Royal Australasian
College of Surgeons

10 March 2021

250–290 Spring Street
East Melbourne VIC 3002 Australia
Telephone +61 3 9249 1200
www.surgeons.org
ABN 29 004 167 766

Private Health Insurance Branch
Medicare Benefits Division
Australian Government Department of Health
PO Box 9848
CANBERRA ACT 2601

Email: PHIconsultation@health.gov.au

To Whom it May Concern

RE: Public consultation of Private Health Insurance reforms announced in 2020-2021 Federal Budget (Second Wave)

On behalf of the Royal Australasian College of Surgeons (RACS) we appreciate the opportunity to provide feedback as it relates to the *Private health insurance reforms – second wave - December 2020* Consultation Paper. RACS is the leading institution for the training of surgical practice for more than 7,000 surgeons and 1,300 surgical trainees and Specialist International Medical Graduates in Australia and New Zealand.

Out of the four consultations presented in the Consultation Paper, only three are of direct significance to our Fellows. These relate to **1. Age of Dependents**, **2. Rehabilitation**, and **4. Certification for Hospital Admission**. The last consultation will have the more substantive impact on the surgical profession, which we will examine in greater detail.

As a disclaimer, discussion had with the Private Health Insurance Branch of the Medicare Benefits Division prior to submitting informed RACS that the Department of Health will only facilitate the established of a "clinician led" 'self-regulated industry panel' which will also welcome the involvement of private health insurers.

Summary of RACS' Position

After careful examination, RACS has some concerns that we wish to articulate and advocate on behalf of our Fellowship and the patients they serve. In summary, here is our submission and critique of the *Private health insurance reforms – second wave - December 2020* Consultation Paper -

- How is a "dependent" defined?
- Rehabilitation criteria cannot be prescriptive but must be individualised.
- Certification for Hospital Admission:
  - What is deemed as "inappropriate" was not clearly defined.
  - The distinction between a simple error made vs deliberate and misleading conduct was not clearly defined.
  - Increase in hospital admission vs. length of stay e.g. market competition, health fund acquisitions, change in government state and territory policies, hospital closures, rural and long distances resulting in overnight stay.
- 'Self-regulated Industry Panel':
  - Panel composition and the need for it to be clinician led majority representation including the Chair, and for this to be clearly stipulated in the Terms of Reference

- Certification to be based upon strict clinical standards and guidelines, not shareholder expectations and profit margins.
- The role of the insurer should be to not provide any clinical assessment as stipulated in the *PHI Circular 37/7, 17 July 2017* .
- What is the true role of the panel? Is it to mediate and pursue matters outside the more serious cases the Professional Services Review (PSR) would normally investigate? Mediation is the preferred option for RACS.
- Does this open the floodgates towards medical colleges, societies, and private health insurers to be transformed into joint regulators with legislative powers? RACS opposes such direct punitive and compliance responsibilities to all parties mentioned.

Age of Dependents – Definition of Dependent & Increase to 31 years

The pivotal issue here relates to how private health insurance funds define a "dependent"? For example, is someone who lives at home but who is working and earning considered a dependent or not? What if they are living away from home but are financially supported by their parents if unemployed etc. There needs to be a clear definition of what signifies "dependence."

Under legislation *Private Health Insurance Act 2007* Schedule 1- Dictionary, a dependent child has been defined as under 18, and under 25 in accordance with the rules of the private health insurer and who does not have a partner (p.29 of the Consultation Paper).

Whether having a partner or not may not be so relevant as the subject in question may still be financially dependent on their parents. Standardisation of definitions and criteria would be much better for consumers to help compare insurance products. However, as mentioned earlier, the definition of "dependence" needs to be clearer. Furthermore, it may not make any difference if they are a student or not.

Increasing the age to 31 years would be better as it is more likely that private health insurance will be taken out at that age compared to those who are in their early 20s.

Rehabilitation - Prescriptive

RACS in principle supports mandatory payment for home rehabilitation if deemed appropriate by a rehabilitation physician. It would potentially cover a vast array of surgical procedures to include nearly every specialty of surgery covered within RACS. For example, orthopaedic, neurosurgery, plastics, general surgery, and urological surgery.

