Chapter 4

Alternative arrangements for second tier default benefits

This chapter describes some alternative arrangements for second tier default benefits, summarises the viewpoints of key stakeholders, and evaluates each of the options against the assessment criteria.

4.1 Options for second tier default benefits

This section summarises the viewpoints of key stakeholders regarding alternative arrangements for second tier default benefits. Two broad categories of alternative arrangements were raised and addressed by stakeholders:

- abolishing second tier default benefits; and
- altering second tier default benefits calculations or eligibility criteria.

Abolishing or restricting second tier default benefits

Abolishing second tier default benefits

This option would remove the obligation of PHI funds to pay non-contract hospitals and day surgeries an amount for admitting private patients. Table 4.1 summarises the reactions of stakeholders to this policy option.

Consumers, doctors and hospitals all oppose the option, noting in particular that it would restrict consumer choice of hospital. Doctors and private hospitals also argued that it would reduce the bargaining power of the hospitals in their negotiations with PHI funds. State/territory health departments were concerned that the abolition of second tier default benefits could lead to an increase in private patients coming to public hospitals. Private health funds were the only stakeholders to support this option, arguing that it would encourage greater competition and higher quality services (see Table 2.3 and Table 4.1).

Table 4.1

STAKEHOLDER REACTIONS TO ABOLISHING SECOND TIER DEFAULT BENEFITS

Consumers	Doctors/practice managers	PHI funds	Private hospitals	State/territory health depts
• Not supportive of option	• Not supportive of option	• Supportive of option	• Not supportive of option	• Not supportive of option
• Many older consumers hold onto their PHI because private care facilities are close to where they live, and their partners have easier access — removal of second tier could reduce choice • PHI funds have to be more answerable to their members with respect to which hospitals they contract with • Likely increase in the incidence and amount of hospital gaps in the absence of the second tier default benefit	• If hospitals close down, where would the people who are currently serviced by these hospitals go — services should be maximised not rationalised	• Would encourage quality • Would allow health care market to work more competitively	• Would make it difficult for hospitals without a contract to function, likely to see consolidation between the smaller hospitals	• Likely to lead to an increase in private patients coming to public hospitals • Could limit consumer choice in rural and regional areas — if former second tier hospitals could not contract with funds and had to charge patients hospital gaps, then consumers who could not afford the gap would have less options for care

Source: Stakeholder consultations

It was generally acknowledged that some non-contracted hospitals would be unable to operate in the absence of the second tier default benefit, and that this could lead either to the closure or the consolidation of smaller hospitals or day surgeries. While it was also noted that there are some day surgeries and smaller hospitals that are better off receiving the second tier default benefit than attempting to negotiate a contract (for an ultimately lower price), it was also acknowledged that in the absence of the second tier default benefit, they would be unlikely to secure a contract because they would have lost their fallback position.

Restricting second tier default benefits

One of the policy options put to stakeholders was restricting the sorts of hospitals that are eligible for the second tier default benefit. This was attempted in 2004 when the government proposed to replace the second tier default benefit with a rural and regional default benefit.[21]

[21] Australian Private Hospitals Association, *Questions and Answers: Second Tier Default Benefit — Common questions answered and all the issues canvassed,* Canberra p. 3. http:// www.apha.org.au/get/2381741967.doc.

The option put to stakeholders was to restrict the second tier default benefit to those hospitals or day surgeries that were unable to expand, or to gain from economies of scale. These are likely to be hospitals in rural or regional Australia that have a limited number of patients, or hospitals that demonstrate a specialisation in a particular procedure.

In general, there was very little support among stakeholders for this option, although for different reasons, as summarised in Table 4.2. PHI funds oppose it because they do not support second tier default benefits of any type. Hospitals, by contrast, oppose it because they see greater benefit in the existing arrangements, as discussed above. The PHIO noted that there is little point in pursuing this policy because it has failed once already.

