Catholic Health Australia

Pre-Budget Submission 2025–26

Health Policy

January 2025

Catholic Health Australia

Contents

Executive summary

A private hospital sector at breaking point

Background

The private hospital sector in Australia is facing significant challenges. Financial performance has been declining, with operating profits and margins decreasing over recent years. This is due to a variety of reasons, in particular cost inflation and lagging premium increases. Additionally, stringent capital reserve requirements for private health insurers have reduced funding flow to hospitals, and wage increases and unfunded capital expenditures are adding to the financial burden. The sector is also struggling with latent capacity, declining viability of psychiatric and maternity services, and a shift in consumer preference from Gold to Silver health insurance products, all of which are impacting sustainability and ability to provide essential services.

Policy priorities

Priority 1: Reduce regulatory burden and red-tape

Several measures are recommended to reduce regulatory burden and red-tape for private hospitals, improve efficiency, and ensure timely payments to hospitals. This includes:

- implementing and enforcing payment terms and conditions in contracts to prevent delays, and any outstanding payments not under dispute promptly paid
- Align the requirements for Type B and Type C certification under the *Private Health Insurance (Benefit Requirements) Rules 2011* with service availability, provision, and practice
- ensure alignment between the Medical Services Advisory Committee (MSAC), Therapeutic Goods Association (TGA) and the *Private Health Insurance (Benefit Requirements) Rules 2011* requirements on determining the Medicare Benefits Schedule (MBS) and certification
- modernise legislation to fit with contemporary care environments as hospital-in-the-home (HITH) expands (for example, updating pharmacy arrangements to allow private hospitals to provide medications for home-based care)
- harmonise data and reporting requirements into a single dataset by consolidating the Hospital Casemix Protocol and Private Health Data Bureau reporting.

Priority 2: Fund enterprise agreement (EA) wage growth in private hospitals

The government can fund EA wage growth in private hospitals through several mechanisms under the *Commonwealth of Australia Constitution Act.* 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.

Priority 3: 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. Additionally, premium adjustments should be transparent and based on solid evidence, without arbitrary thresholds, ensuring insurers can cover healthcare costs. 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.

Priority 4: Adjust the capital reserve requirements for private health insurers

The Australian Prudential Regulation Authority (APRA) implemented a new capital framework for private health insurers in July 2023, which resulted in the capital instruments for private health insurers to be in a similar format to life and general insurance. While private health insurers share some characteristics with the life and general insurance industries, private health insurance has a different risk profile compared with life and general insurance. 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. In the short-term, the capital requirements should be adjusted 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. In the long-term, the appropriateness of APRA as the prudential regulator should be reviewed.

Priority 5: 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 a minimum benefit return ratio.

Priority 6: Increase default benefits for regional, rural, and remote private hospitals

Regional, rural, and remote private hospitals often struggle due to smaller patient volumes and higher operational costs. Second-tier default benefits are crucial for these hospitals, ensuring patients can access care even without insurer agreements. It's recommended to increase the current second-tier default benefit rate from 85 per cent to 100 per cent for hospitals in Rural, Remote and Metropolitan Area (RRMA) 4-7 areas, and 90 per cent for metropolitan hospitals.

Priority 7: 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 incentivising state and territory governments to utilise private hospital capacity for public hospital waiting lists. This could involve additional federal funding to encourage states and territories to meet performance targets.

Priority 8: Introduce default benefits for HITH

In 1999, HITH trials were introduced, funded by private health insurers, to provide various types of care. In 2000, default benefits for these services were introduced, but were later withdrawn in 2007, limiting private patient access. Reintroducing default benefits for HiTH would support funding reform and improve patient outcomes by allowing care at home.

Priority 9: Adopt risk equalisation measures to ensure fair financial treatment of health insurance products covering maternity and mental health services, and review private health insurance product design

The current risk equalisation regulations do not adjust for differences in claim costs for pregnancy-related services and mental health services, as outlined in the recent Finity review commissioned by the Department of Health and Aged Care. The report suggested that access and affordability of maternity services could be improved through a hybrid risk equalisation system that "better matches expected differences in claim costs by age and sex. In particular, it provides more support to insurers covering younger people who claim for pregnancy or mental health treatment." Despite strong support across the sector, this recommendation has not been implemented. It is crucial that this recommendation be implemented to enhance the accessibility and affordability of maternity and mental health services. Alongside adjusting the risk equalisation regulations, a review of product design should also be performed to ensure the policies governing maternity and mental health cover are fit-for-purpose.

Priority 10: Reduce patient out-of-pocket costs

The high out-of-pocket expenses in Australia's healthcare system drive patients to the public sector, increasing the strain on public hospitals and threatening the viability of private hospitals. Efforts like the Medical Costs Finder Website aim to improve fee transparency but have seen limited use and do not address the root cause of high medical fees. Patients need tangible measures to reduce their financial burden. A proposed solution is to cap doctor fees at the Australian Medical Association (AMA) Fees List rate for those accessing the MBS, with doctors charging above this rate losing access to the MBS.

Priority 11: Expand private hospital mental health capacity

Allowing overseas trained psychiatrists to work in private hospitals could alleviate pressure on mental health services in metropolitan areas, reducing wait times and providing timely interventions. This policy could enhance collaboration and resource utilisation across public and private sectors. Additionally, there are opportunities to increase the scope of practice for general practitioners with mental health qualifications as well as psychologists to support the diagnosis and treatment of low complexity mental health disorders, as well as admit patients, under the clinical governance of psychiatrists.

Priority 12: Revise guidelines for mental health day programs

The current guidelines for accessing mental health day programs require patients to be admitted under the care of a hospital credentialed psychiatrist, which can limit access and cause treatment delays, especially in areas with a shortage of such psychiatrists. It is proposed that these guidelines be revised to allow assessments by appropriately trained and qualified health professionals.

Priority 13: Reform private health funding models

key aspect of funding reform would see an independent pricing body, such as IHACPA, determine a National Private Price for private hospital services. This price would be determined based on cost data provided by private health providers, meaning that price growth would mirror cost growth, similar to what has been the case for public hospitals over the past decade. 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. Additionally, funding reform would aim to reduce the administrative burden and risks associated with claim assessment and retrospective audits conducted by private health insurers. The role of the NPP in determining private hospital funding will also need to be determined, as the NPP could act as a sector-wide indicator of cost inflation, a binding price that funders are required to pay, or a benchmark that provides a starting point for negotiations.

The public hospital crisis

Background

Public hospitals in Australia are essential to the health system but face significant challenges, including inadequate funding, which leads to overcrowded emergency departments, longer elective surgery wait times, and strained resources. Additionally, there is poor transparency in the utilisation of funds from the National Health Reform Agreement (NHRA), making it difficult to ensure efficient use. The NHRA also fails to integrate hospitals with primary, aged, and disability care systems, crucial for seamless care. Furthermore, many public hospitals are suffering from outdated infrastructure and insufficient capital funding, exacerbated by the COVID-19 pandemic.

Policy priorities

Priority 1: Influence the National Health Reform Agreement to improve efficiency and performance

The Commonwealth Government should advocate for inclusions in the NHRA that encourage states and territories to improve the efficiency and performance of public hospitals.

Priority 2: Setting and achieving defined targets in primary care and placement of patients in aged and disability care packages

Recognising that some types of care can be delivered more affordably and with better health outcomes in primary care settings, the Commonwealth Government should develop and commit to measurable and targeted improvements in access to primary care services. This could be achieved by including a Statement of Responsibilities in the NHRA clarifying the Commonwealth Government's commitment to providing adequate primary care access to help states and territories manage public hospital demand.

Priority 3: Commonwealth contribution to capital development of public hospitals with a demand-based allocation of funding

The NHRA should specifically link capital development funding from the Commonwealth to demand-based development for both refurbishments and new builds. This model should also be applied where specific, discrete funding uplifts are required for public hospitals, such as meeting new cyber-security requirements. In these instances, such funds from the Commonwealth should be quarantined to prevent reallocation.

