Submission to the Department of Health
September 2017

CONSULTATION ON REDUCING PRESSURE ON PRIVATE HEALTH INSURANCE PREMIUMS BY ADDRESSING THE GROWTH OF PRIVATE PATIENTS IN PUBLIC HOSPITALS

The Australasian College for Emergency Medicine (ACEM) welcomes the opportunity to provide comments to the Department of Health’s (the Department) consultation on reducing pressure on private health insurance premiums by addressing the growth of private patients in public hospitals. It is in the public interest to have a high quality and responsive health system. Achieving this outcome is of vital importance to each patient’s health care experience and for the quality of life for the individual, their family and the broader community.

ACEM is the not-for-profit organisation responsible for the training of emergency physicians and the advancement of professional standards in emergency medicine in Australia and New Zealand. As the peak professional organisation for emergency medicine in Australasia, ACEM has a vital interest in improving the quality of training and clinical supervision of its Members, while ensuring the highest standards of emergency medical care are provided for all patients. ACEM welcomes the opportunity to engage with the Department as it works to identify opportunities to improve efficiency in the shared Commonwealth-State policy.

Private emergency departments (Private EDs) commenced operating in Australia in 1988. (1) In 2015-16, there were 289 private hospitals and 30 Private EDs¹ in hospitals around Australia. (2) From 2011-12 to 2015-16, patient demand for public emergency departments (public EDs) in Australia rose on average by 2.7% each year to a total of 7.5 million presentations in 2015-16. In 2014-15, there were 533,000 presentations to 25 private hospitals² with dedicated EDs, representing 7% of public ED demand.³ (3)

ACEM considers that access block⁴ is the most significant issue facing EDs in Australia as it negatively affects the provision of safe, timely and quality medical care to patients. (4) Access block is a key indicator of systemic crisis and it demonstrates the ongoing challenge for governments to match resources to patient demand. For example, from 2011-12 to 2015-16 public hospital beds increased on average by 1% per year (to a total of 61,000 available beds). (5) However, only 49% of patients admitted from the ED to the hospital were admitted within 4hrs. (3) This demonstrates that public hospital resourcing has not kept pace with this increased demand.

¹ As of July 2017
² An additional five private EDs were under construction during 2014-15.
³ Data for 2015-16 was not yet available from the Australian Institute of Health and Welfare.
⁴ Access block is defined by ACEM as “the situation where patients who have been admitted and need a hospital bed are delayed from leaving the Emergency Department because of lack of inpatient bed capacity”.


Against this rising demand for services, Government private health policy encourages individuals and families to hold private health insurance (PHI). In 2013, 47% of Australians held PHI, and private hospital inpatient care accounted for approximately 41% of all inpatient care. (6) In 2017, the proportion of Australians with PHI remained relatively static at 46.5%. (7) As care (not leading to admission) provided in Private EDs is classified as outpatient services, with insurance only applying to inpatient services, Private EDs are subsequently not recognised by PHI companies. This creates a gap between the cost of service provision and the insured amount of that service. (8) Medicare payments go part of the way to covering costs incurred through running a Private ED (approximately 15-20%), with the remaining amount paid for by the patient. This results in all Private EDs operating at a financial loss and helps to explain why there are limited numbers of Private EDs compared to public EDs. Addressing this funding gap is considered by ACEM to be a priority area for government. A reduction in out-of-pocket costs will:

- Result in a likely increase of utilisation of private health insurance
- Result in a likely increase in private health insurance membership
- Provide patients with greater access to specialist emergency physicians in Private EDs; and
- Assist with easing the burden on public health services.

ACEM strongly believes that patients have the right to access acute care services regardless of their insurance status. Public and private emergency departments (EDs) are vital components of hospital infrastructure and must be supported by governments as core elements of health care systems. In times of emergency, Private EDs have been called on to assist public resources in managing increasing patient demand. This is most recently evident in Victoria, with government triggering emergency arrangements with Private EDs following the 2016 Thunderstorm asthma event and in response to the 2017 influenza crisis. (9, 10) However, ACEM believes that Private EDs are an under-utilised resource. If harnessed appropriately, Private EDs could significantly assist in reducing the impact from privately insured patients in public hospitals.

ACEM advocates that all privately insured patients are afforded every opportunity to attend a Private ED and be admitted at that private facility (if required). ACEM considers it necessary that the Department and private health insurers communicate and engage with privately insured patients on their rights and choices, including the financial impact of utilising public or private systems. Patients must be supported to make informed decisions about their healthcare and privately insured patients should be enabled to base these decisions on a greater understanding of these impacts.