Question 2 on page 18 of the Consultation Paper at first glance appears to allude to a set box ticking exercise that is prescriptive without taking into account the differing nature of any procedure and their individual patient's needs. The clinical expertise of a medical practitioner based upon their peak body's standard guidelines are required to determine each individual case. The criteria cannot be prescriptive but must be individualised based upon the needs of the patients as they may need help from physiotherapy, occupational therapy, speech pathology, psychology, nursing etc.[i]

Any clinical plans should be put together formally by rehabilitation physicians and then sent to all allied health personnel involved and treating doctors including general practitioners. However, the metrics are hard to measure. A reasonable starting point could be to measure patient satisfaction, cost effectiveness and return to normal activity postoperative compared to inpatient rehabilitation. This would be a reasonable starting point.

Certification for Hospital Admission – 'Self-Regulated Industry Panel'

The proposed way forward seems appropriate in the first instance. The panel suggested could include members from private health insurers and Private Healthcare Australia as well as medical colleges to be on a specialty case by case basis e.g. RACS for surgical cases. The Professional

Services Review (PSR) appears to be conditionally the most appropriate body to regulate disputes. Simplification of forms for treating doctors will be critical to help reduce disputes, with perhaps the inclusion of a range of criteria identifiers that may assist practitioners and streamline the selection and reasoning for certification. But concerns still remain for RACS.

Defining "inappropriate practice"

The Consultation Paper on page 23 indicated that only a "small number of providers" provide "inappropriate" certification of Type B and Type C. The term "inappropriate" was not defined and it raises the question if the Department of Health was referring to misleading conduct or an error made. Discussion had with the Private Health Insurance Branch of the Medicare Benefits Division prior to submitting, RACS was advised that the definition "inappropriate practice" is based on the PSR's interpretation.

However, this interpretation raises other concerns for RACS, as it relates to the establishment of a 'self-regulated industry panel' to manage disputes expressed in the Consultation Paper. With respect to the definition of "inappropriate" on closer examination the PSR's definition is as follows-

> *"whether a practitioner's practice/conduct when providing or initiating Medicare services would be unacceptable to the general body of their peers"*[i]

In a surgical context this would suggest that "peers" refers to the surgical clinical standards and guidelines as set out by RACS and their specialty societies and associations, and not the private health insurers.

"Clinician Led" 'Self-Regulated Industry Panel'

Discussion had with the Private Health Insurance Branch of the Medicare Benefits Division prior to submitting, informed RACS that the panel is to be "clinician led." It would in practice reconstitute itself for a topic or case about a specific specialist by which only a small number of cases will go to the panel.

This means, if a matter concerns a surgical specialty then RACS will be informed and asked to contribute and nominate a candidate for the panel as facilitated by the Department of Health. If this is the case, then the composition of the panel will not only have to be clinician led, which would include the Chair, but this composition will need to be clearly stipulated in the Terms of Reference.

Furthermore, the PSR and the Department of Health will not be arbiters if the panel were to reach a stalemate in their decision-making process for a case. The PSR is only activated at the request of the panel, and only high-level cases are referred to the PSR. There may be instances when a matter does not require the heavy hand of the PSR to rectify. Does this panel become a toothless tiger? Any form of mediation powers requires legislative support, but by doing so the panel drifts into the realm of a regulatory body through legislation, which RACS does not wish it to become.

RACS is of the opinion that no college, medical society, medical association, or private health insurer should possess powers reserved for a government regulatory body. This panel may be "considered low-cost" and "practical" for the Department of Health, but it creates a possible regulatory pathway for private health insurers to question item number related cases. It has yet to be seen if there will be a change in legislation that will open the floodgates to such powers.

Professional standards may come into conflict with perceived financial recompense by the private health insurers. What then becomes of the Medical Board of Australia in this context? Will the panel become a mechanism to recover benefits and payment for the private health insurers?

Composition of the 'Self-Regulated Industry Panel'

The panel's composition, in the opinion of RACS, will require clinical experts to help provide a medical assessment as to why a certification has been made based on strict clinical standards and guidelines, not shareholder expectations and profit margins. The same would apply for the Professional Services Review in relation to its composition and how many clinical experts are included in their governance and decision-making structure.