Table 4.2

STAKEHOLDER REACTIONS TO RESTRICTING SECOND TIER DEFAULT BENEFITS

Consumers	Doctors/practice managers	PHI funds	Private hospitals	State/territory health depts
• No comment	• No comment	• Not supportive of option	• Not supportive of option	• Generally not supportive of option, but if second tier default benefits were removed restricted default benefits would be essential
		• There should be no second tier default benefit of any type • Any second tier default benefit underwrites the market	• It is unclear what policy objectives would be advanced by this proposal	• Second tier default benefits are essential in rural and regional areas, so if the second tier default benefit is removed, need to maintain eligibility for default benefit in these areas at least

Source: Stakeholder consultations

Altering second tier default benefits calculations or eligibility criteria

Revising second tier default benefits calculations

Under this option, the way in which the second tier default benefit is calculated would be modified. In particular, this option addresses hospitals' and funds' concerns about the information gaps in this area, the lack of transparency with respect to how the second tier default benefit is calculated, and the quality of services delivered under the second tier default benefit.

The private hospitals argue that while the funds are required to pay 85 per cent of the average rates referred to in their contracts for particular episodes of care, the rates in the contracts are not publicly available so hospitals are unable to verify the second tier rate for themselves. In addition, the APHA notes that the derivation is further clouded by a loophole in the administrative arrangements. Specifically, PHI funds can use arrangements that are similar to Hospital Purchaser-Provider Agreement (HPPAs) for calculating the second tier default benefit schedules. The term 'similar arrangement' is not defined in the administrative arrangements and, as a result, any kind of benefit paid by a fund can be included in the second tier default benefit calculation.

Hospitals would also like to see the second tier default benefit calculated for a greater range of hospital types and sizes. The current categorisation by number of beds does not always recognise small, specialist hospitals or day surgeries that have only a few beds, but an excellent standard of care. For example, one of the stakeholders noted that a private thirty-bed hospital in Brisbane that provides complex neurological, medical, general surgery, oncology and palliative care services receives the same second tier default benefit as an outback hospital of similar size that provides only basic medical services.

Overall then, **stakeholder reactions to this option are mixed**, as shown in Table 4.3. PHI funds and private hospitals are supportive of at least some changes that lead to greater transparency and a closer relationship between second tier default benefits and outcomes. Doctors and practice managers, by contrast, prefer to leave the current arrangements as they are.

Table 4.3

STAKEHOLDER REACTIONS TO REVISING SECOND TIER DEFAULT BENEFITS CALCULATIONS

Consumers	Doctors/practice managers	PHI funds	Private hospitals	State/territory health depts
• No comment	• Not supportive of option • Would like to leave things as they are	• Supportive of option • Would like second tier default benefits tied to outcomes	• Supportive of option • Would like more transparency as to what the second tier default benefit is calculated as 85 per cent of • Suggested increasing the stratification with respect to hospital categories	• No comment

Source: Stakeholder consultations

Introducing higher quality and safety eligibility criteria for second tier default benefits

From the perspective of the funds, there is a concern about how the quality of hospital services is measured. Their view is that second tier default benefit was introduced to provide an incentive for hospitals to improve quality, but it is not clear if this objective has been achieved. Currently, the requirements for second tier status are that the hospital must:

> ... have a provider number, a licence to operate, proof of successful accreditation with a recognised body, the ability (not necessarily the intention) to accommodate simplified billing, have a suitable informed financial consent form (a generic copy is available to the industry), and have the ability to provide HCP data electronically.[22]

Because a fund must pay the same second tier default benefit to all eligible non-contracted hospitals within a category, it cannot use the second tier default benefit to encourage hospitals to improve quality. Moreover, it has no right to audit the quality of the hospitals or day surgeries that receive the second tier default benefit. Additionally, both the PHIO and PHIAC observed that rehabilitative and psychiatric hospitals benefit substantially from the second tier default benefit because they are able to recoup their costs, but it is difficult to assess the quality of the services provided.

The option in this case is to have an independent body specify quality criteria and regularly audit private hospitals against these criteria. **Most stakeholders support this option.** There is broad support among hospitals and funds, and both suggested establishing a quality committee with industry representation for these tasks. AHIA and APHA mentioned the former Private Health Industry Quality and Safety Committee (PHIQS) — which coordinated and led quality and safety enhancement initiatives in the private hospital sector — as an example of how this committee should be designed. Responsibility for enhancing quality and safety in the private sector is now part of the Australian Council for Safety and Quality in Health Care.

Consumers also support greater transparency in quality assessments, but doctors and practice managers are of the view that current quality criteria seem reasonable. These views are reflected in the stakeholder reactions summarised in Table 4.4.

