Inquiry into the value and affordability of private health insurance and out-of-pocket medical costs

Submission by the

Australian Physiotherapy Association

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AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

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Executive Summary

The Australian Physiotherapy Association (APA) welcomes this opportunity to make a submission to the inquiry into the value and affordability of private health insurance and out-of-pocket medical costs (the Review) by the Senate Community Affairs References Committee (the Committee) on behalf of the physiotherapy profession.

We recognize that a major challenge facing modern health systems internationally is how to ensure that quality services are available to all citizens at an affordable price. We also recognize that fiscal sustainability is a concern for health insurance schemes across Australia.

Our profession, at both the level of individual physiotherapists, and collectively, is focused on maximising value in health care – on achieving the best health and related outcomes at the lowest cost. We bring this focus to this submission.

Physiotherapy can improve the value in private health insurance, however some of the systems and structures of the current system make that difficult to achieve.

We support a reduction in the number of available policies, the development of standard product definitions and clinical terminology; and a ban on so-called 'junk' policies.

We appreciate that the evidence to support a particular therapy may strengthen over time (as it has with Clinical Pilates). However, we take the view that the provision of private health insurance rebates needs to be constrained to therapies for which there is clear evidence of clinical effectiveness.

Advances in physiotherapy practice increasingly provide the option for members of the community to undertake care in the community (including at home) when previously that care would have been provided in hospital. Despite innovations in the private health insurance arena, such as Broader Health Cover, the proportion of hospital substitutable care provided is low. We believe that this suggests that the mechanisms to facilitate hospital-substitute care are relatively ineffective. The legislation needs to put hospital-substitute care on a level playing field with hospital care.

We are concerned that policy-holders may misunderstand the basis of so-called 'preferred provider' schemes and take this view that any such program needs to be based on a 'preference' based on the quality of health outcomes achieved by the physiotherapist.

We support the use of membership and related health data in some circumstances – where it is used to improve quality at the individual professional or practice level and where it is used to help plan for better use of health resources. We believe that there needs to be careful separation of any role in private health insurance and any provision of health services such that there is strict adherence to Australia's privacy laws and that a level playing field is maintained in the competitive service provision market.

We believe that more can be done to capture the opportunity that community-based physiotherapy presents to prevent hospitalisation. We also take the view that more can be done to capture the opportunity that community-based physiotherapy presents to reduce the length of hospitalisation. This requires that we re-think the view that general cover is somewhat 'ancillary' or supplementary and re-orient the private health insurance system towards a model that allocates resources to evidence-based early/conservative interventions, especially those which would reduce preventable hospitalisation and surgery and reduce the length of stay.

In this context, we take the view that there needs to be further exploration of the notion of 'episode payments' in primary care – the use of episodes payments is traditionally a model used in the hospital context.

We are concerned about the problems that Australians who need comparatively high cost aids face and take the view that more needs to be done to align private health insurance and the arrangements for funding such aids.

The profession of physiotherapy is rapidly adopting digitally-mediated models of service provision which can bring improved value to private health insurance policy-holders and the system as a whole. We need to have these models of health care funded by private health insurance. Policy-holders also need to know that any models of service provision by private health insurers (through whichever means it occurs) is on a level playing field with their physiotherapist and that any model of service provision by private health insurers would automatically attract a rebate under their private health insurance.

We want to see improvements in access to services, especially for people in rural and regional Australia. The enhancement of the funding of digitally-mediated services, the treatment of hospital-substitute care on an equivalent basis to hospital care and the funding of tasks delegated to physiotherapy assistants by private health insurers will also help achieve this.

Physiotherapy needs a consistent and dynamic schedule of services funded by private health insurers. Policy-holders should expect that a service within that schedule would attract a rebate through their private health insurer.

We take the view that the intent of the legislation with respect to supporting primary and secondary prevention must be made clear. Physiotherapy can provide substantial value to policy-holders through primary and secondary prevention; however, we understand that the private health insurers believe that the legislation prevents them from funding these activities.

We are interested in the potential to explore a model of 'choose and review'. We believe that being able to *choose* to agree to remain with a private health insurer for a period would increase the opportunity for services that have a high initial cost.

We believe that the risk equalisation arrangements need to promote improvements in the value provided. We believe that they need review in order to overcome the way in which they disperse the benefits accrued when private health insurers undertake strategies to promote good health and reduce the costs associated with hospitalisation. We also take the view that private health insurers need to be allowed to provide a limited range of incentives to providers in order to encourage high quality care.

We continue to be concerned that some Australians may 'fall through the cracks' between funding arrangements and seek to have the intersection between private health insurance and other funding schemes considered.

We support a 'best practice regulation' model. Thus, underpinning our entire approach is the view that we need to carefully consider the regulatory burden and impacts created.

We would be happy to meet with the Senate Community Affairs References Committee on behalf of the physiotherapy profession and have provided a summary of our recommendations at the end of our submission.

1. Introduction

The Australian Physiotherapy Association (APA) welcomes this opportunity to make a submission to the inquiry into the value and affordability of private health insurance and out-of-pocket medical costs (the Review) by the Senate Community Affairs References Committee (the Committee) on behalf of the physiotherapy profession.

We recognize that a major challenge facing modern health systems internationally is how to ensure that quality services are available to all citizens at an affordable price. We also recognize that fiscal sustainability is a concern for health insurance schemes across Australia.