As this is a 'self-regulated industry panel', composition and membership will be self-determined, as RACS was informed by representatives from the Department of Health. If the panel is to be clinician led, who then will the private health insurers nominate? With respect to Type C, the *PHI Circular 37/7, 17 July 2017, Clarification of roles in the certification process*, the role of the insurer has already been set out[iii] in the context of the *Private Health Insurance (Benefits Requirements) Rules 2011*. RACS supports the viewpoint expressed in this 2017 Private Health Insurance (PHI) Circular -

> *However, insurers should be aware that the Rules do not provide for any clinical assessment by insurers of the medical conditions/special circumstances certified by a medical practitioner.*

Delineating "inappropriate practice" and their outliers

When delineating "inappropriate practice" RACS has expressed its viewpoint; in a previous Submission sent to the Senate Standing Committee on Community Affairs Legislative Committee[iv]. The revised concerns in the context of this Consultation Paper regarding compliance when it comes to the use of MBS Item numbers are as follows-

1. What if a simple error was made but the medical practitioner has been accused of deliberate and misleading conduct?[v]
2. When an accusation is made about a medical practitioner, there must be procedural fairness and a right to an appeals process.
3. Outlier behaviour may occur which is not deliberate but a product of market forces or changes in policies and legislation

Outlier behaviour in certification can inadvertently effect specialties like surgery. Day hospital admittance is not without its own permutations in their operational variants and outcomes. For example, if there is an increase in the volume of an existing surgical specialty, this may not be due to anything "inappropriate". There could be several other reasons why an increase in hospital admission and length of time spent in a facility effecting Type B and Type C have occurred. For example-

- A hospital operator has attracted surgeons from a competitor hospital facility.
- An acquisition has been made with one health fund having amalgamated with another. This will increase the pool of PHI membership and consequently an increase in a private health insurance fund seeking admission to a facility.
- A competitor hospital or facility has closed (e.g. NSW Northern Beaches hospital).
- Change in state and territory policy affecting private patients in public hospitals.
- Rural maldistribution due to a patient living a long distance away from a facility, resulting in overnight stay. An internal surgical variance report RACS conducted with Medibank 2018-2019 regarding hernia day surgery and on day care raised questions as to the availability of transport. Some patients live too far from a facility and this reality is often not included as a valid reason to stay overnight. And not every hospital has a medical-hotel facility for discharge, leaving patients vulnerable to a diminishment of quality care and safety by comparison to some other metropolitan facilities.

Conclusion – Regulatory Powers?

The main concerns for RACS revolve around the creation of a 'self-regulated industry panel' that does not have any regulatory powers but an expectation to resolve punitively rather than mediate matters. The threshold for PSR involvement is quite high, but that does not resolve the problem of how to reconcile and mediate lower level issues.

Furthermore, how will a panel logistically be created, activated, and enforce their final decision on any matter in absence of any legislative powers? How will the Department of Health facilitate these needs?

To reiterate, RACS is of the opinion that no college, medical society, medical association, or private health insurer should possess powers reserved for a government regulatory body. Matters at the level of a 'self-regulated industry panel' should be mediative at best.

RACS looks forward to receiving your response and is open to continual engagement with the Private Health Insurance Branch in the interest of our blended healthcare system.

Yours sincerely,

Dr Anthony Sparnon
President

Office of the President
Telephone +61 3 9276 7404
college.president@surgeons.org

[i] Discussion had with the Private Health Insurance Branch of the Medicare Benefits Division prior to submitting had attempted to assure RACS that Question 2 was more an issue of semantics and that a medical practitioner's discretion is respected for each individual case. This should also include proper financial recompense to the medical practitioner.

[ii] https://www.psr.gov.au/about-the-psr-scheme/what-is-inappropriate-practice

[iii] https://webarchive.nla.gov.au/awa/20201112230524/https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-phicirculars2017-index1

[iv] Inquiry into the Health Insurance Amendment (Compliance Administration) Bill 2020

[v] Discussion had with the Private Health Insurance Branch of the Medicare Benefits Division prior to submitting had attempted to assure RACS that only a very small number of disputes revolves around conflicts concerning information, details of certificate, and acceptable medical practice. Many disputes are dealt with between PHIs and the hospital as speculated by the Branch.