Table 4.4

STAKEHOLDER REACTIONS TO INTRODUCING STRICTER SECOND TIER DEFAULT BENEFITS ELIGIBILITY CRITERIA

Consumers	Doctors/practice managers	PHI funds	Private hospitals	State/territory health depts
• Supportive of option if it provides more transparency	• Not supportive of option	• Supportive of option	• Supportive of option	• No comment
• How is quality currently managed, measured and compared? • Would like more transparency around quality assessments • Contracting arrangements shouldn't lead to people being sent home from hospital before they're able to be cared for properly	• Current quality criteria seem reasonable	• Quality criteria need to be *applied,* currently they only need to be 'in place' • Funds should be able to audit the quality of facilities receiving the second tier default benefit	• Supportive of this, as long as the criteria are administered by a body that contains industry representatives	

Source: Stakeholder consultations

[22] Australian Regional Health Group 2005, *Submission to the Allen Consulting Group's review of second tier and basic default benefits and gap cover arrangements,* Melbourne, p. 3.

4.2 Assessing options for second tier default benefits

This section assesses the likely impacts of introducing alternative arrangements for second tier default benefits according to the four criteria listed in chapter 1:

- consumer confidence, awareness and choice;
- affordability of private health care;
- health industry efficiency; and
- health care quality.

For each option, we discuss its advantages and disadvantages in terms of these criteria. This provides a structured way to assess and compare alternatives.

Abolishing second tier default benefits

The impact of abolishing second tier default benefits is difficult to predict because it would depend on the responses of health funds, hospitals and consumer groups, each of which could respond in a number of ways. Nevertheless, it is possible to draw some conclusions based on the probable responses of these key parties.

Figure 4.1 shows that abolishing second tier default benefits could result in three possible scenarios:

- under the first one — PHI funds pay contracted hospitals at agreed benefits levels — the affordability of private health care would likely increase;
- under the other two scenarios — funds pay non-contracted hospitals either a baseline benefit or no benefit at all — the affordability of private health care would likely decrease.

The scenarios are discussed further below.

Chapter 2 shows that an insignificant share of episodes is covered by second tier default benefits. This suggests that the outcomes of the first scenario are likely to be realised to a greater extent than those of the second and third scenarios. The discussion below, however, examines the implications of each scenario in turn.

Figure 4.1

ABOLISHING SECOND TIER DEFAULT BENEFITS

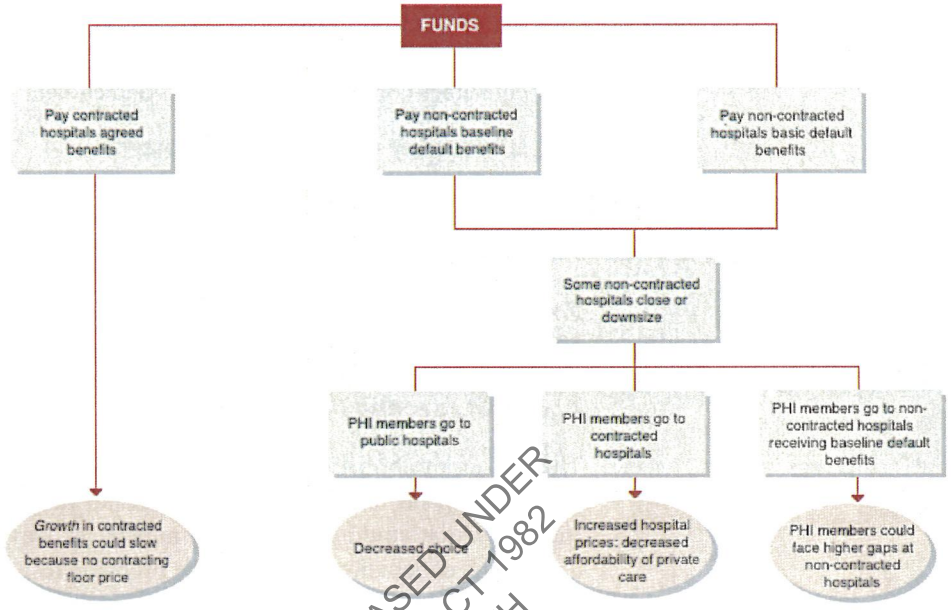

Figure 4.1 does not depict an increase in the number of contracts between health funds and hospitals. Stakeholder consultations suggest that funds are already contracting with all the hospitals they wish to, so there would be no incentive for them to contract more in the absence of the second tier default benefit. Consequently, we do not consider an increase in the number of contracts as a possible outcome of abolishing second tier default benefits. Instead, it appears that the most likely outcome of abolishing second tier default benefits would be based on a combination of the three pathways, or scenarios, depicted above.