1.1 Our focus is on maximising value in health care

As a profession, we pursue what has come to be called 'value-based healthcare'.[1] At its core value-based healthcare is about maximizing value for patients: that is, achieving the best health and related outcomes at the lowest cost.[2]

Although value in health care is understood in different ways by consumers, clinicians and other stakeholders[3], there is an increasing consensus that we need to identify low-value care and seek to reduce the likelihood that it will be provided. Low value care can be defined in terms of net benefit. It is a function of the expected (though uncertain) benefit and cost for an individual or group, as is assessed relative to alternatives, including no treatment.[4]

The physiotherapy profession engages in a range of strategies to reduce the prevalence of low value care. For example, we participate in Choosing Wisely Australia.[5] We are involved in a number of 'incremental fixes'[6], including implementing coordinated electronic health records, improving the uptake of clinical guidelines, reducing error and harm, and strengthening the skills of patients as 'consumers'.

Although incremental, we understand the central importance of these components of improving the value which is created for consumers.

Many of these 'fixes' improve technical efficiency – how we can use the fewest resources necessary to consistently provide the necessary health outcomes.

As a result, a substantial focus of our submission is on the facilitators and barriers within the existing system to the optimising value (the best health and related outcomes at the lowest price). We believe that parts of the system need to be re-shaped in order to make the capture of value easier and more reliable. This requires mechanisms that, collectively, are more transformative – that create allocative efficiency (the allocation of resources to the places where value will be maximised) as well as technical efficiency.

It has been argued, however, that in order to maximise value, we need to move beyond a focus on these incremental fixes.

It has been argued that "It's time for a fundamentally new strategy."[7]

We appreciate that the private health insurance arena is not a 'green-fields' site. However, we believe that it is important to have a discussion about whether fixes to the existing platform will bring sufficient improvement and whether we need to explore alternate models such as health savings accounts.[8]

Jack's story

Jack is 92 years old. He was a baker. He lives alone after his wife passed away 3 years ago from cancer.

Jack manages to live independently in his own home in north Queensland. He has some support from the community, but his quality of life is limited by chronic obstructive pulmonary disease (COPD). Between 2013 and 2016, Jack had an average of 4 hospitalisations each year from exacerbations of his COPD.

In early 2016 Jack started a physiotherapist-led preventive program which incorporates chest physiotherapy, therapeutic exercise, home oxygen and physiotherapist-prescribed mobility aids including a wheeled walker.

Jack's function has significantly improved with physiotherapy. He recently managed to drive himself to Brisbane to visit his children. He continues to live independently, remains active in the community and has only had a single hospital admission in the past 18 months (for an acute condition unrelated to COPD).

Jack's typical hospital admission had been 7-10 days, with a cost of around $25,000. The reduction in admissions has likely led to a saving of over $100,000 to the hospital service. The cost of the physiotherapist-led preventive program over the same period was just over $2,000. (The rebate Jack gets when seeing his physiotherapist is approximately half of the full average cost of the visit, and Jack pays the balance as a co-payment).

He recently asked about that – because he has realised that the 'saving' from his prevented hospitalisation doesn't provide him with the balance of the cost of his physiotherapy.

COPD is considered the second leading cause of preventable hospital admission with nearly $500-million in direct hospital related costs to our health system each year.[9]

1.2 Physiotherapy can improve the value in private health insurance

Physiotherapy services represented approximately 8.2% of the $1,322 million in general treatment (ancillary) benefits paid in the March 2017 quarter.[10] This is cost follows dental (51.6%) and optical (18.5%)

Physiotherapy tends to be seen as a health service focused in the general benefits arena.

In the March 2017 quarter, private health insurers paid $3,479 million in hospital treatment benefits.

Unlike dentistry and optometry, physiotherapy, has a substantial profile in the hospital treatment arena (e.g. in orthopaedics, respiratory care, and cardiac care).

Physiotherapy offers substantial potential to tackle some low-value areas across the continuum of care, should the private health insurance environment be re-shaped to capture this opportunity.

Through this submission we identify a series of structural and systemic barriers to optimising the role of physiotherapy. The later parts of this submission will provide illustrations of the opportunities physiotherapy can provide and potential ways to facilitate this.

2. Private and public hospital costs and the interaction between the private and public hospital systems including private patients in public hospitals and any impact on waiting lists

It has been suggested that up to 80% of patients referred to orthopaedic outpatient services can be managed without surgery.[11]

The implementation of a physiotherapy paediatric orthopaedic triage clinic resulted in 77% of patients being managed independently without orthopaedic consultant intervention and the reduction of the mean waiting time from 101.9 weeks pre-2010 to 15.4 weeks in 2013. [12] Similar outcomes have been found in other similar clinics in Australia.

This suggests that hospital services with waiting list pressures benefit from the screening of potential referrals by a specialised physiotherapist.

Screening can ensure that people for whom a non-surgical path of care is appropriate are identified and surgery avoided. It can also lead to shorter waiting times by removing people whose conditions can be managed through other strategies from the waiting list.

The option to use publicly managed outpatient physiotherapy is limited by capacity in the system and many potential candidates for surgery choose to use their private health insurance (general cover) to have the physiotherapy care they need to avoid surgery.

As a result, it is important to look beyond the impact of private health insurance of waiting lists at the 'pointy end' when surgery is being planned, and consider the impact it can have in preventing people entering the surgical trajectory.

3. Private health insurance product design including product exclusions and benefit levels, including rebate consistency and public disclosure requirements

Some of the ways in which private health insurance products are designed militate against the capture of the opportunity afforded through the provision of high quality physiotherapy.

3.1 The number of available policies needs to be reduced

We are aware of the problems created for consumers by the complexity of private health insurance. We are aware of the difficulties consumers face when trying to understand and compare different products. Some of these difficulties are discussed later in this submission.

