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

Type C delisting

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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 98% of people covered by private health insurance. PHA member funds provide healthcare benefits 15 million Australians.

Introduction

Across the globe, health systems are shifting care from hospitals to the community to reduce the burden on consumers, harness new technologies, and improve patient safety and outcomes.

Australia is almost unique in reinforcing policy settings that increase the proportion of care delivered in hospitals, thereby entrenching outdated models of care. This approach results in lower quality outcomes at a higher cost to consumers, and places additional strain on patients and the health system alike.

PHA recommends that governments consider international evidence and promote more care out of hospitals. Policy settings should promote day hospitals, out of hospital care, procedures in doctors' rooms and community-based care, in line with modern standards of clinical safety, efficacy and efficiency.

Governments should not be making it easier to hospitalise patients unnecessarily, both on economic and safety grounds. Increasing the cost of private health care without increasing quality is bad for consumers, health funds and in the medium to long term, bad for the sector overall.

PHA welcomes the opportunity to comment on proposals to delist several Medicare Benefits Schedule (MBS) items that are currently Type C categories. This provides an opportunity to reduce administrative burden on hospitals and health funds alike. However, this must be considered in the context of the risk to the community of allowing the possibility of more low-value care and higher costs to consumers.

The consultations and procedures highlighted by the Department are generally done in hospital as part of an admission for another procedure. They are rarely the main reason for hospital admission, so are rarely accompanied by a Type C certificate. Initial data from member health funds demonstrates the administration load is minimal at best.

While the objective of removing any unnecessary paperwork is appreciated, there is significant danger in the Department's proposal.

Without certification, hospitals could admit patients for trivial procedures and claim a day hospital rate from health funds. Funds would then be required by law to pay for the hospital day rate, increasing costs to consumers (through health insurance premiums) and government (through the Private Health Insurance Rebate).

For example, a pathology company, doctors' rooms or similar could designate their premises a hospital under state and territory legislation and "admit" every patient that needs a blood test or consultation. The regulation of hospitals is too weak to prevent such an occurrence, and every hospital designated as such under state or territory laws is automatically recognised by the Commonwealth and afforded the right to legislated payments.

Commercial operators are already manipulating this regulatory framework to receive additional income for procedures and consultations. We have also seen some providers promote low-value care, such as intravitreal eye injections in hospital, as a way of cost-shifting to health funds – even when the legislation currently requires a Type C Certificate.

Delisting consultations, pathology and procedures could make this type of low-value care endemic across the country. Should even a fraction of one percent of these MBS items be transferred from community care to hospital, health funds would be required to pay tens of millions of dollars in unnecessary hospital benefits.

The risk to consumers is high, and our initial assessment is that the actual administrative burden of the current regime is very low. However, there is always room for improvement, and PHA welcomes the opportunity to work towards greater efficiency.

PHA recommends a phased approach, which will allow time to accurately assess the administrative load on hospitals and health funds, so the industry and government can take a balanced approach to protecting consumer interests and reducing unnecessary paperwork.

About type C certification

Type C settings are designed for doctors to 'turn their minds' to whether a procedure that can be safely done outside a hospital should be done in-hospital, and to certify that it is reasonable and necessary for the procedure to be done in the more intrusive, higher-cost setting. Removing this modest requirement would remove a prompt for the clinician to consider less intrusive care options.

While not stated, the certification also acts as a prompt for the medical practitioner to consider if the desires of the hospital provider for a higher payment are justified. This is particularly important with more services being owned and operated by private equity and other commercially focused operators. Doctors are increasingly reporting pressure from employers (including in the public system) to increase income.

Progressive delisting of some Type C items

Phase one – immediate

There is no justification for maintaining dual listing for Type A and Type C procedures. These should be immediately delisted (42782, 42785, 42788, 42791, 42809, 45026, 52039).

There are also a range of items on the list that are specifically referred to as in-hospital items, or the conditions required can only be met in-hospital. These could also be delisted immediately (328, 16501, 16502, 16505, 16508, 17680, 13842, 13899).

While PHA notes the following procedural items can safely and effectively be provided in doctors' rooms, they are currently overwhelmingly done in hospital. For practical reasons, these can also be delisted (41755, 59715, 41668, 41698, 41704, 41828). However, PHA asks that the Government consider also allowing health funds to cover these items in community settings to promote safer, more effective and more efficient care at a lower burden to patients.

There's also one item, a bulk-billing incentive, that cannot be claimed alone and, therefore, any certification is redundant (74994).

PHA would like to continue working with our member funds over the coming weeks to propose more items we would be comfortable delisting. We are confident that more time to consider the issues, collect data and receive clinical advice will enable the above list to be expanded.

Phase two – procedural items

There are a significant number of procedural items where it is safe and effective to provide them out of hospital, although some patients will require hospitalisation.

PHA notes the administrative burdens with certification and the risks associated with the delisting highlighted above, hence we propose a pathway for further assessment.

The Department should invite health funds to provide data on the number of Type C certificates to determine if the administrative load is significant enough to justify the risk. Many of these items would not be the reason for hospitalisation, so no certificate would be required.

The Department should also allow health funds to cover these procedures out of hospital to remove the implicit financial incentives to conduct them in- hospital, and to provide patients and medical practitioners with more choice as to where to receive and provide care.

In addition, the Department should obtain clinical advice to develop a clear set of rules that provide guidance to the sector on circumstances where alternatives may be appropriate in place of Type C certification. For example, the guidelines could specify that hospitalisation is permissible without a certificate for certain patient demographics, whereas in all other circumstances, certification would remain mandatory. These guidelines should be supported by a robust regulatory framework that outlines the consequences for providers who fail to comply. The framework should also detail mechanisms through which consumers and their health funds can seek redress in cases of non-compliance.

Phase three – pathology, diagnostics and professional attendances

In the overwhelmingly majority of cases, Type C certificates are not required for pathology, diagnostics and professional attendances. These are generally undertaken in conjunction with procedures or other reasons for hospitalisation and are very rarely the sole reason for hospitalisation. The administrative burden is negligible.

While the administrative load may be minimal, the risk to consumers is significant. A small number of providers abusing the delisting and routinely admitting patients for basic tests or consultations would cost consumers tens of millions of dollars each year.[1] This risk is unacceptable while the current regulatory regime is in place.

To consider delisting these items, PHA requests the Department first reform hospital certification in each state and territory to ensure that garages, side rooms and other "hospitals" cannot be accredited without a site visit first. The Department would also need to amend legislation to allow the Minister's delegate to refuse to certify a hospital, or remove certification, where the delegate is satisfied consumers' interests are not met. Clinical guidance on when it may be appropriate to hospitalise a person for a blood test, diagnostic test or consultation is also necessary.

Conclusion

We would be happy to continue working with the Department to reduce the regulatory burden on hospitals by progressively delisting Type C items where the administrative burden outweighs the risk to consumers. This will require more data and more consideration from health funds, clinical advice and consideration of regulatory change by government. PHA will gladly invest in this process to improve efficiency across the system and outcomes for consumers.

[1] To illustrate this point, ten hospitals (including those associated with ophthalmologists' rooms) currently collect almost $40 million per annum in hospital payments for intravitreal eye injections.