Scenario 1: funds pay contracted hospitals agreed benefits

Under the first possible response to abolishing the second tier default benefit, there would likely be downward pressure on future contracted benefits levels (and hence premiums). Although contracted benefits are unlikely to decrease, given the ongoing advances in medical technology and increased consumer expectations that characterise the current health environment, the growth in contracted benefit levels could slow slightly. This would occur because the second tier default benefits level, which acts as a floor price for negotiations between funds and hospitals, would be removed.

All else being equal, this would increase the affordability of private health care. However, it is likely the overall level of contracted benefits would continue to exceed the second tier default benefits level. Thus, if more episodes were conducted at contracted hospitals (as discussed below), the extent to which private health care became more affordable could be dampened.

Scenarios 2 and 3: funds pay non-contracted hospitals a baseline benefit or basic default benefits

Following from the assumptions that there would not be an increase in the number of contracts between health funds and hospitals and that health funds need to provide their members with sufficient levels of coverage across hospitals, it is likely that funds would pay some non-contracted (former second tier) hospitals a baseline default benefit in the absence of the second tier default benefit. This benefit would presumably be set at a level that maintained the viability of private hospitals, but it could fall below the current second tier default benefits. Baseline default benefits could be varied by hospital type, size or outcomes.

If funds do not want to pay some hospitals a baseline benefit, they will pay these hospitals basic default benefits. (If basic default benefits were abolished in conjunction with second tier default benefits, health funds could refuse to pay these hospitals all together.)

Under these scenarios, outcomes depend on the reactions of hospitals to the new benefit arrangements and the reactions of consumers regarding preferred facilities for care. From the hospital perspective, hospitals receiving baseline benefits could increase hospital gaps if the baseline benefits are too low or, in the extreme, they could close or consolidate.

Similarly, hospitals receiving basic default (or zero) benefits, would likely be forced to close or scale down because basic default benefits fall substantially short of hospitals costs. This situation would likely lead to the consolidation of private hospitals. Although hospital consolidation holds the promise of higher quality, better coordinated and more tailored care, recent research from the United States found that consumers were worse off as a result of hospital consolidation. In particular, consolidated hospitals gained higher prices through increased market power, but they did not translate the financial gains into higher quality inpatient care.[23]

In response to potentially higher hospital gaps, consumers may be encouraged to attend public hospitals (as a private or public patient) or attend contracted hospitals more than they would have otherwise. In both instances, this would decrease consumer confidence and choice. It could, for example, severely limit the access of PHI members to private care in rural and regional areas if hospitals in these locations were forced to close or downsize.

In the second instance — where consumers are more likely to attend contracted hospitals — the overall level of health fund benefits would increase. Contract benefits would be higher in response to hospital consolidation and, in general, they would exceed the baseline benefits. On the whole, therefore, this scenario would decrease the affordability of private health care.

[23] A. E. Cuellar and P. J. Gertler 2005, 'How the Expansion of Hospital Systems Has Affected Consumers', *Health Affairs*, vol. 24, no. 1, January/February, p. 217.

Other impacts

Regardless of the reaction of health industry players to the abolition of second tier default benefits, the policy would have an ambiguous impact on health industry efficiency. Removing the second tier default benefits could increase efficiency in the private health sector by limiting government intervention. This would enable PHI funds to contract with providers on the basis of quality and efficiency, which could increase competition among private hospitals and improve quality. As noted above, however, if this process resulted in hospital closures and consolidation, it could increase hospital market power without any gains in efficiency or quality. Finally, if health funds reacted by giving hospitals baseline default benefits on a case-by-case basis, this could increase administration costs and lose what could then be considered efficiency gains from having a universal approach to calculating second tier default benefits.