We support the work of the Private Health Ministerial Advisory Committee (PHMAC) on developing consistent product requirements and descriptions so that consumers know what is covered (or excluded) from private health insurance policies.

We support the PHMAC's work on the development of standard definitions and terminology for medical procedures and other services so that consumers to compare policies more easily.

We are concerned about the presence of so-called 'junk' policies. Although we understand the notion of policies that involve 'carve-outs' (exclusions), we believe that most consumers want policies to cover a range of expected and unexpected life events.

In that context, we support the work being done to ensure that 'carve outs' do not undermine the utility of products to most Australians.

Recommendation 1:

We recommend that the Senate Community Affairs References Committee support the completion of the work of the Private Health Insurance Ministerial Advisory Committee on product design.

3.2 The provision of rebates needs to be constrained to therapies for which there is clear evidence of clinical effectiveness

We are aware that some general cover products subsidise access to 'natural therapies'. For example, HCF's Premium Hospital and Gold Extras covers naturopathy.[13] Health Partners, for example, provides an 'optional add-on cover' that provides benefits for a range of natural therapies including iridology.[14]

A review of the Australian Government rebate on private health insurance for natural therapies found no clear evidence that a number of 'natural therapies' are clinically effective.[15] Despite this, it has been reported that natural therapies have become the fifth most common claim on general cover with a growth rate of 1873% compared with optical (for example) at 320% (the next highest).[16]

We appreciate that the evidence to support a particular therapy may strengthen over time (as it has with Clinical Pilates).

We also appreciate that the financial expenditure on natural therapies continues to be comparatively small compared with the costs of some other low-value care (e.g. avoidable hospitalisation for surgery and rehabilitation).

However, the funding of therapies for which there is no clear evidence of clinical effectiveness illustrates an inconsistent of approach within some private health insurers who fund natural therapies but refuse to fund evidence-based preventive and conservative management physiotherapy (e.g. digitally-mediated consultations).

It also sends an ambiguous signal to the community – that it is appropriate for a health system to fund such therapies.

Australia's Therapeutic Goods Administration (TGA) has published "evidence guidelines" which outline the evidence required to support indications for listed complementary medicines.[17] The Medicare Benefits Schedule is underpinned by the Medical Services Advisory Committee and is undergoing a review to consider how services can be aligned with contemporary clinical evidence and improve health outcomes for patients.

We believe that a nationally consistent approach needs to be taken to determining the threshold for funding of health services through private health insurance.

Recommendation 2:

We recommend that the Senate Community Affairs References Committee consider how constraints can be placed on the ability for private health insurers to subsidise therapies for which there is no clear evidence of clinical effectiveness.

3.3 The legislation needs to put hospital-substitute care on a level playing field with hospital care

Advances in physiotherapy practice increasingly provide the option for members of the community to undertake care in the community (including at home) when previously that care would routinely have been provided in hospital.

Despite innovations in the private health insurance arena, such as Broader Health Cover, the proportion of 2014 same day admissions that were reported as hospital substitutable was 5.5%.[18]

We believe that this suggests that the mechanisms to facilitate hospital-substitute care are relatively ineffective.

From a patient viewpoint, choosing a non-hospital option is affected intrinsic and extrinsic factors.[19]

The intrinsic factors include the previous experience of the patient or known others, the perceived benefits of the chosen mode, and a sense of entitlement. Some of these intrinsic factors can be addressed in the model of service. For example, the reported benefit of hospital care – of being able to compare progress, and interact with people in the same situation – has been replicated in non-hospital models which use patient groups and/or digital modalities.[20]

The extrinsic factors include the model of service delivery in place at the hospital in question.

> At one site, a number of patients interviewed went through surgery and outpatient therapy afterwards without even knowing that inpatient rehabilitation was an available option. Alternatively, at the second site, all patients interviewed were aware of inpatient rehabilitation as an option, and it was often presented as 'part of the package' at preadmission sessions.

In this study, clinicians indicated that patients admitted for therapy to particular rehabilitation inpatient units may have had no significant clinical indicators for admission as the mode of rehabilitation.[21]

Where it can be reasonably anticipated that the clinical outcome would be equivalent, the options for a hospital episode of care and a non-hospital episode of care need to be on a level playing field.

Three tactics would appear to be useful in this context.

Firstly, the opportunity for patients to undertake prehabilitation needs to be strengthened.

A recent systematic review of the effectiveness of prehabilitation or preoperative exercise for surgical patients found that there is evidence that prehabilitation may reduce admission to rehabilitation for patients who have had knee or hip arthroplasty for osteoarthritis.[22]

Secondly, hospitals, when booking patients for surgery, need to provide those patients with information about hospital-substitutable rehabilitation pathways which are equivalent to the in-hospital rehabilitation.

Thirdly, patients need to be in a position to elect to be treated in a hospital-substitute program and have no different co-payment to that which they would have in a hospital admission. This needs to include day- and over-night admissions. Presuming that the patient can expect that the clinical outcome would be equivalent, this choice cannot be only on referral from a hospital – it needs to be driven by the patient.

Fourthly, particularly for rural patients, the rebate for the non-hospital option need to include any transport or accommodation costs (accommodation and other costs are factored into the hospital payment).

Fifthly, consideration needs to be given to the withdrawal of a minimum benefit for rehabilitation (including that paid for admissions on a same day basis).

This means that we need to move further from the historical dichotomy between 'hospital' and 'general' cover, and that the legislative, regulatory and policy arrangements need support high cost and high complexity care in the community.

