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RACP Feedback to AMA Consultation Paper *A whole of system approach to reforming private healthcare*

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About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 18,863 physicians and 8,830 trainee physicians, across Australia and New Zealand. The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine.

Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

Foreword

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to provide input to the Australian Medical Association's (AMA) discussion paper *A whole of system approach to reforming private healthcare*.

Physicians are an integral part of the healthcare system across the public and private sectors and are responsible for providing a considerable proportion of services through the MBS and private hospitals. In the 2020–21 year, there were 36.6 million MBS-subsidised referred medical specialist consultations; these attendances were provided to 8.6 million Australians (34% of people). Of these attendances, most (77%, or 28.2 million services) occurred in non-hospital settings, such as private consulting rooms and private outpatient clinics, and were provided to 8.3 million patients.[1]

Independently of their work setting, physicians strive to provide quality, accessible and patient-centric care across the Australian healthcare system and are well placed to comment on the contents of this paper.

Our submission offers a short summary of individual member perspectives on:

- The role of the private healthcare sector in Australia's healthcare system
- Key issues facing the private healthcare sector
- The role of regulatory reform in the private healthcare sector, including a new regulator
- Other measures to improve the sustainability, responsiveness and person-centredness of healthcare in both the private and public healthcare sectors.

We note this is a complex area and urge that appropriate and comprehensive consultation is undertaken on any forthcoming proposals. The opinions included in this submission are a summary of feedback from a limited number of individual members who were in a position to contribute to this consultation and should only be treated as an early and personal commentary on the issues raised in the paper.

We emphasise that the RACP currently has no official position on the discussed issues and we recognise that member opinions on private health insurance and the private health system in general vary considerably across our membership. It is not intended to provide an organisational view on the proposals.

. The following feedback is provided for the AMA's consideration as it works on refining and strengthening its proposal for the authority and related reforms. The RACP would appreciate being involved in further consideration of matters relating to private healthcare reform which will have to be considered by our membership and leadership throughout the development process for this and related proposals.

The role of the private healthcare sector

The small number of individual members who were able to contribute to this consultation generally agree on the important role of the private healthcare sector, including the private hospital system. This importance is captured in recent statistics that show most procedures occur in private hospitals and more than 40% of the Australian population holds private health care insurance.[2] Provided appropriate design and regulation, the private healthcare sector can support patient choice and open additional options for clinician training, supporting the overburdened public healthcare system.

However, respondents believe that there is a need to distinguish between the private healthcare sector's contribution to the care for many Australians and its value. Factors that impact its value include:

- access and equity concerns, with people on lower incomes being likely to defer healthcare owing to high and increasing co-payments
- differing thresholds for admission to private hospitals which mean that privately provided services often do not work as a support to and substitute for the public system

[1] Referred specialist medical attendances (2022), AIHW, https://www.aihw.gov.au/reports/medical-specialists/referred-medical-specialist-attendances

[2] Duckett, S. and Moran, G. (2021), Stopping the death spiral: Creating a future for private health. Grattan Institute

- resultant provision of treatments of low priority or low value vis a vis the public system which overall do not lead to shorter wait times or improved outcomes in public care.[3]

The value and benefits of private healthcare in Australia need to be considered in tandem with the subject of private health insurance and examined in light of evidence from other countries in order to arrive at the optimal role and model of private healthcare within our healthcare system. A coordinated system of quality wrap-around care, with comprehensive primary healthcare and collaboration with disability and aged care sectors must be underpinned by robust governance, need prioritisation and commitment to excellence in clinical practice, independently of the provider of these services. Care delivery decisions should be based on capacity and likelihood of benefit rather than capacity to pay or extent of insurance coverage.

Key issues facing the private healthcare sector

Responding members broadly agree with the scope of issues covered in the discussion paper. Individual members highlight that a lack of cost transparency for patients between private hospitals, insurers and providers before the point of healthcare delivery is particularly concerning. The absence of a single platform to access patient cost information compounds this transparency concern.

We ask that the AMA note the following member feedback as it continues to develop its reform agenda for the private health system:

- Private health insurance premiums have increased faster over the last 20 years than both wages and inflation[4]
- Unexpected, excessive or disproportionate out-of-pocket costs stem from some providers charging more than the recommended benefit level[5]. Excessive or disproportionate gap charges levied by some doctors add to the impression that private insurance is overly expensive or unable to defray the cost of private health care. This has led increasing numbers of patients to give up private health entirely and instead rely on the public system.
- Overservicing is more common in private hospitals, including longer length of stay and reported higher incidence of low-value care practices[6].
- Poorly communicated, fragmented and confusing insurance coverage results in high levels of patient dissatisfaction and drives out-of-pocket costs.
- Variable contract terms between each private hospital and each private health fund are confusing and do not contribute towards patient satisfaction or retention in private insurance.
- The policy of allowing public hospitals to compete with private hospitals for private health fund payments has been noted as a concern by some individual respondents who believe this policy adds to public hospital patient loads and interferes with clinical autonomy, to the detriment of the public system, public patients and the disadvantage of private hospital services. The RACP does acknowledge the complexity of this matter; in previous submissions we recognise the need for public hospitals to be sufficiently funded and call for the impacts of changes to funding sources to be accounted for in any proposed reforms[7].
- The role of the private healthcare system in educating and employing junior medical staff, particularly for outpatient medicine; there are many missed opportunities for high quality teaching in this sector while the public system hosts disproportionately high numbers of students.
- Some non-procedural physicians charge 'no gap' in hospital consultation fees and receive no payment for out-of-hours phone consultations resulting from private hospital consultations. Combined with the barriers to the use of private health insurance for outpatient consultations and the need to minimise out-of-pocket costs for patients, this results in unrewarding working conditions for some non-proceduralists.
- Markets for prostheses are insufficiently competitive.