The urgent need for workforce solutions

Background

Workforce shortages in the health, aged care, and disability sectors are severely affecting service efficiency and effectiveness. These sectors are competing for the same workforce, both domestically and internationally. The shortages stem from poor workforce planning since the abolition of Health Workforce Australia in 2014, leading to ineffective use of health workforce data and uncoordinated state and territory initiatives. Additionally, attracting and retaining healthcare professionals is challenging due to high housing costs and wage stagnation, causing dissatisfaction and high turnover rates.

Policy priorities

Priority 1: Restore national leadership to health workforce planning through the re-establishment of Health Workforce Australia

Health Workforce Australia, or a similar workforce planning body, should be reestablished to ensure the care workforce meets the current and future healthcare needs of the population, though planning, coordination and policy advice.

Priority 2: Permit rent subsidisation up to a specified ceiling to be exempted from salary packaging caps, for nurses renting within a certain proximity to their work

It is recommended measures be implemented to promote and subsidise suitable accommodation close to nurses' workplaces, similar to the historical advantage provided by Nurses' Homes.

Priority 3: Funding to trial new medical and nursing workforce models

The Commonwealth Government should directly fund pilot programs for new workforce models, with a particular focus on scope of practice and scalability.

Chapter 1

A private hospital sector at breaking point

Catholic Health Australia

Background

Private hospitals play a crucial role in the Australian healthcare system, providing significant capacity and resources to complement and relieve pressure on the public sector. During the COVID-19 pandemic, the partnership between the federal government and private hospitals was instrumental in bolstering the nation's healthcare response by redeploying staff to public health settings, managing COVID-19 patients, and providing critical infrastructure and resources like ventilators and personal protective equipment. This strategic alliance not only helped manage the immediate health crisis but also ensured the resilience and sustainability of the healthcare system during and after the pandemic. Despite this crucial role, the private hospital sector is facing significant challenges which are impacting sustainability, including:

Financial performance

The financial performance of private hospitals has been declining for several years. Figure 1 shows the operating profit of the sector in millions before tax. Figure 2 shows the operating profit as a percentage of revenue. Between 2017–18 and 2022–23 operating profits and operating margins have both materially decreased.

Figure 1: Operating profit ($millions) before tax of the private hospital sector, 2017–18 to 2022–23

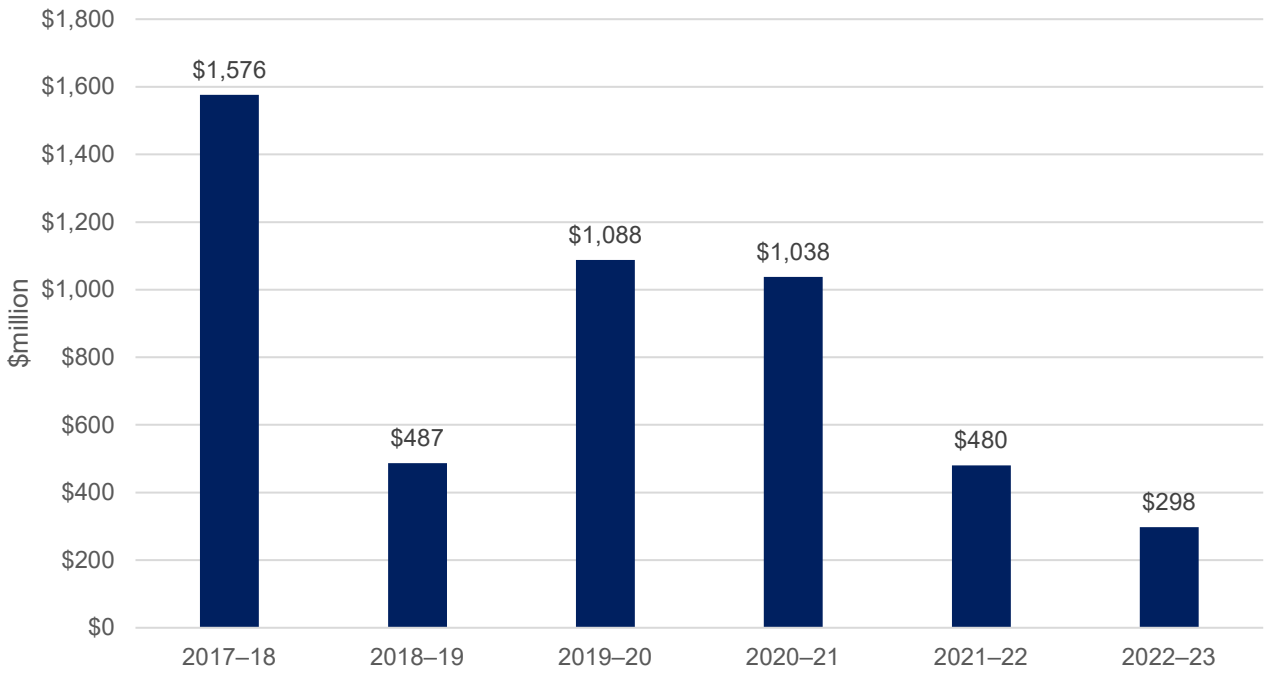
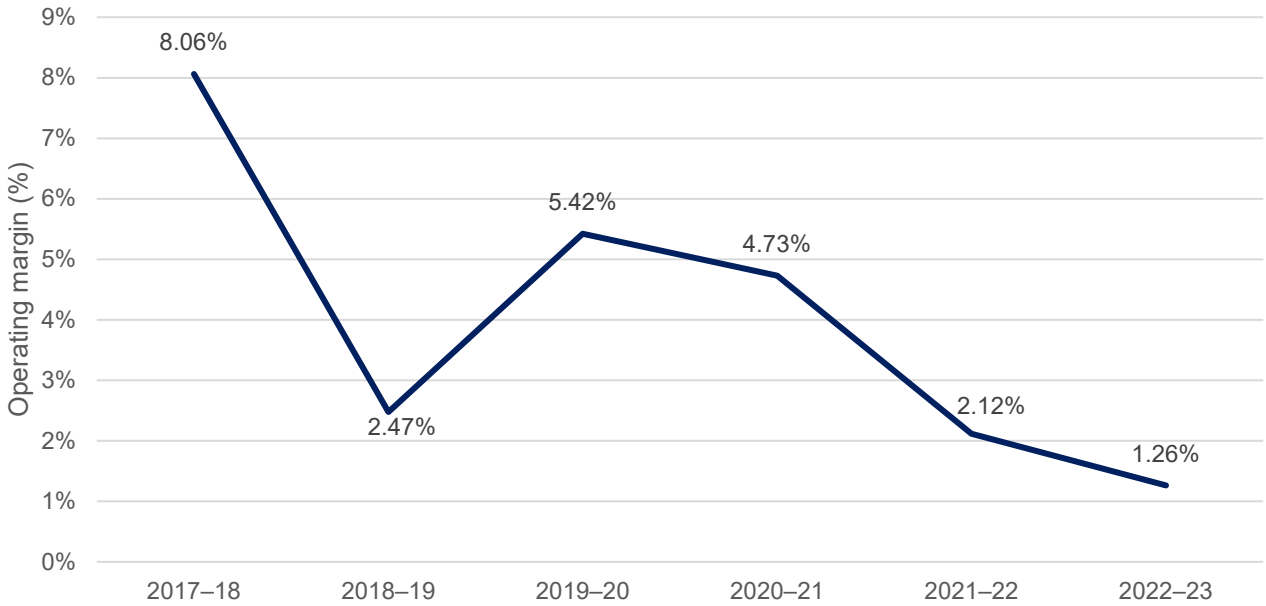