Recommendation 3:

We recommend that the Senate Community Affairs References Committee consider ways to ensure that hospital-substitutable care is treated on an equivalent basis to the hospitalisation for which it substitutes.

3.4 So-called 'preferred provider' schemes need to be based on the quality of health outcomes

We are aware of so-called preferred provider schemes operated by private health insurers such as Members' Choice and Members' First.

As we understand Medibank Private's scheme, Members' Choice, a policy-holder who pays the same insurance premium could receive a lower rebate should they choose to use a physiotherapist who is not a part of Members' Choice. As we understand it, the same outcome can occur if a Bupa policy holder chooses to use a physiotherapist who is not a part of the Members' First program.

We see the operation of schemes that suggest a 'preference by members' and yet provide some members with a lower rebate for exercising *their* preference as problematic.

Such a differential might be justified if the private health insurer were paying for a superior health outcome. This does not appear to be the case.

Recommendation 4:

We recommend that the Senate Community Affairs References Committee explore mechanisms that would prevent a private health insurer from paying a differential rebate for the same service unless the payment is to reward reliably better value (better health and related outcomes).

4. The use and sharing of membership and related health data

There are a number of ways that membership and related health data could be used. These include the use of data for safety and quality improvements and the use of the data for service planning.

4.1 We support the use of membership and related health data in quality improvement activities

We see data that is similar to membership and related health data being used in at least three quality improvement methodologies.

Firstly, membership and related health data is used in quality improvement strategies within health professions.

We know other professions, such as anaesthetics rigorously study outcomes based on patient data. We recognise the real improvements in safety and quality that can occur because of this.

We have embarked on a strategy to ensure that Australian physiotherapists participate effectively in the digital health arena. One of the elements of this strategy is to enhance the use of electronic health records. Embracing the digital environment will improve the experience of clients and their health outcomes. Within the parameters of the privacy laws, our ability to communicate with our patients and other members of their healthcare team will improve. We will have enhanced capacity to review in-practice data to compare health outcomes for our clients, and make comparisons to peers in physiotherapy. Although we are keen to do this, "it costs before it pays".[23]

Over time, we believe that clients of physiotherapy will begin to seek more information about health and outcomes, and a solid digital foundation will assist physiotherapists to be transparent about this.

Secondly, it is used in site-based safety and quality activities.

We understand that public reporting of some safety and quality indicators (e.g. hand hygiene and health-care associated infections) from both public and private hospitals is available through the MyHospitals website. In addition this data, we are aware that health services managed in the public sector routinely engage benchmarking other safety, quality and outcome measures. We believe that it would be useful for private hospitals to report benchmark data on privately insured patient in areas where there is substantial variation in the Australian health system (e.g. those identified in the recent report by the Australian Commission on Safety and Quality in Health Care [ACSQHC] and Australian Institute of Health and Welfare [AIHW]).[24]

Recommendation 5:

We recommend that the Senate Community Affairs References Committee consider requiring that private hospitals provide consumers with a range of information about safety, quality, and outcomes (including length of stay and costs), especially in areas of high variation in these factors across Australia, as a precursor to being funded through private health insurance.

Thirdly, it is used to assist in identifying opportunities for quality improvement 'across the system'.

Consumers (in this case, policy-holders) are increasingly seeking information about the performance of products, and private health insurance policies are products in much the same way.

Outside the private health insurance arena, the physiotherapy profession increasingly meets with health funders to have structured discussions aimed at improving the quality of physiotherapy provided to people covered by those schemes. The basis for these discussions is aggregate data, the use of which protects the identity of both the people using the services and those providing them.

We understand that one of the challenges may be that there are a number of private health insurers who operate in a competitive environment. We are also informed by the private health insurers that they do not have sufficient data on the clinical conditions of members to make such comparisons. This is true in some other contexts.

Despite this, we believe that the private health insurers have data which could be used to look at safety, quality and access issues that could make a substantial improvement in the value delivered in the private health insurance arena.

A simple illustration of this is their data on the time and which and reasons for policy-holders 'capping out' (running out of general/ancillary cover prior to the end of the coverage year). We understand that the 'average' policy-holder may not face this problem. However, it is increasingly reported to us as a problem by consumers and we think that private health insurers could provide data about issues like this as the basis for discussions about systems improvements.

Recommendation 6:

We recommend that the Senate Community Affairs References Committee consider ways in which private health insurers could be encouraged to report aggregate data on matters that affect the access to, safety and quality of health services in order to ensure that the public is aware of the variation and can participate in discussions about systems improvement.

4.2 We want to ensure that there is a level playing field with respect to planning health services

As a result of the necessary capture of data on policy-holders and their use of health services, and the necessary capture of data on service providers (including the range of services they provide and their location), private health insurer hold information that would be valuable in planning health services.

We believe that the use of that data in the planning of health services would provide a competitive advantage to the organisations using it.

We hold the view, as a result, that there needs to be careful separation of any role in private health insurance and any provision of health services such that there is strict adherence to Australia's privacy laws and that a level playing field is maintained in the competitive service provision market.

Recommendation 7:

We recommend that the Senate Community Affairs References Committee consider separation between any role as a private health insurer and service provider can be ensured in order to ensure the privacy of policy-holders and providers, and a level playing field in the provider market.

5. Medical services delivery methods, including health care in homes and other models

Physiotherapy can play a substantial role in keeping people well and in maximising their wellbeing and quality of life if they have a health condition.

In Australia, physiotherapy is involved in a range of innovations which are yet to be fully captured within the private health insurance arena.

