



Private Healthcare Australia
Better Cover. Better Access. Better Care.



Health impacts of alcohol and other drugs in Australia

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About Private Healthcare Australia (PHA)

Private Healthcare Australia (PHA) is the Australian private health insurance industry’s peak representative body. We have 24 registered health funds throughout Australia as members and collectively represent more than 98% of people covered by private health insurance. PHA member funds provide healthcare benefits to 15 million Australians.

Response

PHA welcomes the opportunity to provide feedback to the House of Representatives Standing Committee on Health, Aged Care and Disability’s inquiry into the health impacts of alcohol and other drugs (AOD) in Australia.

Private health insurers are major funders of alcohol and other drug treatment for our members. Federal Government Hospital Casemix Protocol (HCP) data outlined in the tables below shows that in 2023–24, privately insured AOD hospital treatments totalled 38,049 separations in private hospitals, with \$338 million in total benefits paid. Alcohol-related cases accounted for around 75% of all AOD separations (29,069), while drug-related treatments increased by 21.5% on the previous year, with 8,980 separations in 2023-24.

Private Sector Alcohol and Other Drugs (AOD) Hospital Treatment Services (2023–24, Private Health Insurance Funded)

Alcohol-Related AR-DRGs

AR-DRG version 11.0 code	Description	Separations	Annual Change (%)	Avg. LOS (days)	Benefits Paid (\$)	Annual Change (%)
V60A	Alcohol Intoxication & Withdrawal – Major Complexity	309	3.0%	15.6	\$4,977,616	10.3%
V60B	Alcohol Intoxication & Withdrawal – Minor Complexity	250	-13.8%	13.7	\$2,615,678	-10.2%
V62A	Alcohol Use & Dependence – Major Complexity	8,338	14.2%	8.2	\$116,706,736	8.5%
V62B	Alcohol Use & Dependence – Minor Complexity	20,172	-3.9%	3.1	\$120,549,687	-3.0%
Subtotal – Alcohol		29,069	0.6%	4.8	\$244,849,717	2.3%

Source: [HCP annual report 2023-24](#)

Table Notes: Overall benefits paid in the tables below represent combined insurer and Medicare benefits, as HCP annual reporting does not separately identify these components properly.

Other drug-related AR-DRGs

AR-DRG version 11.0 code	Description	Separations	Annual Change (%)	Avg. LOS (days)	Benefits Paid (\$)	Annual Change (%)
V61A	Drug Intoxication & Withdrawal – Major Complexity	306	61.1%	9.2	\$4,164,434	68.1%
V61B	Drug Intoxication & Withdrawal – Minor Complexity	232	16.0%	13.1	\$2,884,115	58.0%
V63Z	Opioid Use & Dependence	1,139	3.5%	5.8	\$11,342,162	-3.4%
V64A	Other Drug Use & Dependence – Major Complexity	1,278	16.2%	9.3	\$18,526,923	10.2%
V64B	Other Drug Use & Dependence – Minor Complexity	6,025	25.5%	3.9	\$56,623,432	7.5%
Subtotal – Other Drugs		8,980	21.5%	5.4	\$93,541,066	9.4%

Source: [HCP annual report 2023-24](#)

Table Notes: AOD hospital treatment services typically fall under DRG procedures starting with ‘V’ within MDC 20: Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders.

Overall Total (all AOD Hospital Treatment)

	Total Separations	Annual Change (%)	Avg. LOS (days, 2023–24)	Total Benefits Paid (\$)	Annual Change (%)
All AOD AR-DRGs Combined	38,049	4.9%	4.9 days	\$338,390,783	4.2%

Source: [HCP annual report 2023-24](#)

Health funds want to expand access to treatment for AOD problems, but current regulations make this difficult. The *Private Health Insurance Act 2007* restricts certain types of care from being funded or conducted out-of-hospital (OOH), while requiring health funds to pay for expensive, inefficient in-hospital care. The legislation also restricts existing programs to specific professional groups, limiting the scope of services that can be delivered – even in cases where there is overwhelming evidence to suggest alternative OOH and community-based models are considered global best practice.

As a result, Australian patients are not receiving healthcare supported by the best available evidence. Clinicians are unable to offer the most effective and innovative models of care because the current system does not allow them to deliver treatment in the ways shown to work best, while requiring health funds to pay for in-hospital care which is proven to be less optimal.

Australia’s health financing system was designed in the 20th Century, yet we are dealing with 21st Century problems. Demand has grown at an unsustainable rate, driven by the dual burdens of a rapidly ageing population and the growing prevalence of chronic disease. This unsustainable growth is placing pressure on access to care and

healthcare costs, for both patients bearing out-of-pocket costs and taxpayers more broadly. Yet we are not rising to the challenge.

Our private healthcare system is leaving more than \$1 billion of potential efficiency on the table by lagging well behind other countries in the uptake of OOH care models. Health insurers are paying for old fashioned, cost-intensive care that promotes inpatient admissions and keeping patients in hospital for longer.

Funds have been taking action to grow OOH models of care and will continue to do so. These actions include:

- 1) changes to funding models to better align the incentives of stakeholders to promote best practice,
- 2) expanding access to OOH care models by increasing funding or provision of care in line with global levels (see example in box), and
- 3) increasing consumer awareness and education for OOH models of care.

Specifically, funds are reconfiguring financial incentives where it is in their ability, for example, by scaling up voluntary financial incentives for clinicians involved in OOH care models, reducing or removing gap payments where associated with OOH care, moving away from per diem payment structures that incentivise length-of-stay and moving towards outcome-based funding models.

Funds, however, can only achieve a limited portion of the total potential value-at-stake for the system, given the restrictions imposed by current funding and regulation regimes. Funds, clinicians, consumers, providers and governments need to do more to ensure consumers are presented with the best care possible, not just the best care available.

PHA outlines a range of recommendations promoting OOH care – defined as models of care designed to achieve hospital avoidance or hospital substitution – in our 2023 report [There’s no place like home: reforming out-of-hospital care](#). The report argues Australia’s private health system is uniquely positioned to unlock OOH opportunities, which can improve healthcare access, reduce the burden on hospitals and relieve pressure off the struggling public health system.

Clean Slate

Members of more than a dozen health funds are able to access programs through [Clean Slate](#) if they have the appropriate cover. Clean Slate offers a 12-month program of assessment, withdrawal and recovery, delivered fully via virtual care, for individuals struggling with alcohol dependence.

The service has been independently [evaluated by Sydney University](#) as highly adoptable, acceptable and feasible.

The Productivity Commission's 5-year Productivity Inquiry report notably highlighted the Government's need to reform sectors where regulations unnecessarily impede new entrants such as in private health insurance.¹ In particular, the Commission indicated that PHIs are well positioned to play an active role in facilitating models of care to improve prevention and long-term outcomes, including in OOH services.²

The report identifies strong evidence of improved clinical outcomes in the reduction of hospital admission risk by about 60% in mental health and substance misuse management.³ Similarly, it identifies evidence of reduction in readmission risk by up to 40% in mental health and substance misuse management.⁴

PHA and our member funds are committed to working with the government to improve accessibility and efficiency in healthcare delivery. Amendments to regulatory structures will enable health funds to deliver more AOD treatment – and a range of other healthcare – to the 15 million Australians with private health insurance.

¹ Productivity Commission. 5-year Productivity Inquiry Report. March 2023.

² Ibid

³ Caplan G. A. "Systematic reviews - a meta-analysis of 'hospital in the home,'" The Medical Journal of Australia, 197(9):512-9, Nov 2012.

⁴ Ibid