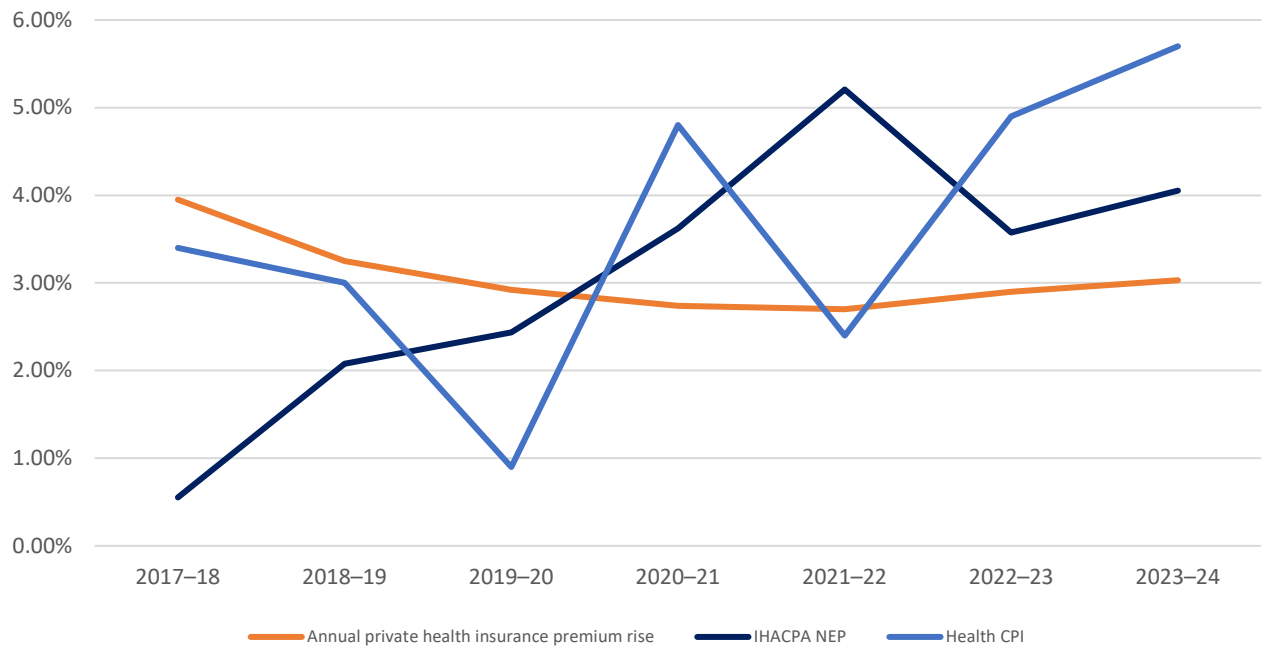
Figure 2: Operating margin of the private hospital sector, 2017–18 to 2022–23



Cost inflation

In the last few years, premium increases have lagged operational costs, and consequently so too has the annual indexation for contracts between private hospitals and private health insurers. Figure 3 demonstrates that in recent years, the annual private health insurance premium increases have lagged inflation indicators (the public equivalent Independent Health and Aged Care Pricing Authority (IHACPA) National Efficient Price (NEP), indexation which provides a benchmark for the cost of providing service in public hospitals, as well as the health consumer price index (CPI)).

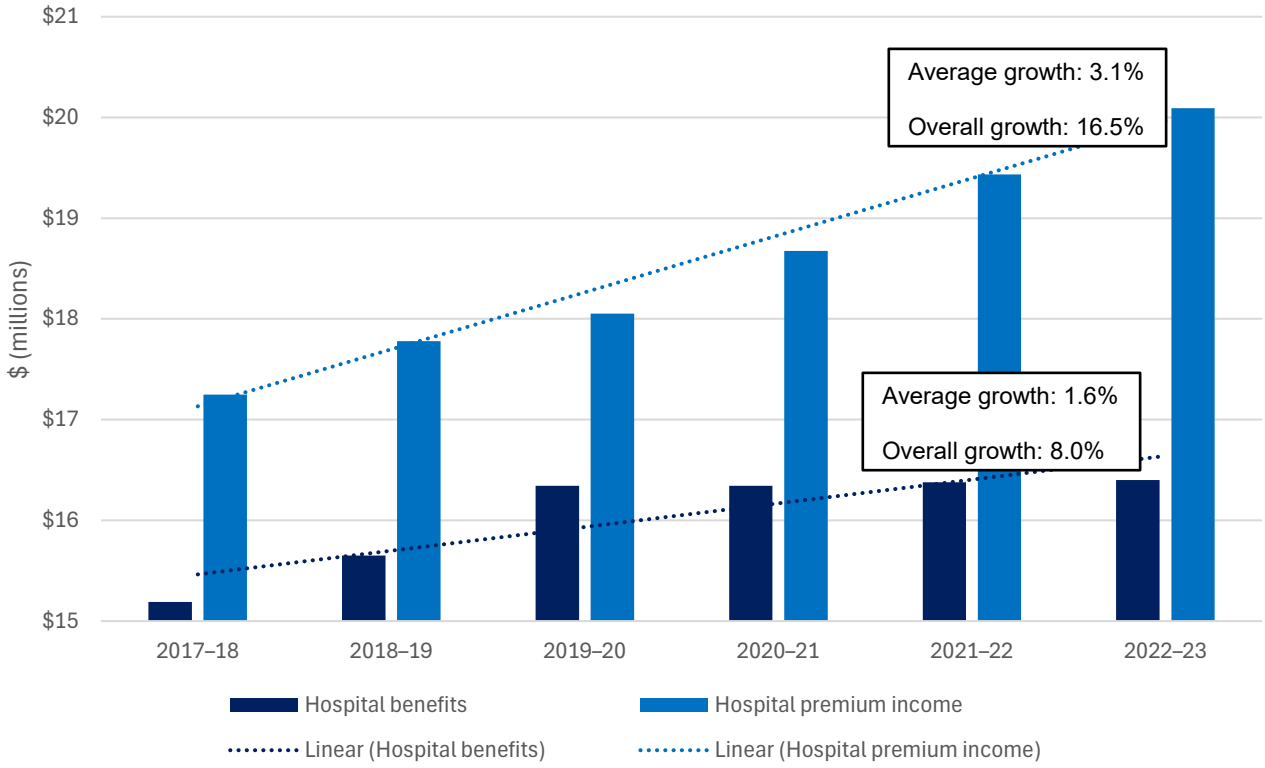
Figure 3: Comparative analysis of annual private health insurance premium increases, and inflation indicators, 2017–18 to 2023–24



Funding flow from insurers to hospitals

Private health insurance premium income for hospital cover is increasing at a faster rate than private health insurance hospital benefits paid by insurers to hospitals (Figure 4). Since 2017–18, hospital premium income increased by 16.5 per cent (with an average annual growth of 3.1 per cent) however benefits paid for hospital treatment have only increased by 8.0 per cent (with an average annual growth of 1.6 per cent).

Figure 4: Private health insurance hospital premium income vs benefits, 2017–18 to 2022–23



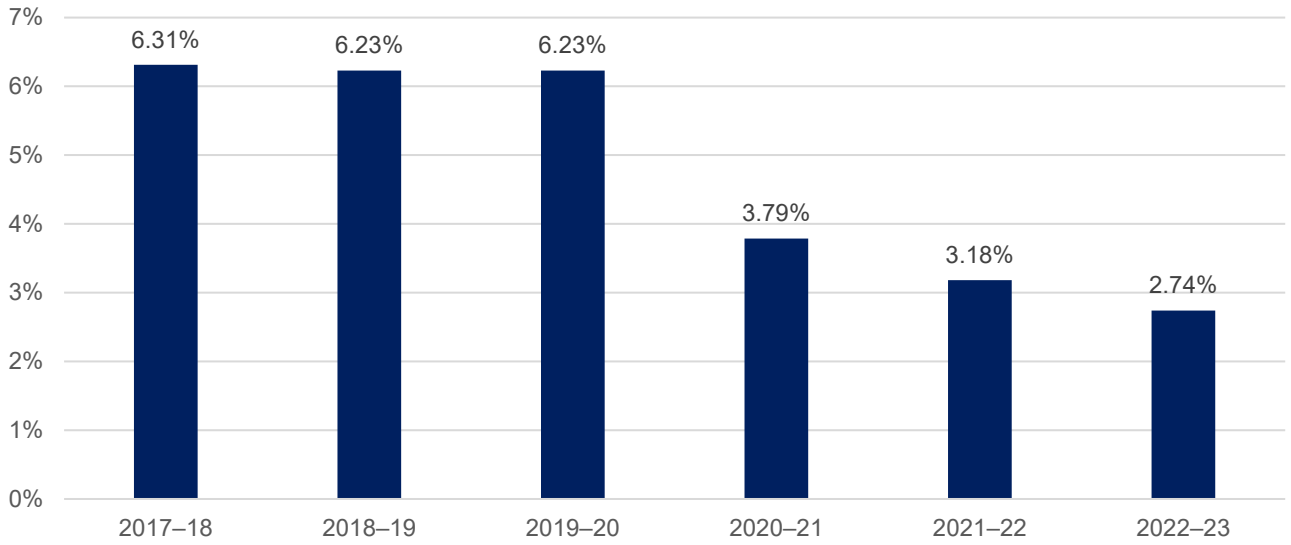
Wage increases

The Fair Work Commission Aged Care Application and Priority Review will have a significant impact on private hospitals. The recent endorsement of a 28.5 per cent wage increase in Victoria, combined with the other incentives including paying HECS debt, is likely to trigger a national cascade. For each 10 per cent increase in wage costs, private hospitals could experience an estimated wage cost increase of $1.1b (which would require an estimated 5.5 increase in private health insurance premiums be funded by household budgets).