5.1 We need to capture the opportunity that community-based physiotherapy presents to prevent hospitalisation

There are over 100,000 hospital admissions with a primary diagnosis of osteoarthritis and close to 50,000 knee replacements performed in Australia each year. Knee replacements cost the health system more than any other procedure, amounting to well over $1.2 billion a year.[25]

> Glenys's story
>
> Glenys is Greg's wife. Although this story is mostly about Greg, I want you to know that it is very much about his wife and the ways she has benefited from his decisions.
>
> Greg is a 68 year old ex-miner who lives in Bundaberg with his wife Glenys. They enjoy travel and regularly take the caravan interstate to visit relatives. Greg's knee was injured during his time mining.
>
> He has experienced intermittent knee pain ever since. In 2005 an orthopaedic surgeon considered his advanced osteoarthritis on x-ray and told him he would be back in the next 2 years for a total knee replacement and to "let him know when he was ready" to go ahead.
>
> Greg decided to do everything he could do to keep his native knee healthy. He went to see his local physiotherapist who guided him on therapeutic strengthening exercise, weight management, activity pacing, provided an unloading knee brace, and advised a cycling program.
>
> Now 12 years later, Greg is very active, travels regularly and says he only has mild knee pain after he mows his whole lawn. He boasts that he still hasn't been back to the surgeon.
>
> The total cost of all Greg's physiotherapy over 12 years has been just under $12,000. The average cost of a hospital admission, knee replacement surgery, rehabilitation and ongoing care over the same period is estimated at $35,000 to $50,000.
>
> For Glenys, it's worth being a 'bike-widow' and ensuring that she limits the temptations in the fridge.

A recent report suggests that almost half of the potentially preventable hospitalisations in Australia are due to five conditions:

- Chronic obstructive pulmonary disease (COPD)
- Kidney infections and urinary tract infections
- Heart failure
- Cellulitis, and
- Diabetes complications.[26]

Physiotherapy has the potential to reduce hospitalisation in a number of these conditions. However, the current private health insurance arrangements mitigate against this.

One of the challenges with this area is the cost of care. A study published in 2016 found that adults with asthma, emphysema and COPD had 109% higher household out-of-pocket healthcare expenditure than those with no health condition.

It also found that people with a chronic condition were more likely to forego care because of cost and that people with asthma, emphysema and COPD had 6.16 times higher odds of skipping healthcare than people with no health condition.[27]

We see private health insurers as bearing the cost of the preventable hospitalisations. We understand that some of them are using programs to prevent this. However, the same methodologies for hospital prevention are not availed of physiotherapists in community practice when it is the continuing care of their patients which could play a central role in preventing the hospitalisation.

Physiotherapy, like many other health services, has seen continuing development that has allowed services previously provided in hospitals to be safely provided in community settings.

Despite this, the legislation and regulation in private health insurance mitigates against the adoption of clinical effective and high value community-based options. They suggest that admissions to hospital for rehabilitation (particularly same day admissions) are occurring because there is a financial incentive for private hospitals to provide this at no cost to policy-holders, despite the likelihood that, at a whole-of-system level, community-based models provide higher value to consumers and the system.

This situation continues despite the reforms (often called Broader Health Cover) which began in 2007 and which allowed private health insurers to broaden their suite of products so that they could cover disease management and health and wellness programs.[28]

Accessing physiotherapy services in the community before referral to surgery is vital to significantly reduce preventable hospital admissions. Such a move has the potential to make considerable savings, given that just one total knee replacement surgery can cost $19,700 in the public setting.[29] This figure is for surgery only, and does not include extended lengths of stay, complications arising from surgery, rehabilitation or other out-patient costs. This sort of cost, when compared with the cost of conservative management in the community makes our profession question the underlying structural arrangements that allow such surgery to occur when prevention and conservative management could prevent it and come at a lower cost.

We are also aware of policy-holders who have complex pre-admission circumstances and who present at emergency departments of private hospitals seeking care. In some of these cases, the hospitalisation would be preventable through a team-based approach which could be coordinated through general practice.

The use of the term ‘ancillary’ cover indicates one of the fundamental mind-sets that needs to be changed in order to ensure value and affordability of private health insurance and manage out-of-pocket medical costs.

In terms of longterm health gain and affordability of the private health insurance arrangements into the future, physiotherapy covered by ‘general cover’ can play an important role in ‘bending the cost curve’. This is not ‘ancillary’ or supplementary. This is core to the purpose of private health insurance.

Recommendation 8:

We recommend that the Senate Community Affairs References Committee explore mechanisms that will re-orient the private health insurance system towards a model that allocates resources to evidence-based early/conservative interventions, especially those which would reduce preventable hospitalisation and surgery.

5.2 We need to capture the opportunity that community-based physiotherapy presents to reduce the length of hospitalisation

Following, we provide information about the potential positive impact of community-based physiotherapy on the length of hospitalisation for post-surgical rehabilitation. We do this as an illustration. There are a number of other circumstances in which hospital-substitutable community physiotherapy could have a similar impact.

The report by the ACSQHC and the AIHW canvasses variation in the rate of knee replacement hospitalisations for people eighteen (18) years and over indicates that the rate was four times as high in the area with the highest rate compared to the area with the lowest rate. It finds that 69% of hospitalisations for knee replacements were for privately funded patients. Further, it indicates that potential reasons for the variation include differences in access to models of care that a coordinated approach to alternatives to surgery such as physiotherapy.[30]

In a recently published Australian study[31], inpatient rehabilitation followed by a monitored home program did not provide superior mobility when compared with a monitored home program alone. Although this study did not study cost-effectiveness, recent evidence suggests that cost-effectiveness is reduced if total knee arthroplasty is associated with a stay in an inpatient rehabilitation facility.[32]

A recently published Australian study explores these issues and gives useful insights into why a lower-value, inpatient model is chosen.[33] This study suggests that both factors that are intrinsic to the patient and extrinsic factors influence the choice of the site of rehabilitation. Particularly relevant to this Inquiry, the private hospital business model (sometimes not disclosed to the patient) and insurance provider involvement influenced choice.