The removal of second tier default benefits could also impact on the quality of health care. Second tier accreditation acts as one mechanism for ensuring basic quality standards in private hospitals (although, as noted above in section 4.1, there are some questions about the extent to which the second tier criteria measure quality in a meaningful way). Without this standard, hospital quality could decrease. On the other hand, the abolition of second tier default benefits could encourage hospitals to increase quality in efforts to secure ongoing health fund contracts.

Restricting second tier default benefits

Restricting the second tier default benefits to selected hospitals — such as those in rural or regional areas or with a limited number of beds — would have similar impacts as abolishing the second tier default benefits altogether. On the whole, this option would:

- reduce consumer confidence and choice;
- increase the affordability of private care (because there are so few episodes currently covered by second tier default benefits);
- have ambiguous impacts on health industry efficiency; and
- have unclear effects on health care quality.

The magnitude of these impacts would be smaller under this option than under the full abolition of second tier default benefits. Choice for consumers under this policy, for example, would be slightly higher because access to private hospitals in certain regions or of particular specialties or sizes would be maintained. For instance, in 2003-04 there were 103 private hospitals outside of capital cities in Australia (out of a total of 291 private hospitals).[24] Similarly, if smaller hospitals were included in the restrictions, then these hospitals would have a safety net to protect them from closure. This suggests that hospital consolidation would be less than it would be under a full abolition of second tier default benefits and, therefore, increases in hospital prices could be lower.

[24] Australian Bureau of Statistics, *Private Hospitals 2003-04*, Cat No. 4390.0, p. 20.

Revising second tier default benefits calculations

Hospitals would also like to see the second tier default benefit calculated for a greater range of hospital types and sizes. The current categorisation by number of beds does not always recognise small, specialist hospitals or day surgeries that have only a few beds, but an excellent standard of care. Some stakeholders believe that second tier default benefit calculations create perverse incentives for hospitals to increase their volume of low cost services. There are particular concerns about this issue for psychiatric and rehabilitations hospitals, which some believe create unnecessary demand and deliver minimal services with no benefits to the patient. To the extent that supplier-induced demand exists, better calculation of second tier default benefits would reduce excessive hospital episodes and, therefore, reduce overall benefits (and hence increase the affordability of private health care). Better alignment of services to medical need in this way would also contribute to improved health care quality.

Revised second tier calculations would also increase health industry efficiency by improving the match between hospital payments and costs. Health funds and hospitals would equally benefit from this type of revision and perverse incentives to manipulate the system would fall. Moreover, if second tier calculations were revised to reflect hospital costs more accurately, there could be a reduction in hospital gaps.

Introducing higher quality and safety eligibility criteria for second tier default benefits

Introducing higher quality and safety criteria for eligibility for second tier default benefits would increase health care quality and consumer confidence and choice. These impacts would be accompanied by short-term reductions in the affordability of private care; however, they would likely lead to long-term costs savings that would ultimately increase the affordability of private care.

Current second tier criteria are not particularly rigorous, nor are accredited facilities regularly monitored for compliance with the required standards. Introducing stricter criteria for second tier accreditation that included meaningful quality measures should increase health care quality and, in doing so, increase consumer confidence and choice.

The importance of hospital quality to consumers is underscored by recent survey results. When asked about interest in a variety of types of health information, 75 per cent of survey respondents were interested in having public and private hospitals publish infection rates and patient satisfaction survey results.[25] This suggests consumers would favour a second tier status that was a real signal of quality and empowered people to make informed decisions about preferred care settings.

[25] TQA Research 2005, *Health Care and Insurance - Australia 2005*, Section 4, p. 14–5.

In response to the introduction of stricter criteria for second tier accreditation, non-contracted private hospitals would either take measures (if necessary) to gain second tier status at the higher standards or receive basic default benefits. In the first instance, hospital gaps could increase if hospital costs rose to meet the new criteria. This would reduce the affordability of private health care in the short term. In the second instance, hospitals could either charge substantial gaps to consumers or close, which would lead to consolidation and increased prices in the private hospital market.

If hospital gaps increased in response to stricter second tier criteria, individuals could respond by selecting different hospitals than they otherwise would have done. For example, they could choose contracted hospitals, which receive higher benefits in general, instead of second tier hospitals. Alternatively, they could choose public hospitals, which would reduce private health costs, but would increase the burden on the public sector.