Capital expenditure

Private hospitals have an unfunded capital expenditure of around nine per cent (Figure 5), due to negligible hospital margins throughout the COVID-19 pandemic, delayed capital works due to movement restrictions, and increased capital expenditure for legislative compliance (such as central sterilisation supply department, digital health strategy and security of critical infrastructure). Viability agreements negotiated with state and territory government did not include reimbursement of all operating costs (e.g. rent and interest were excluded) and any profits were required to be repaid if the hospital group made a profit in any part of the quarter.

Figure 5: Capital expenditure as a proportion of revenue



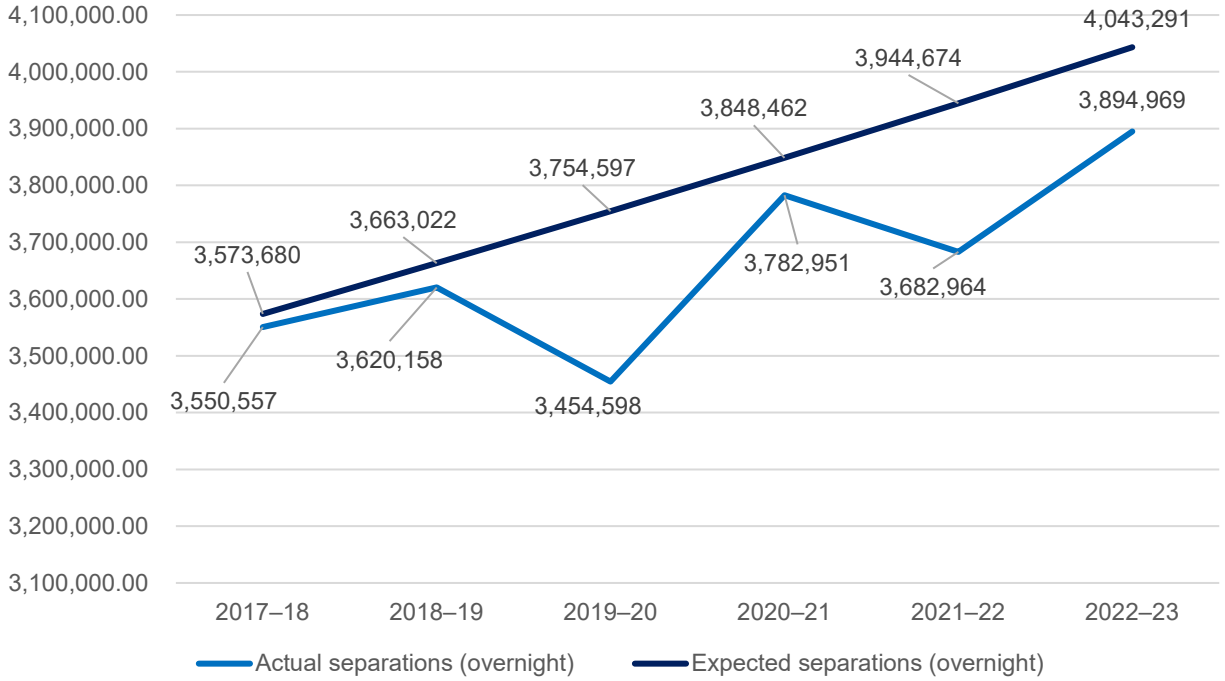
Stringent capital reserve requirements for private health insurers

The Australian Prudential Regulation Authority (APRA) capital framework for private health insurers was implemented on 1 July 2023 following lengthy consultation. While private health insurers share some characteristics with the life and general insurance industries, private health insurance has a different risk profile compared with life and general insurance due to built-in features of the system such as community rating risk sharing through the high-costs claims pool. These mechanisms reduce the volatility and increase the predictability of claims compared to life and general insurance sectors. The stringent capital requirements imposed on private health insurers are inadvertently resulting in less funding being directed to hospitals, as they compel insurers to maintain high reserves and therefore have less liquidity available for immediate expenditure, such as hospital reimbursements. Additionally, some private health insurers are holding onto more capital than required. This is resulting in total assets as a proportion of premium revenue increasing year on year (from 62 per cent in 2019–20 to 74 per cent in 2023–24 — around $5 billion which has been diverted away from private hospitals).

Latent capacity

During the COVID-19 pandemic, state and territory governments imposed sometimes lengthy restrictions on elective surgery and other services that could be offered by private hospitals. This resulted in a material decrease in occupancy rates for overnight hospitals. While occupancy rates have improved, private hospital activity has not returned to pre-pandemic levels in line with projected growth rates, which suggests private hospitals are currently operating below their potential capacity (Figure 6).

Figure 6: Capital expenditure as a proportion of revenue



Declining viability of private psychiatric services

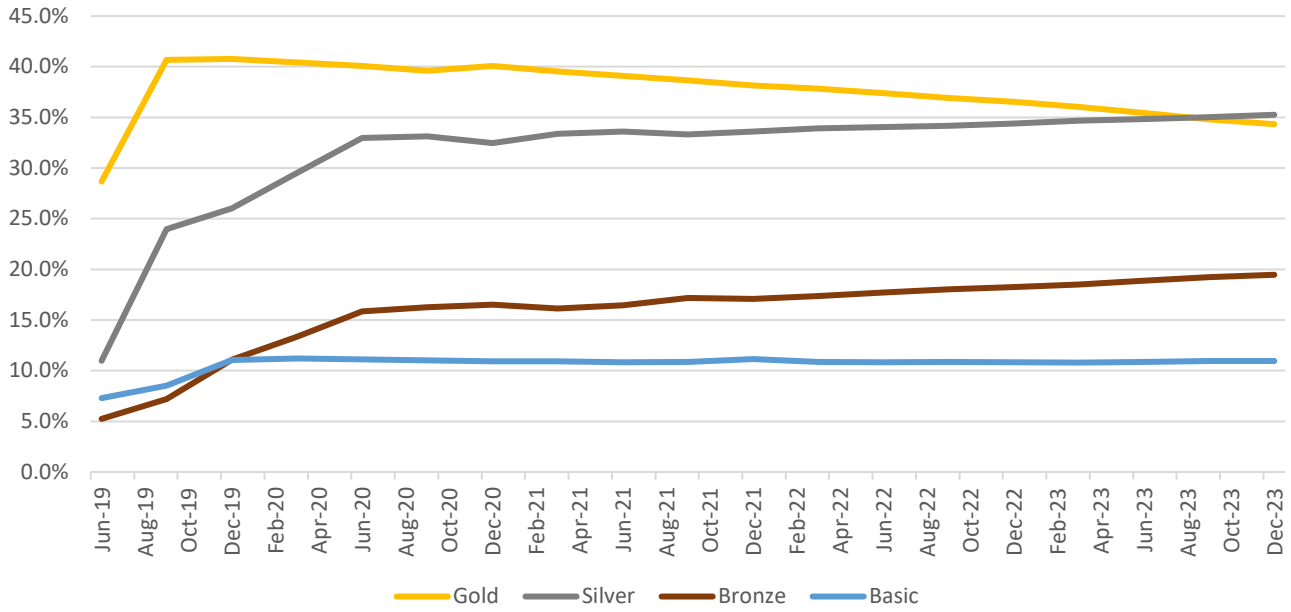
The key issue in private mental health is shortages of psychiatrists (who earn more money doing Telehealth consultations with their patients than they would either admitting or working in private hospitals). Many patients with private health insurance are not able to get the mental health care they need in a private hospital, and they end up in the public hospital. It is estimated up to 17,000 people are unable to be admitted to private hospitals due to workforce shortages. Unlike maternity patients, for example, who fortunately can access the public health system, public hospitals are not suitable for mental health patients. The latest AIHW data shows that the public hospitals do not have the capacity to deal with mental health patients, who are awaiting anywhere from 12 hours (Queensland), to 28 hours (Tasmania) for care in an emergency department.