As we understand it, same day admissions for rehabilitation account for a substantial proportion of private hospital separations despite the potential for equivalent rehabilitation to be provided on a non-inpatient basis.

It is clear that hospital-substitute models for rehabilitation (including, but beyond knee arthroplasty which is illustrative) could make a substantial difference for rural Australians. However, as we outline elsewhere in this submission, the workforce issues for rural Australia also need to be addressed in order to truly grasp the opportunity afforded by physiotherapy.

Recommendation 9:

We recommend that, as a matter of priority, the Senate Community Affairs References Committee support the establishment of a government-facilitated industry working group on private health insurance funded rehabilitation to examine opportunities to improve the value provided in rehabilitation.

5.3 The notion of 'episode payments' in primary care needs to be explored further

Some private health insurers have reported to us that the 'average' policy-holder rarely reaches annual caps on physiotherapy rebates. We have not seen data on the distribution of annual expenditure on physiotherapy by policy-holders and have not seen data on the point in a policy year that policy-holders reach the cap. (We refer to this as 'capping out'.)

Nonetheless, we hear that policy-holders with chronic conditions either 'cap out' or cease their active management of health conditions (e.g. COPD) in conjunction with their physiotherapist because:

- they fear that they will 'cap out' and this will prevent them claiming physiotherapy for other acute conditions
- their cover is generic and using the cover on physiotherapy is at the cost of getting other services.

This can lead to a 'roller-coaster' in which policy-holders' conditions decline when they cease care, then improve again when they can return to seeing their physiotherapist in the new policy year. Of course, this occurs again in that policy year.

We understand that some of the policy-holders are offered programs through their private health insurer which are equivalent to that which their physiotherapist could provide (e.g. assertive outreach by telephone or other media); but which are not funded as a service under general cover.

> Betty's story
>
> Betty is 58. She lives 60km from the nearest major town.
>
> She has type 2 diabetes and chronic obstructive pulmonary disease (COPD). Betty has been told many times by her local GP that she should lose weight and go for some walks to help manage her blood sugars. (But more importantly to take her metformin to manage her HBA1C levels).
>
> Her family is a bit perplexed why her drugs are so heavily subsidised, but not the physical activity program she needs.
>
> The problem is that Betty finds the rural summer heat unbearable to go outside and exercise in any daylight hours. She gets very painful feet and the more she tries to walk to more pain she gets.
>
> Betty's GP referred her to the podiatrist (200kms away – it was the closest one) to help with her foot health.
>
> As a result, she cannot claim on Medicare to see a physio to help with the long term barriers of her sedentary lifestyle and chronic conditions.
>
> This has added to her sense of helplessness and disempowerment. It's become 'all too hard' and Betty is beginning to lose motivation to walk at all. As a result she is becoming housebound and showing signs of depressive behaviour. Cooking for one is lonely and wasteful, so she has taken to large portion sizes of pre-packaged meals. They are easy to fix and stop her standing for long.
>
> Betty's local physio has mapped out a solution. Well, sort-of-local – they are actually a 'mobile physio' who visits Betty's community regularly.
>
> It involves a 'burst' of visits to assess Betty, help her learn the key exercises, walk the path with her to check for obstacles and risks and organise some workable goals. After that, it involves a structured plan of 'touching base'. The physio expects that Betty will lose heart and will need some regular confidence building from someone she respects and trusts. That will involve some phone calls, and some short visits. Betty is talking about getting Skype so that she can speak with her grandchildren. The physio is keeping that in mind.

Betty's challenge is to get her private health insurer to come to the party before hospital comes knocking.

We understand that one of the reservations of the private health insurers is the financial risk associated with an 'uncapped' approach. However, a systematic review and meta-analysis of the effects of private health insurance on the utilisation of allied health services by people with chronic conditions points out that

> " … if a program … demonstrated benefit with 10 therapy sessions, there is no guarantee that providing five sessions only will lead to the same improvement."[34]

Thus, it is increasingly important for private health insurers and providers to look at models that will ensure that effective programs of care, rather than occasions, are readily available to policy-holders.

We see value in a mechanism that would allow policy-holders to have an 'envelope of funds' that is held for the provision of care for a particular condition (e.g. diabetes) and which separate to the balance of the general cover.

In this context, early in 2017, we offered to look further at episode-based models (including an annual episode – a form of 'capitation') for some chronic conditions seen by our patients and to discuss these ideas with the General Cover Committee at Private Healthcare Australia. We maintain our willingness to do this in 2018.

Recommendation 10:

We recommend that the Senate Community Affairs References Committee support the exploration of episode payments, including episodes which are funded separate to, but within a general cover product for the assertive management of specific conditions.

5.4 We need a better model for addressing the needs of high cost aids

Micah's story

We want to tell you about our son Micah.

He was born with a club foot. This is a serious deformity that, if left untreated, would prevent him from walking, cause significant pain and make his foot look terrible.

Physiotherapy is the major part of Micah's treatment.

This involves a physiotherapist applying whole-leg plasters to Micah's legs every week, and special foot splints until he is at least 4 years old.

We thought our private health insurance cover would meet the costs of this incredibly important care. We get some cover for our visits, but nothing for his plasters or splints.