Given the small number of episodes covered by second tier, however, these impacts are likely to be minimal. Box 4.1 provides results on illustrative modelling of the impact of this option on short-term private health care costs.

Box 4.1

ILLUSTRATIVE IMPACT OF DEVELOPING STRICTER SECOND TIER CRITERIA

Changes to the eligibility criteria for second tier default benefits would have very little impact on premiums, due to the small number of PHI episodes occurring at second tier hospitals.

Suppose, for illustrative purposes, that no existing second tier hospitals choose to meet stricter eligibility criteria. Some of these hospitals close, while others receive the basic default benefit and charge patients out-of-pocket fees to bridge the gap. As a result, all privately-insured patients who would have attended a second tier hospital under current arrangements instead attend a contracted hospital, where they can minimise their out-of-pocket costs.

To estimate the impact of this scenario on premiums, we assume that the average benefit paid for all existing second tier episodes increases from second tier rates to contracted rates. This would increase total benefits paid for these 6336 episodes by 37 per cent, or $2.9 million. The average premium paid by the 8.6 million people with private hospital cover would rise by just 34 cents a year. This increase is equal to less than 0.05 per cent of contribution income per average person covered by PHI in 2003-04.[26]

The quality improvements that would be associated with this alternative could also generate long-term reductions in private health costs that would ultimately increase the affordability of private health care. Quality improvements could, for example, reduce hospital infection rates and complications and, therefore, lower future medical utilisation.

Finally, stricter second tier criteria would contribute to greater health industry efficiency in three distinct ways.

[26] Contribution income per average person covered by PHI in 2003-04 was approximately $850. See Private Health Insurance Administration Council 2004, *Operations of the Registered Health Benefits Organisations, Annual Report 2003-04*, p. 15.

- First, hospitals may be forced to make efficiency gains in order to control costs while taking measures to increase quality and meet the new criteria.
- Second, quality improvements made by hospitals to meet second tier accreditation could encourage more contracting between funds and hospitals. This argument follows from funds claiming that they do not contract with some hospitals because they do not meet their quality standards. Increased contracting would improve industry efficiency.
- Third, industry wide efficiency could increase if efficiency standards were included in the revised second tier criteria.

At the same time, there would be a minimal decrease in efficiency if this option distorted the allocation of patients across hospitals, particularly across public and private sectors.

4.3 Evaluating options and recommendations

Evaluating options

Table 4.5 summarises the preceding discussion by 'scoring' each policy option against the four assessment criteria. For each criterion, the table indicates whether an option would:

- work against meeting the objective of the criterion;
- contribute a little to meeting the objective;
- contribute substantially to meeting the objective;
- have a negligible impact on meeting the objective; or
- have an ambiguous impact on meeting the objective.

The table shows that abolishing or restricting second tier default benefits would contribute to making private health care more affordable; however, this would come at the cost of reducing consumer confidence, awareness and choice. It is not possible to identify the impact of either option on health industry efficiency or quality.

Revising second tier default benefits calculations, on the other hand, would have positive impacts across all of the government's objectives for private health care. It would increase consumer confidence, awareness and choice, make private health care more affordable, and improve health care efficiency and quality.

Introducing stricter second tier default benefits eligibility criteria similarly would have positive impacts, particularly in terms of increasing consumer confidence, awareness and choice and health care quality. The one downside of this option would be a short-term increase in private health care costs. This option could, however, result in long-term savings through reduced secondary infections and related medical utilisation.

Table 4.5

EVALUATING ALTERNATIVE ARRANGEMENTS FOR SECOND TIER DEFAULT BENEFITS

	Confidence, awareness and choice	Private health care affordability	Health industry efficiency	Health care quality
Abolishing second tier default benefits	×	√	?	?
Restricting second tier default benefits	×	√	?	?
Revising second tier default benefits calculations	√	√	√	√
Introducing stricter second tier default benefits eligibility criteria	√√	×*	√	√√

Notes:
× means option would work against meeting objective;
√ means option would contribute a little to meeting objective;
√√ means option would contribute substantially to meeting objective;
— means option would have a negligible impact on meeting objective; and
? means option would have an ambiguous impact on meeting objective.