Product design

Gold private health insurance products have historically been the most common products purchased by consumers, however in recent years there has been a trend of patients opting for Silver products over Gold. This is due to the increasing cost of Gold products, with many insurers deliberately pricing Gold products at a premium with large excesses making them unaffordable, and some not offering them at all. One of the ways private health insurers are able to do this is through a practice known as 'phoenixing', where they close products and open nearly identical ones at higher prices (as identified in a recent report by the Commonwealth Ombudsman). Additionally, the allowance of Silver Plus products has further eroded the value proposition of Gold products. This has made Silver the predominant product purchased by consumers (33.2 per cent have Gold, 37.6 per cent have Silver), which will shift procedures and services such as joint replacements, cataract extractions, dialysis, and pregnancy and birth, weight loss surgeries, insertion of insulin pumps, insertion of pain management devices, and sleep studies onto the public sector.

With over 25,000 health insurance products currently in the market, it is clear the standardisation created by the Private Health Ministerial Advisory Committee (PHMAC) through the Gold, Silver, Bronze and Basic reforms did not reduce complexity for consumers in the long-term.

Figure 7: Breakdown of hospital treatment policies by tier, June 2019 to December 2023



Declining viability of private maternity care

The Australian health system relies on the long-established maternity services infrastructure in the private hospital sector to provide high-quality services, however there are several key issues that are resulting in maternity service closures and volume reductions, including:

- Economic, market, and demographic factors are influencing the choice preferences of expectant mothers and families.
- The value proposition of private maternity services is being limited by high out-of-pocket costs.
- Workforce shortages and the incentives provided to employees in the public sector are posing challenges for private maternity.
- The costs of providing private maternity care are not commensurate with revenue received.
- Increasing costs and medico-legal risks for private hospitals are impacting viability.

Policy priorities

Priority 1: Reduce regulatory burden and red-tape

Overview

Private hospitals are subject to a significant amount of regulatory burden and red-tape which could be reduced. Examples include:

Payment delays

The lack of standardised payment terms and conditions results in lengthy disputes between private hospitals and private health insurers, which impacts hospital cash flow. There is also confusion around the *Private Health Insurance (Reforms) Amendment Rules 2018*, resulting in claim rejections. Recommendations include fact-checking advice from advocacy bodies, creating a Q&A webpage for departmental advice, the introduction of standardised payment terms and conditions, and providing education on legislation and rules.

Certifications

The certification process for private hospitals is burdensome and outdated, particularly for Type B and C certificates. The requirements for Type B and C certificates under the *Private Health Insurance (Benefit Requirements) Rules 2011* should be aligned with service availability, provision, and practice. Recommendations include applying age-based exemptions for patients over 65, time-based exemptions for procedures starting after 3pm, and excluding multiday stays from certification requirements.

Align MSAC, TGA, and the Private Health Insurance (Benefit Requirements) Rules 2011

Alignment is needed between MSAC, TGA, and the *Private Health Insurance (Benefit Requirements) Rules 2011* requirements on determining the MBS and certification.

Modernise legislation to fit with contemporary care environments as HITH expands

The legislation should be modernised to fit with contemporary care environments as HITH expands. For example, when hospital services are provided at home, patients needing specialist medications must find alternative pharmacy arrangements because the *National Health Act 1953* excludes private hospitals from providing pharmacy services for hospital substitute treatments. It is recommended Section 94 be redrafted to include both hospital and hospital substitute treatments. This change would streamline medication access for patients receiving home-based care.

Harmonise data and reporting requirements

Private hospitals must provide data to multiple agencies, creating a significant burden. Harmonising data and reporting requirements into a single dataset by consolidating the Hospital Casemix Protocol and Private Health Data Bureau reporting submitted could reduce this burden. Hospitals also face challenges with storing sensitive health information and dealing with inconsistent templates and audit requirements from private health insurers. Standardising data submission processes and implementing legislation on data retention periods could improve efficiency and security.

Risks and implementation

Reducing the regulatory burden and red tape for private hospitals may require initial investments in technology and training for private hospitals, private health insurers, and medical device manufacturers. Additionally, monitoring and enforcement of new regulations will require robust oversight mechanisms to ensure that the intended benefits are realised without compromising patient care quality.

Priority 2: Fund enterprise agreement (EA) wage growth in private hospitals

Overview

The Fair Work Commission's Aged Care Application and Priority Review is set to have a profound impact on the viability of private hospitals across Australia. To ensure the sustainability of private hospitals, it is crucial for the government to step in and fund enterprise agreement (EA) wage growth in this sector. Government funding would help absorb the additional costs, preventing a significant rise in private health insurance premiums and ensuring that private hospitals can continue to operate effectively.

Risks and implementation

Government has several mechanisms under the *Commonwealth of Australia Constitution Act* to fund EA wage growth in private hospitals:

Subsidies

Under various subsections[1] of Section 51, the federal government is able to direct funding to private hospitals through subsidies. In the 1980s, during the Hawke Government, the federal government intervened to address wage disparities for nurses in private hospitals, which was part of broader health sector reforms at that time. The federal government, leveraging its constitutional powers under Section 51, intervened to provide supplementary funding to private hospitals. This funding aimed to ensure that nurse wages in these hospitals were competitive and aligned with those in the public sector, thereby stabilising the workforce and improving healthcare delivery across the board. Similar constitutional powers were leveraged with the Private Hospital Viability Guarantee during the COVID-19 pandemic, which included a financial package to cover the operating costs of private hospitals.

Grants

Under Section 96, funding (through grants) could be directed to private hospitals if it is deemed to be in the national interest or part of a broader health care strategy that involves cooperation with states.

Rebates

Under Section 51(ii), the federal government could provide tax incentives or rebates to private hospitals to offset the costs of EA wage increases. Alternatively, specific tax measures could be introduced to support hospitals facing financial strain due to increased wage costs.

Offsets

The federal government could offset the costs by:

- Paying the superannuation contributions on behalf of private hospitals (11.5 per cent, increasing to 12 per cent from 1 July 2025).
- Subsidising electricity, gas or medical consumables.
- Covering the Pharmaceutical Benefit Scheme (PBS) co-pay for inpatient dispensing ($320 million annually).
- Subsidising capital expenditure for legislative compliance (such as central sterilisation supply department, digital health strategy, and cyber security).
- Subsidising the unfunded capital expenditure throughout the COVID-19 pandemic (e.g. use of services for public patient treatment).
- Subsidising costs associated with compliance and accreditation.

Priority 3: Incorporate hospital costs into the annual private health insurance premium round process

Overview

The cost pressures faced by private hospitals must be integrated through an external cost model to ensure premium increases account for hospital cost pressures. A formalised and standardised approach to integrating hospital cost data into the premium round process should be implemented, with transparent pathway of how this advice is considered with equal weighting to other contributions. If hospitals are to provide cost data, this process must be well designed and resourced, with a formal agreement on how commercially sensitive information will be collected, stored, and used.

Risks and implementation

The annual DVA Cost Indexation Report would be a simple and sensible first integration into premium round of the cost pressures private hospitals are facing. Even when considered as is (acknowledging that it focuses on historical cost impacts rather than forecasts and therefore would require adjustments for anticipated changes in costs for the upcoming year), the report offers a robust, evidence-based, independently generated annual overview of cost pressures in private hospitals. Additionally, it is available for no cost or administrative burden. This report could be considered as part of the premium round each year, with funders expected to reference it within their application, explaining how they will ensure health service providers are sufficiently reimbursed to meet these accepted cost pressures.