The Department has identified and highlighted impacts on public resources stemming from privately insured patients in the public system. Efforts to reduce this impact are to be applauded as the consultation paper outlines that national emergency admissions by private/self-funded patients increased by 38% from 2012-13 to 2015-16. This needs to change as it is having an increasing impact on public hospital resourcing. For the public and private hospital systems to work effectively, ACEM reiterates that any change must encourage privately insured patients to utilise private facilities. ACEM considers it necessary that any change introduced following this consultation does not negatively impact the overall funding of public hospitals, nor to act as a mechanism to increase the costs to patients in public hospitals.

Regarding the proposals and questions raised by the Department, ACEM considers that they require further detail and explanation. The proposals have the capacity to implement changes that would significantly alter the existing public and private health care landscape, particularly for EDs. ACEM requests the opportunity to discuss these issues further with the Department and suggests a workshop with other interested stakeholders would provide the best avenue to do so.
Option 1 – Limit private health insurance benefits to the medical costs of private treatment in public hospitals with no benefits paid to the hospital

With this in mind, ACEM considers that limiting PHI benefits to the medical costs of private treatment in public hospitals, with no benefits paid to the hospital, is unlikely to work as an incentive in reducing the impact of private patients in public hospitals. Although this might act as an incentive to encourage some privately insured patients to seek out private facilities, based on their previous experience of private facilities and their insurance arrangements, it would have limited influence on patients who require emergency care. In a medical emergency, existing systems are designed to provide timely care for the patient and are not based on their insurance status.

ACEM also considers this approach would result in shifting hospital costs currently covered by insurance organisations onto patients electing to be admitted as privately insured, or it would require additional funding from government to meet this lost revenue stream. Under this option, it is in the patient’s interest to be admitted as a public patient in the public hospital because they would not be affected by this proposed change. This would not reduce demand for public resources and would have a limited impact to influence privately insured patients into private facilities.

Option 2 – Prevent public hospitals from waiving any excess payable under the patient’s policy

ACEM acknowledges that this option could act as an incentive to encourage more privately insured patients to choose a private facility for their treatment. However, if this option was implemented ACEM considers it would again shift the cost onto the patient and is therefore unlikely to result in a decrease of privately insured patients in public hospitals. ACEM notes that it would also be difficult to implement given jurisdiction support is required in order to further develop this proposal. Seeking agreement and coordinating the execution of this option would require unanimous agreement, rather than being undertaken in only a number of jurisdictions. ACEM questions what timeframe the Department considers necessary to develop this proposal.

Option 3 – Remove the requirement for health insurers to pay benefits for treatment in public hospitals for emergency admissions

ACEM supports the principle of removing the requirement for health insurers to pay benefits for emergency admissions in public hospitals. However, for this incentive to work PHI organisations must recognise Private EDs for emergency care. This recognition would act as a complimentary incentive – a patient is treated no differently in a public ED but if they hold PHI, they can claim for emergency care at a Private ED. This would help to relieve pressure on public resources by providing greater choice to privately insured patients as to where they want to receive their care; and allowing the opportunity for market mechanisms to respond to increased demand for private facilities.

ACEM notes that if this option was to be implemented it would have broader effects on emergency care systems. In a medical emergency it isn’t possible for a patient to choose which ED to receive care and this option may penalise patients with recognised PHI presenting at a public ED. For example, existing systems seek to assist patients receive the care they need at the closest facility that can meet their care needs (eg. ambulance services), rather than matching the patient’s insurance with the closest facility covered. If this approach was to be considered, ACEM is willing to work with the Department and other organisations (for example, PHI organisations and ambulance services) on the potential changes required to system processes.
Option 4 – Remove the requirement on health insurers to pay benefits for episodes where there is no meaningful choice of doctor or doctor involvement

ACEM considers it would be difficult to enforce the proposal to remove the requirement on health insurers to pay benefits for episodes where there is no meaningful choice of doctor or doctor involvement. ACEM seeks further clarification as to what the Department means by ‘no meaningful choice of doctor or doctor involvement’ as the qualitative nature of this descriptor is too vague to make an assessment of its potential value. In private settings, many emergency patients seek out specialists with whom they have a pre-existing relationship. This is a key point of difference between public and Private EDs. Additionally, patients in Private EDs are given a choice of which consultant to contact for a new problem.

Thank you for the opportunity to provide feedback to this consultation. We look forward to further engaging with the Department on this issue. Should you require clarification or further information, please do not hesitate to contact the ACEM Policy Manager Fatima Mehmedbegovic on (03) 9320 0444 or via email at Fatima.Mehmedbegovi@acem.org.au.

Yours sincerely,

[Signatures]

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References