We feel we are stuck between a rock and hard place.

We want Micah to get the best care.

We trust our physiotherapist as he is extremely experienced and works closely with our orthopaedic surgeon but he's not in the hospital.

If we go to the hospital, it is free – all the plasters and splints are free – but we prefer to have consistency for Micah.

We can't afford this package of care.

> We wish we hadn't taken out extras cover and had just used this money to pay for the physio treatment for our child and their splinting needs.
>
> Surely it doesn't have to be either / or – that's a terrible choice.

Australia has a number of schemes that support the provision of aids such as the (federal) Continence Aids Scheme and Rehabilitation Appliances Program and the state-based schemes such as the (Queensland) Medical Aids Subsidies Scheme and compensation schemes.

If one were to take the view that aids are an integral part of what is required under an insurance model, the approach of the National Disability Insurance Scheme suggests that it would be inappropriate to only partially fund the supports that people need to help them lead ordinary lives.

Recommendation 11:

We recommend that the Senate Community Affairs References Committee consider how the obligations under private health insurance policies could be better aligned with other schemes which provide aids.

5.5 Digital health

We can see substantial potential for health services and supports which are digitally mediated.

The Hospitals Contribution Fund of Australia (HCF) established a program called My Health Guardian in 2009. This program provides individualised support via telephonic nurse outreach and online tools for self-management, behaviour change and wellbeing.[35] The authors of a study on the benefits of the program, report that participation resulted in significant reductions in hospital admissions, re-admissions and bed-days. The cumulative average savings per participant policy-holder over the entire four-year intervention were $3,549 (prior to the impact of the risk equalisation arrangements).

HCF, has also developed the HCF Catalyst program through which it aims to promote health technology innovations that will shape the way and channels through which care is delivered in the future.

Amongst the innovations that the HCF Catalyst program has supported is The Pelvic Expert – a one-stop digital destination providing evidence-based and holistic women's healthcare programs for pelvic pain, pregnancy and postpartum problems. The Pelvic Expert was founded in 2016 by Heba Shaheed, a women's health coach and physiotherapist, and Nabeil Allam, a business strategist, after witnessing the lack of education and accessible services in pelvic health.[36]

Other private health insurers (or companies which are part of a larger corporate structure) also provide clinical services through digital channels.

On 5 July 2017, Andrew Wilson, Group Executive, Healthcare and Strategy, Medibank Private Ltd told the Committee that Medibank had no interest in owning dental practices or general practices.

When Mr Wilson was asked whether Medibank Health Solutions competed with primary care providers, he answered:

> "Not at all. One of our biggest programs is actually working with GPs, We are actually supporting GPs, We are working with them."

Medibank Private, through Medibank Health Solutions is:

> " ... a leading provider of telephone and web-based health care services in Australia … (and delivers) targeted outbound 'support' calls aimed specifically at engaging and triaging participants into appropriate health programs with 10,000 outbound 'support service' calls per week."[37]

We take the view that Medibank Private, through Medibank Health Solutions, does compete with physiotherapists in private practice. The website for Medibank Health Solutions tells readers that:

> "Although face-to-face consultations with doctors and other trained health professionals are essential, telephone interactions can increase the frequency, timeliness and overall access to services.
>
> The use of clinical software for regular monitoring of each patient's health status allows telephone case managers and other healthcare professionals to manage larger numbers of patients without the constraint of a traditional face-to-face workload …"[38]

At its simplest, the provision of physiotherapy services by private health insurers is simply part of the competitive market. However, we are concerned about a number of ways in which the 'level playing field' of competition is disrupted.

For example, although both Medibank Private and HCF can demonstrate the health and economic benefits of their telephone support programs, neither will fund such services where they are provided by a physiotherapist through that physiotherapist's private practice (or as a part of a rehabilitation program following discharge from a public hospitals where the admission was funded by a policy-holder's private health insurance).

The private health insurers will only fund services when the patient and physiotherapist are collocated.

In effect, this creates a two-tier system within the private health insurance arena – for those who are willing to forego the continuity of care from their physiotherapist and engage in these programs, and those who are not.

Apart from their own studies, the funds are aware of the growing body of evidence that demonstrates the utility of digitally mediated services.

For example, a recently published Australian study[39] studied a group of patients with stable chronic heart failure who received a twelve-week real-time exercise and education intervention delivered in the person's home twice weekly, using videoconferencing. The study found that these patients had significantly higher attendance rates than their counterparts who received a traditional hospital outpatient-based program of similar duration and frequency. Importantly, health outcomes were not inferior.

In another innovation, a telehealth care model for spinal fractures, undertaken by the Hunter New England Local Health District reduced average length of stay by five days – from nine to four days. An estimated $1.2 million in efficiency savings for the Health District (due to reductions in transfers and bed days) was achieved. The fitting of thoracic lumbar sacral orthosis at local sites reduced travel for patients and families by 24,324 kilometres.[40]

The federal government introduced a new Medicare rebate for online videoconferencing consultations with psychologists in the May 2017 Budget.

Icare, the statutory insurer responsible for delivering workers compensation insurance and care for NSW employers and workers provides funding for some video consultations.

The funds may argue that the physiotherapy schedule of services does not include such a service. However, in our December 2015 submission to the private health insurance consultation announced by (then) Minister for Health, the Hon Sussan Ley MP, we argued that, for the purposes of physiotherapy care subsidised by private health insurance, the definition of an attendance or consultation need to be broadened to include synchronous audio-visual communication other than 'in-person' attendance (e.g. videoconferencing).

We are keen to see a level playing field.