Priority 4: Adjust the capital reserve requirements for private health insurers

Overview

The regulation of private health insurers includes capital adequacy requirements monitored and enforced by the Australian Prudential Regulation Authority (APRA). Each private health insurer has a capital management policy and unique arrangements to ensure that it meets mandatory prudential standards.

APRA's new capital framework for private health insurers was implemented on 1 July 2023 following lengthy consultation. The aim of this framework is to "maintain an appropriate level of financial protection for policy holders" to address the concern that the previous framework "did not appropriately reflect the risks faced by insurers or adequately allow for consideration of adverse events." In summary, the new standards strengthen risk sensitivity, improve comparability across insurers, and align with APRA's capital framework for life and general insurers (LAGIC) which is consistent with international best practice.

Many private health insurers believe these capital requirements overstate the risks facing the private health insurance sector. While private health insurers share some characteristics with the life and general insurance industries, private health insurance has a different risk profile compared with life and general insurance due to built-in features of the system such as community rating risk sharing through the high-costs claims pool. These mechanisms reduce the volatility and increase the predictability of claims compared to life and general insurance sectors. Consequently, private health insurers contend that this framework does not adequately account for these unique aspects, potentially leading to higher costs and operational challenges for the sector.

The stringent capital requirements imposed on private health insurers are inadvertently resulting in reduced funding flowing to hospitals, as they compel insurers to maintain higher reserves and therefore have less liquidity available for immediate expenditure, such as hospital reimbursements. Additionally, some private health insurers are holding onto more capital than required. 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 private hospitals.

Risks and implementation

The new framework will need to determine how private health insurance differs from life and general insurance to avoid overstating or understating risks. Private health insurers will need to make changes to their financial strategies and operations. A thorough assessment of the financial impact on insurers will need to be conducted, including evaluating how the adjustments will affect liquidity and operational costs. Establishing a realistic and phased implementation timeline will help insurers transition to the new requirements in a way that minimises disruption to operations.

Priority 5: Allocate the entirety of the private health insurance rebate to patient benefits

Overview

The private health insurance rebate is an income-tested benefit that helps Australians cover the cost of their private health insurance premiums. The rebate varies based on age and income, with higher rebates for older Australians and those with lower incomes. Despite its intention to make healthcare more affordable, there is growing concern that a substantial portion (around 20 per cent) of the rebate is consumed by private health insurer administrative and management expenses rather than being used for patient care. This misallocation reduces the effectiveness of the rebate in achieving its primary goal of enhancing patient care and affordability. Private health insurers should be required to allocate the entirety of the rebate to patient benefits.

Risks and implementation

To implement this policy effectively, the government would need to establish regulatory frameworks and oversight mechanisms to ensure compliance to ensure the rebate is being fully utilised for patient benefits. There is also a risk private health insurers will increase premiums to cover management expenses, potentially reducing the affordability and attractiveness of private health insurance. To mitigate this risk, this proposal should be implemented alongside a minimum benefit return ratio.

Priority 6: Increase default benefits for regional, rural, and remote private hospitals

Overview

Regional, rural, and remote private hospitals are often less viable due to smaller patient volumes and higher operational costs. Second-tier default benefits are particularly important for these hospitals as they ensure patients can access care at hospitals that may not have negotiated agreements with insurers. This is particularly important in communities where alternative healthcare options are limited. The current second-tier default benefit rate for private hospitals in Australia is at least 85 per cent of the average charge for equivalent treatments under an insurer's negotiated agreements with comparable private hospitals. It is recommended this be increased to 100 per cent for private hospitals in services in Rural, Remote and Metropolitan Area (RRMA) 4-7 (regional, rural and remote areas). Additionally, it is recommended the default rate be increased to 90 per cent for metropolitan hospitals.

Risks and implementation

The impact of increasing default benefits on private health insurers needs to be considered, as higher reimbursement rates could lead to increased premiums for policyholders. There is also a risk that smaller hospitals may struggle to meet the eligibility criteria for second-tier benefits, potentially limiting the intended positive impact on rural healthcare access.

Priority 7: Leverage latent capacity in private hospitals to support public hospitals

Overview

National Cabinet announced on 6 December 2023 an increase to the National Health Reform Agreement (NHRA) funding cap, including a first year 'catch up' growth premium and continued focus on addressing elective surgery waiting lists as a priority. Details and key performance indicators (KPIs) have not been announced. There is an opportunity to shape the KPIs in a form that also offers a financial sustainability solution for private hospitals in the future. One way to achieve this would be to incentivise state and territory governments to use the latent capacity in private hospitals to address public hospital waiting lists. This would efficiently utilise the strengths and improve the viability of both public and private hospitals.

Risks and implementation

State and territory governments could purchase services from the private hospital sector by attracting extra funding under the National Health Reform Agreement (NHRA). For example, additional top-up performance funding from the federal government could be introduced to encourage states and territories to actively participate and improve their performance (e.g. top up funding if x per cent of patients are treated within the clinically recommended timeframe). The Department of Veterans' Affairs (DVA) has individual schedules with most private hospitals as well as agreed medical rates with doctors, which could be leveraged immediately.

The current Surgery Connect mechanism in Queensland is an example of a successful model, as it is additional funding above the hospital/Local Health District budget. In addition, public hospitals should be required to transfer patients to a private facility to support viability. Public hospitals should also not be able to wave the excess when a patient uses their health fund.

Priority 8: Introduce default benefits for HITH

Overview

In 2000, default benefits for some OOH services were introduced, giving private patients equal access to services already funded for public patients. The publication of new private health insurance legislation in 2007 resulted in the default benefit and accreditation processes for OOH services being omitted from the new regulation, restricting patient access to hospital treatment in the home and communities to those services where the private health insurer had contracted with the patient's service provider. Loss of default benefits reduced the hospital treatment patients could access in the home and community.

Despite the enormous opportunity for improved productivity and health outcomes, OOH 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. 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. In the United Kingdom, 20 per cent of bed capacity is dedicated to OOH care, while some regions in Canada allocate 10 per cent. 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.

A default benefit for HiTH care delivered by or on behalf of a private hospital would pave the way for future funding reform. HiTH leads to better clinical outcomes for patients who can undergo care in the comfort and privacy of their own home.

Risks and implementation

The Catholic health care system is uniquely placed to support HiTH given the vast network of private hospitals. Delivering high quality care with is possible – and often preferable - in a home setting for many treatments. A default benefit for out-of-hospital (OOH) services, including HITH, is a crucial reform to enhance 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.

Priority 9: Adopt risk equalisation measures to ensure fair financial treatment of health insurance products covering private maternity and mental health services, and review private health insurance product design

Overview

The current risk equalisation regulations do not adjust for differences in claim costs for pregnancy-related and mental health services, as outlined in the recent Finity review commissioned by the Department of Health and Aged Care. The report suggested that access and affordability of maternity services could be improved through a hybrid risk equalisation system that "better matches expected differences in claim costs by age and sex.

In particular, it provides more support to insurers covering younger people who claim for pregnancy or mental health treatment." Despite strong support across the sector, this recommendation has not been implemented. It is crucial that this recommendation be implemented to enhance the accessibility and affordability of maternity and mental health services.

Risks and implementation

Alongside adjusting the risk equalisation regulations, a review of product design should also be performed to ensure the policies governing maternity cover (e.g. the 12-month waiting period, obstetrics cover being exclusive to Gold products) and mental health cover are fit-for-purpose. It is estimated that including pregnancy in the risk equalisation pool will reduce the cost of premiums by 5–10 per cent.

Priority 10: Reduce patient out-of-pocket costs

Overview

The current healthcare landscape in Australia is marked by significant out-of-pocket expenses associated with medical services. These high costs often drive patients to seek care through the public system, exacerbating the strain on already burdened public hospitals. This situation not only affects the quality and accessibility of public healthcare but also threatens the financial viability of private hospitals, as many patients with private health insurance are opting to receive care through the public system as their insurance does not cover all out-of-pocket costs (in particular, the costs associated with medical practitioners).