[3] Duckett, S. and Moran, G. (2021), Stopping the death spiral: Creating a future for private health. Grattan Institute
[4] Duckett S, The problematic place of private payment for healthcare in Australia. Healthcare Management Forum. 2021;34(4):225-228. doi:10.1177/0840470421994139
[5] *Ibid*
[6] Duckett, S. and Moran, G. (2021), Stopping the death spiral: Creating a future for private health. Grattan Institute.
[7] RACP (2019), Complex care, consultant physicians and better patient outcomes [online]; c-final-mccm-document.pdf (racp.edu.au)

It is also important for the AMA to consider how good governance and clinical excellence might be encouraged through reforms to the fee-for-service model of payment prevalent across the health system. This issue is one that bridges the private and public systems and needs to be addressed across both.

The RACP has contributed extensively to policy discussions about reforms to models of care and payment through our work to identify the principles and design of an evidence-informed model for chronic and complex care (MOCC) management. The model, which is intended to target primary care and local hospital districts and involves multidisciplinary teams of public and private clinicians and allied healthcare workers, is designed for people with co-morbidities at an intermediate level of care. More information on the RACP model of chronic care management, including potential alternatives to the fee-for-service model, is available at the RACP's MOCC website.

Regulatory reform and the private healthcare sector

Individual member feedback was generally supportive of reforms to improve governance, consumer confidence, quality of care and relationships between health service providers in the private healthcare sector through the establishment of a new regulatory authority. Respondents note that regulatory reform is just one part of the broader approach towards reforming the private health system.

Any new regulatory authority must be planned well to be effective in delivering responsive, patient-centred and appropriate care. The AMA's further consultation and strategic planning should focus on:

- How the regulator could maintain collaboration with public healthcare systems to facilitate seamless transitions between services and the complementarity of public and private systems and services.
- How the regulator could improve private provider value, transparency and accountability to patients, the Government and the Australian community at large, noting that while the Government has an interest in maintaining private health care services, it is not the responsibility of the Government to assure financial viability of private companies.
- How the specific design and governance arrangements for the authority might address the identified issues within the current regulatory environment of the sector. In particular, while the paper indicates that policy and regulatory functions held by the Department of Health should be separated in the interest of independence, the current proposal suggests that the authority will itself be responsible for regulation as well as policy development and standard setting. Any forthcoming proposals need to elaborate on and resolve this fundamental conflict.
- How the regulator will be funded, and the detailed costings required to establish the agency. The proposed budget of $28 million dollars, plus additional establishment costs, is based on the estimates of the private health insurance component of APRA's work. However, APRA works on a cost recovery basis and the proposed budget seems unlikely to receive broad support.
- How the regulatory authority would be governed. The governance arrangements should provide clarity on the extent of ministerial oversight and policy direction under the Minister for Health. and offer a better articulated argument for the removal of specific functions, such as monitoring and enforcement, from ministerial oversight. If established under a governing Board, it should be explained how the risk of regulatory capture by vested interests will be managed.
- Discussion of possible alternatives to the proposed model. This is an important consideration in making significant changes to the operation of private healthcare.

The authority: one solution among other necessary measures

Along with the establishment of the proposed authority, Australia's private health care sector should consider:

- working to develop innovative payment models, including collaborating with the Independent Hospital Pricing Authority on setting an 'efficient price' for private hospital care
- instituting reforms to the burdensome and confusing billing processes
- developing an industry plan focused on improving private hospital efficiency with input from the Government, private health insurers, private hospitals, private device manufacturers and importers, as well as private medical specialists.[8] [9]

[8] Duckett S, The problematic place of private payment for healthcare in Australia. Healthcare Management Forum. 2021;34(4):225-228. doi:10.1177/0840470421994139

[9] Duckett, S. and Moran, G. (2021), Stopping the death spiral: Creating a future for private health. Grattan Institute.

Most importantly, reforms to strengthen the capacity of the private healthcare sector should not occur in isolation from reforms to deliver improved capacity in our public healthcare system. Falling patient confidence is not confined to the private healthcare sector and funding, financing, regulation and monitoring of healthcare deserves parallel attention in the public healthcare system. The various roles of the two systems require review so that together, they can best serve the needs of Australian communities.

Additional comments

Should the AMA use parts of the discussion paper in its future iterations, we suggest that the drafters:

- Integrate an equity and accessibility lens into page 20, which features a strong emphasis on the sustainability of private healthcare. The RACP is committed to equitable access to healthcare, and we suggest greater emphasis on this in the discussion paper beyond the present sustainability focus
- Resize the puzzle image on page 18 to make each piece of the puzzle a differing size.

Thank you for this early opportunity to comment on the discussion paper. We are looking forward to the future iterations of this proposal and to ongoing participation in this important dialogue.