* Option would increase affordability of private health care in the long term.

Recommendations

The analysis in chapter 2 suggested that the second tier default benefit policy has a limited impact on the private health sector, with less than one-half of one per cent of episodes covered at second tier rates. However, abolishing the second tier default benefits could have negative consequences, particularly in terms of reduced consumer choice at the margin. If hospitals formerly receiving second tier default benefits were unable to contract with health funds and were forced to increase the hospital gaps faced by fund members, they would become less viable options for consumers. A majority of stakeholders, furthermore, do not support the abolition of second tier default benefits, as outlined in Table 4.1.

We, therefore, conclude that second tier default benefits should be retained. The analysis, however, further suggests that this mechanism should be used to encourage improvements in health care quality and efficiency.

Recommendation 2: retain second tier default benefits.

As noted above, there are efficiency gains to be made by removing second tier default benefits. Moreover, second tier default benefits set a floor price for negotiations between PHI funds and hospitals and, in their absence, *growth* in PHI benefits would be anticipated to slow slightly.

These results suggest that the second tier default benefits should be removed on grounds of efficiency and affordability of private health care. Yet, in a market that is as regulated and government-supported as the private health sector, these arguments carry less weight. Instead, our analysis suggests there are other factors that outweigh these justifications for removing second tier default benefits.

Chapter 2 shows that second tier default benefits account for a very small share of episodes covered by PHI funds. However, our consultations revealed that for some hospitals, particularly day surgeries, second tier default benefits are very important. Day surgeries have the potential to improve the efficiency of health care provision by substituting services away from acute care hospitals, which are more expensive and may represent use of excessive health care resources for certain treatments. It is uncertain what would happen to day surgeries, which have little bargaining power against funds, in the absence of the second tier.

Another important characteristic of the second tier default benefits is the interest of hospitals in receiving second tier accreditation. Currently, 130 hospitals and day facilities (about one quarter of all private hospitals) have second tier default benefit status. Even though many hospitals with second tier status do not receive second tier default benefits (because they have contracts with funds), it is clear that hospitals value this accreditation. This is underscored by the rapid increase in accredited hospitals that occurred when the government was considering the abolition of second tier default benefits.

This reliance of private hospitals on second tier accreditation as a fallback or security option presents an opportunity to use second tier as a mechanism to increase health care quality and appropriateness of care.

While recommending that the second tier default benefits be maintained, we also recommend that it is used as a mechanism for encouraging industry wide quality improvements.

Recommendation 3: use the second tier default benefit regime to improve health care quality and efficiency by:

(a) establishing new categories of hospitals for second tier default benefits that allow better alignment between costs and benefits and recognise hospital outcomes; convene a taskforce — including representatives from hospitals and health funds — to draft new categories;

(b) setting higher quality and safety criteria for second tier benefits; establish a subcommittee of the Australian Council for Safety and Quality in Health Care — which includes industry representatives and experts — to develop the criteria.

The second tier default benefit regime should be revised with:

- better hospital categorisation that includes measures based on outcomes; and
- revised eligibility criteria that include meaningful measures of quality.

To establish new categorisation for second tier default benefits, a taskforce including representatives from hospitals, day surgeries and health funds should be convened. Categories should be established that allow better alignment between costs and benefits and recognise hospital outcomes (such as staff ratios or nursing coverage). At the same time, care should be taken so that the number of categories is not so large that only a few hospitals fit into each one.

Eligibility standards for second tier criteria should be developed through the establishment of a subcommittee of the Australian Council for Safety and Quality in Health Care, which includes industry representatives and experts. Given the scope of the Council's work, it would be beneficial to have a subcommittee that could focus on the issues for the private sector.

The subcommittee could focus on designing revised criteria for second tier default benefits that will encourage real quality improvements. Care should be taken to ensure that new criteria do not simply impose a duplicated accreditation regime that only adds to administrative burden and costs for hospitals and the Second Tier Benefit Advisory Committee.

This recommendation bridges the gap between the opposing viewpoints of health sector stakeholders. Improved quality and efficiency are objectives that all stakeholders agree on. Moreover, they have the potential to impact positively on the Australian community, more generally, as well as future health care expenditures.