Efforts to address this issue have included the introduction of the Medical Costs Finder Website, designed to improve transparency around medical fees. However, the tool has seen limited use, and while transparency is important, it does not directly address the root cause of high medical fees. Patients need more than just information; they need tangible measures that reduce their financial burden. Government should introduce policy that caps doctor fees at the AMA Fees List rate for those wishing to access the MBS. Doctors can charge above the AMA fee, however if they do, they will not be able to access the MBS. Additionally, the uploading of fees to the Medical Costs Finder should be made a compulsory requirement to access the MBS.

Risks and implementation

This policy would require amendments to the *Health Insurance Act 1973* which governs the operation of Medicare and the MBS. Regulations and guidelines would also need to be developed to support implementation, including how the cap will be monitored and enforced, procedures for auditing and reporting non-compliance, and appeal processes.

Priority 11: Expand private hospital mental health capacity

Overview

The 10-year Moratorium was introduced to ensure that overseas trained doctors contribute to areas with critical shortages of medical professionals. While this has been beneficial for rural and remote communities, it has also created barriers for these professionals to practice in metropolitan settings where their expertise is equally needed. Mental health services in metropolitan areas are often overwhelmed, and the integration of overseas trained psychiatrists into private hospitals could alleviate some of this pressure.

Allowing overseas trained psychiatrists to work in private hospitals would increase the availability of mental health services in metropolitan areas. This could reduce wait times for patients and provide more timely interventions, which are crucial for effective mental health treatment. Additionally, by sharing capacity across public and private sectors, this policy could foster better collaboration and resource utilisation. Additionally, there are opportunities to increase the scope of practice for general practitioners with mental health qualifications as well as psychologists to support the diagnosis and treatment of low complexity mental health disorders, as well as admit patients, under the clinical governance of psychiatrists.

Risks and implementation

The policy would require adjustments to existing regulations to allow overseas trained psychiatrists to practice in metropolitan private hospitals. This could include creating specific licenses or permits that outline the scope of practice and ensure compliance with Australian standards. Additionally, to ensure the success of this policy, it would be essential to provide adequate training and support for overseas trained psychiatrists. This could include orientation programs, ongoing professional development, and mentorship opportunities to help them integrate into the Australian healthcare system.

Priority 12: Revise guidelines for mental health day programs

Overview

The current *Guidelines for Determining Benefits for Private Health Insurance Purposes for Private Mental Health Care* require patients to be admitted under the care of a hospital credentialed psychiatrist to access mental health day programs. While this requirement aims to ensure high standards of care and patient safety, it also limits access to mental health day programs, particularly in regions with a shortage of hospital credentialed psychiatrists. This can result in treatment delays. It is proposed that changes to these guidelines be made to allow patients to be assessed for mental health day program suitability by an appropriately trained and qualified health professional.

Risks and implementation

All professional performing assessments should be registered, where registration is required, and possess the necessary training to evaluate and recommend suitable mental health day programs. Robust regulatory and oversight mechanisms will also need to be implemented to ensure these alternative healthcare professionals maintain high standards of care.

Priority 13: Reform private health funding models

Overview

A transition to a more systematic approach to Activity Based Funding (ABF) in the private sector will address several of the key challenges which are currently impacting viability. In an ABF system, a single payment is made for the entire episode of care (for example an admission). The level of payment is based on the reason for the patient's admission (their diagnosis), plus any complicating factors (additional diagnoses) the patient may have.

ABF provides strong incentives for technical efficiency – in most cases hospitals receive the same amount of funding for an admission regardless of length of stay and so are incentivised to discharge patients as soon as is appropriate to do so.

A key consideration in transiting to ABF is the role of the National Private Price (NPP) might have in determining private hospital funding. This price would be set by an independent body, such as IHACPA, and would be determined based on cost data provided by private health providers, meaning that price growth would mirror cost growth, similar to what has been the case for public hospitals over the past decade.

The goal of a move to ABF with a NPP 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. Additionally, funding reform would aim to reduce the administrative burden and risks associated with claim assessment and retrospective audits conducted by private health insurers.

A transition to ABF would also pave the way for value-based funding models, where funding models are aligned to incentivise the delivery of high value care at the lowest cost. ABF and value-based funding models share many technical building blocks, such as classification and costing.

New funding models, such as capitation for subacute care and chronic disease management could also be explored. This is an area which is underdeveloped in the Australian private hospital sector but would facilitate innovation and expansion of services. Finally, ABF frameworks for the funding of public patient services in the private sector (including funding of medical services) could be improved.

Risks and implementation

To develop a NPP and transition to ABF reliable, complete, and consistent activity and cost information is required. It will also be important to establish what the price is intended to cover. In the public system, the National Efficient Price (NEP) covers all costs incurred in providing services to patients, with exception of those that are reimbursed by other means (for example blood products and pharmaceutical products covered by the PBS). It is proposed that this is also the case for the private system — the costs of providing all services required for a patient's episode of care should be covered by the NPP, except where reimbursed through other means. Costs associated with prostheses and human tissue products (which are paid in accordance with the Prescribed List), pathology, and clinical placements may need to be incorporated in the NPP. Additionally, the NPP would need to include a capital component. Adjustments to the price will be required to account for differences between hospitals and patient factors, and a balance between efficiency, risk sharing, and safety and quality will need to be established.

The role of the NPP in determining private hospital funding will also need to be determined, as the NPP could act as a sector-wide indicator of cost inflation, a binding price that funders are required to pay, or a benchmark that provides a starting point for negotiations.

Chapter 2

The challenging public hospital landscape

Catholic Health Australia

Background

Public hospitals are a critical component of Australia's health system however they are facing numerous challenges that are impacting their ability to deliver timely and effective care. One of the most significant challenges is that the current funding formula for public hospitals is failing to meet the growing demands of the population. This funding shortfall has led to overcrowded emergency departments, longer waiting times for elective surgeries, and a general strain on hospital resources. Australia's public health funding models should focus on encouraging ongoing improvement in performance, with additional funding available to public hospitals that improve outcomes. With a growing and aging population, increasing chronic disease, and increasing costs of delivering care, the pressure on public hospitals is only expected to increase.

Poor transparency over public hospital funding

The Commonwealth Government contributes significantly to the funding of public hospitals through the National Health Reform Agreement (NHRA). Despite this, in many cases how these funds are utilised is unclear. This lack of transparency makes it difficult to assess whether the funds are being used efficiently and effectively to meet the needs of the population. It also hinders the ability of stakeholders to hold the system accountable for its performance.

Lack of integration with other care sectors

The current NHRA does not require the Commonwealth Government to take specific actions to assist states and territories in managing hospital demand. In particular, the NHRA fails to promote the integration of hospitals with primary, aged, and disability care systems, which is essential for creating a seamless continuum of care. Additionally, there has been insufficient emphasis on strengthening primary care services, which are crucial for reducing hospital admissions by managing health issues before they escalate.

Lagging capital development

Many public hospitals are facing a critical shortage of capital funding. This shortfall has led to outdated infrastructure, overcrowded facilities, and a lack of essential medical equipment. The COVID-19 pandemic has further highlighted these deficiencies, as hospitals struggled to cope with the sudden surge in patient numbers and the need for specialized care facilities. The current NHRA does not adequately address these capital needs, leaving states and territories to manage with limited resources.

Policy priorities

Priority 1: Influence the National Health Reform Agreement to improve efficiency and performance

Overview

In December 2023, National Cabinet announced significant measures to increase public hospital funding, including the Commonwealth Government increasing its contributions to the National Health Reform Agreement to 45 per cent over a 10-year period starting from 1 July

, replacing the 6.5 per cent cap on funding growth with a more generous cumulative cap, and a first-year 'catch-up' growth premium.

This commitment was welcomed however the Commonwealth Government should advocate for inclusions in the NHRA that encourage states and territories to improve the efficiency and performance of public hospitals. An effective way to achieve this is by adopting an overarching principle that promotes and supports a single healthcare system with integrated public and private providers.

Risks and implementation

Given the current situation of public hospitals, it is possible the increased funding will only result in stabilisation of performance rather than improvements. There is also a risk states and territories become overly reliant on Commonwealth Government funding, reducing their incentive to invest in the necessary reform and efficiency measures. It is therefore important to establish clear guidelines and accountability measures. Additionally, the Commonwealth Government should work closely with state and territory governments to ensure the funding is directed towards improving hospital efficiency and performance.

