shared among insurers.
- **Demographic data:** demographic data, including age, gender, and geographic location, is necessary to understand the characteristics of individuals who utilise mental health and maternity care services. This information can help identify high-risk populations and tailor the risk equalisation framework to better support these groups.
- **Impact analysis:** impact analysis involves modelling the financial effects of including mental health and maternity care in the risk equalisation framework on premiums and product offerings. This analysis should consider various scenarios and parameters, such as different thresholds for high-cost claims, varying proportions of cost-sharing, and the inclusion of different types of treatments. By simulating these scenarios, insurers and policymakers can assess the potential impact on premiums and determine the most effective and sustainable approach to risk equalisation. The analysis should also consider the potential effects on consumer behaviour. For example, if including mental health and maternity care in the risk equalisation framework leads to lower premiums, it may encourage more individuals to seek coverage and utilise these services. Understanding these behavioural responses is crucial for predicting the overall impact on the insurance market and for designing policies that promote access to care while maintaining financial sustainability.
- **Sensitivity analysis:** sensitivity analysis involves testing different scenarios to understand how changes in key variables (e.g. claim costs, utilisation rates) affect the overall impact of the risk equalisation amendments. This analysis can help identify the most critical factors influencing costs and premiums, allowing stakeholders to develop strategies to mitigate potential risks. Sensitivity analysis is particularly useful for understanding the range of possible outcomes and for planning under uncertainty.

- **Regulatory requirements and approvals:** the first step in determining the timeframe for implementation is understanding the regulatory requirements and approvals. This involves identifying the legislative process and timelines for passing the amendments, as well as approvals from the relevant regulatory bodies.
- **Operational readiness:** the operational readiness for insurers to implement the changes needs to be assessed, including the need to update claims processing systems, data management protocols, and reporting mechanisms.

What other changes may need to accompany amendments to the risk equalisation arrangements to support improved patient access to mental health and maternity services?

Additional changes that need to accompany amendments to the risk equalisation arrangements are outlined in Proposal 5 and Proposal 6.