Priority 2: Setting and achieving defined targets in primary care and placement of patients in aged and disability care packages

Overview

Recognising that some types of care can be delivered more affordably and with better health outcomes in primary care settings, the Commonwealth Government should develop and commit to measurable and targeted improvements in access to primary care services. This could be achieved by including a Statement of Responsibilities in the NHRA clarifying the Commonwealth Government's commitment to providing adequate primary care access to help states and territories manage public hospital demand. It should also emphasise the Commonwealth Government's responsibility for ensuring effective interaction between Commonwealth-funded aged care and disability programs and state and territory-funded public hospital services.

The NHRA should include a specific commitment to a defined level of access to primary care MBS items across all regions of Australia. Cash-out arrangements should be established to ensure the Commonwealth funds state or territory-delivered primary care services in regions where primary care MBS utilization falls below a certain target. Enhancing measurement and accountability for primary care and other hospital avoidance strategies will encourage all jurisdictions to work effectively to treat patients in the appropriate system under the optimal funding model, improving affordability for all parties.

Risks and implementation

The NHRA should set defined targets for placing patients waiting in public hospitals into Commonwealth-funded aged and disability care packages. It should include provisions for the Commonwealth Government to fund public hospitals for the cost of these patients once they have been waiting for more than seven days (or another agreed-upon time frame) for Commonwealth-funded services. Regular quarterly reporting by the Australian Institute for Health and Welfare should monitor the Commonwealth Government's performance in meeting these placement times.

Priority 3: Commonwealth contribution to capital development of public hospitals with a demand-based allocation of funding

Overview

Capital allocation methodologies for new hospitals and the maintenance of existing public health facilities are inconsistent across different states and territories. Within individual states, allocation is not transparently related to predicted demand. The NHRA should specifically link capital development funding from the Commonwealth to demand-based development for both refurbishments and new builds. This model should also be applied where specific, discrete funding uplifts are required for public hospitals, such as meeting new cyber-security requirements. In these instances, such funds from the Commonwealth should be quarantined to prevent reallocation.

Risks and Implementation

The Commonwealth is a major investor in public hospital systems across Australia. These hospital systems require Commonwealth Government support to maintain existing hospitals and invest in new facilities in high-growth areas. It is reasonable and in the Commonwealth Government's interest that, in return for a specific contribution to capital expenditure, the Commonwealth links this expenditure to a demand-based allocation of capital expenditure.

Chapter 3

The urgent need for workforce solutions

Catholic Health Australia

Background

Workforce shortages across the health, aged care, and disability sectors are significantly impacting the efficiency and effectiveness of essential services. These sectors are not only competing with each other for the same workforce but also with other countries facing similar challenges. These shortages exist for a variety of reasons.

Poor workforce planning capability

Since Health Workforce Australia was abolished in 2014, no central agency has sufficient oversight of either current or future workforce needs in the health, aged care, and disability sectors. While health workforce data is being collected, it isn't being used effectively to inform resource allocation, strategic planning, and to ensure healthcare services are distributed efficiently to meet the evolving needs of the population.

While the establishment of the Health Workforce Taskforce has been promising, this broader structural deficiency in workforce planning capability has led to the current state where state and territory governments announce workforce incentives and development initiatives without a clear idea of how the additional promised healthcare workers will materialise. State and territory governments adopt these short-term measures as they lack the independent capacity to deliver wider structural solutions. The lack of a coordinated approach means that the effectiveness of these initiatives is limited and in some instances they lead to unintended market distortions.

Challenges attracting and retaining workforce

Many regions struggle to attract and retain healthcare professionals. The escalating cost of housing is a significant barrier to attracting and retaining staff, with nurses and other healthcare professionals often finding it challenging to afford housing near their workplaces, leading to long commutes or the need to relocate to more affordable areas. This issue is not confined to major cities but has spread to regional and rural areas, exacerbating the shortage of healthcare workers in these communities. Additionally, despite the rising cost of living, wages in many sectors have not kept pace. This wage stagnation makes it difficult for employees to meet their financial needs, leading to dissatisfaction and higher turnover rates.

Poor recognition of the generalist workforce

Generalist healthcare professionals are essential in providing broad-spectrum care. They are often the first point of contact for patients and are responsible for managing a wide range of health issues, from acute illnesses to chronic conditions. Despite their importance, value and remuneration structures have been established that incentivise specialisation rather than appropriately recognising the importance of skilled generalist healthcare professionals. In particular, generalist healthcare professionals often receive less recognition and support compared to their specialist counterparts through inadequate training and career pathways, lower renumeration, and limited professional support. While there has been recognition that generalist models help underpin service availability in rural and regional areas in particular, the current workforce shortages span across all regions and therefore a more flexible workforce will be required to meet demand.

Policy priorities

Priority 1: Restore national leadership to health workforce planning through the re-establishment of Health Workforce Australia

Overview

Health Workforce Australia, or a similar workforce planning body, should be reestablished to ensure the care workforce meets the current and future healthcare needs of the population, though planning, coordination and policy advice. This workforce planning body would collate, analyse, and utilise workforce data from the health, aged care, and disability sectors to inform evidence-based policies and strategies, enabling decision-makers to proactively and efficiently adapt to changing healthcare demands and ensure that all Australians have access to high-quality healthcare.

It should also use this data to produce evidence-based national supply and demand projections for various professions based on a range of alternative planning scenarios. This will ensure that Australia has a workforce — with the right skills and in the right locations — to meet community needs and demand.

In addition to its functions in research, planning, and coordination, the workforce planning body should assist with reducing the state-based politicisation of workforce and training incentives in the short term. This practice inevitably means workforce gaps are shifted between states and territories as opposed to being addressed.

Risks and implementation

An analysis of the strengths and weaknesses of Health Workforce Australia should be performed so learnings can be applied to the new workforce planning body. The body must also have a high degree of autonomy to function effectively, and be insulated from political influence to make unbiased decisions based on data and healthcare needs. The body should be considered by the Health Workforce Taskforce as part of its program of work, and its governance should fall under the Commonwealth and state and territory health ministers.

Priority 2: Permit rent subsidisation up to a specified ceiling to be exempted from salary packaging caps, for nurses renting within a certain proximity to their work

Overview

It is recommended measures be implemented to promote and subsidise suitable accommodation close to nurses' workplaces, similar to the historical aMntage provided by Nurses’ Homes. Specifically, rent subsidisation could be achieved by exempting rental deductions up to a certain limit from salary packaging caps for properties located within a certain proximity to work.

This investment from the Commonwealth Government would provide a pay advantage to a workforce that is lagging behind general market rates for equivalent university graduate roles and struggling to attract new entrants. It would also help not-for-profit healthcare providers overcome a key recruitment barrier. Additionally, by incentivising nurses to work at local facilities, it could reduce the appeal of leaving stable positions for costly agency roles.

Risks and implementation

This program could be piloted in select regions to assess the effectiveness and feasibility of the program. Clear eligibility criteria would need to be established for nurses to qualify for rent subsidies to ensure the program targets those most in need. A robust monitoring and evaluation framework would be required to ensure the program is sustainable and prevent distortion of the local housing market.

Priority 3: Funding to trial new medical and nursing workforce models

Overview

The Commonwealth Government should directly fund pilot programs for new workforce models under the oversight of the Health Workforce Taskforce (or a new workforce planning body). Given the recent findings from the Commonwealth's Scope of Practice Review, which highlighted the barriers and opportunities for health practitioners to work to their full potential, this initiative is particularly timely. These pilots should focus on developing models where care is delivered by medical professionals with less training or experience, under the supervision of appropriately credentialed clinicians, to maximize the scope of practice. Refining medical supervision models presents a key opportunity to increase the availability of high-quality care using the existing Australian workforce.

Other areas of focus should include:

- creating new roles that enhance the scope of practice for surrounding roles, such as career medical officers or career hospital officers.
- integrating the workforce across primary, community health, and hospitals.

Risks and implementation

Pilot programs could be funded through grants which are available to both public and private health care providers under the governance of the Health Workforce Taskforce. Applicants should be able to demonstrate that the pilots they propose show promise, that they have the capacity to deliver those pilots, and that the solutions are scalable in the event they are shown to be effective.