We would prefer a form of consequential authorisation in which the adoption of any health technology by a private health insurer for the care of policy-holders triggers an automatic authorisation for their policy-holders to be able to claim for services provided by physiotherapists using equivalent technology. Such a consequential authorisation should include the requirement to subsidise the service at full average cost for the provider as occurs within the private health insurer.

Recommendation 12:

We recommend that the Senate Community Affairs References Committee consider requiring private health insurers to recognise, for funding purposes, that synchronous audio-visual communications where the provider and policy-holder are in different locations are equivalent to consultations in which the provider and policy-holder are collocated.

Recommendation 13:

We recommend that the Senate Community Affairs References Committee consider mechanisms that would ensure that all service providers are able to claim for services provided through any technologies used by private health insurers to provide services to policy-holders.

5.6 Service provision by private health insurers needs to occur on a level playing field

It has recently been reported that Medibank Private is expanding into the domiciliary (home) health care space through its acquisition of HealthStrong. HealthStrong describes itself as Australia's Leading Mobile Allied Health Care Services Provider.[41]

As with the provision of digitally-mediated services, we are keen to ensure that a level playing field is maintained.

Recommendation 14:

We recommend that the Senate Community Affairs References Committee consider ways in which a level playing field in the provision of health services can be assured in the context of the corporate entities of private health insurers taking roles of both insurer and service provider.

5.7 Tasks delegated to physiotherapy assistants need to be funded

We believe that it is important for the Committee to undertake a careful consideration of the role of physiotherapy assistants.

There is an emerging need for physiotherapy assistants, driven by:

- increasing demands for health services due to changing demographics of an ageing population, altered patterns of health and disease, improved technology and increased consumer expectations[42]
- decreasing or inadequate supply of some health care professionals[43], and
- the need for cost containment in health expenditure.[44]

Literature suggests that introducing physiotherapy assistants can lead to increased patient satisfaction, increased intensity of clinical care, more time for allied health practitioners to concentrate on complex tasks and improved clinical outcomes.[45]

In the hospital sector, a consequence of these pressures in our health system has been the increased utilisation of physiotherapy assistants to assist physiotherapists and other allied health practitioners by undertaking some of the duties that require less developed skills.

We see the delay in adoption of models that incorporate physiotherapy assistants as contrary to the statements of private health insurers and other stakeholders that their principal interest is on maximising value, including health outcomes. The current approach appears to focus on inputs, not outcomes.

> Jeff's story
>
> My name is Jeff. I'm 52, and still a farmer. I'd like to keep farming – my family has done it for three generations, but I have osteoarthritis of the knees.
>
> My GP can't fix it – he says I need physiotherapy. That physio will really help manage it and keep me active.
>
> Our public hospital has a long wait for physiotherapy. It is 1-2 years for category 3 patients. This means that I won't get physio in the near future. I'm just like lots of other people where I live, who can't get physio either.
>
> Before going onto the list for surgery at the local public hospital I need to have six (6) physiotherapy sessions. The hospital says that the point of that is to make sure the surgery list only has people on it who need to be on it. Medicare only covers five (5) sessions, and that's providing I don't need anything else for my health problems.
>
> So despite the need to see a physio when things get worse, surgery is looking inevitable, even though I don't want surgery.
>
> The regional area in which I live has one of the lowest socio-economic profiles in Australia. I know the local physiotherapist keeps her prices low (I looked when I went to visit my daughter), but she's got to stay in business. I won't be able to afford the gap for long.
>
> The physio's a gem. She ran group sessions for locals with knee problems but stopped when the rebate from the insurers got so low it wasn't viable.
>
> We don't seem to be able to attract more physios to the local area. I've seen our physio's ads in the regional papers. I guess she's advertised wider than that now, with no success. She can't offer high wages and still keep physio affordable, I guess.
>
> I wondered if she could have a physiotherapy assistant. That's what they have at the regional hospital. When I asked my health insurer, they said,
>
> "No. We only pay when the physiotherapist does the care."

> I don't understand that. At the hospital, the physiotherapist supervises the assistant. The assistant is trained and works on straightforward tasks. They watch the exercises until the patient can do them correctly all the time. They watch people while they are practising their walking. They encourage – that's important because I see how hard it can be and how disillusioned people can get. Otherwise, the physio would need to do it.
>
> So … My physio is between a rock and a hard place. She tries to make sure that she sees the people with the complex problems. But when she does, it means that they have to wait to see her. She is always very busy and I'm beginning to wonder if she will burn out.
>
> I want my health insurer to pay for physiotherapy, or at least a physio-assistant. I can see the knock-on effects. More of the people in my community could get the care they need. The care could be more affordable. More … I can see that the alternative for me is surgery. I don't want that if I can get physio; and, it's more expensive to everyone – the insurer, the community and the country.
>
> I don't get why they won't.

6. The role and function of medical pricing schedules, the Australian Prudential Regulation Authority, the Department of Health and the Private Health Insurance Ombudsman

The role and function of pricing schedules appears to differ based, in part, on the historical position of the medical profession. The role and function of pricing schedules needs to have an equivalent status, regardless of whether the health profession is medicine, or not.

6.1 Physiotherapy needs a consistent, and dynamic schedule of services

The Australian Physiotherapy Association has established the National Physiotherapy Service Descriptors (NPSDs). The NPSDs are our description of services provided by physiotherapists and physiotherapy services in their day-to-day practice. The purpose of the NPSDs is to provide consumers and third party insurers with a description of the services provided by physiotherapists and physiotherapy services. The NPSDs are endorsed by our Board, and thus represent the profession's view on the scope of each service type and the differentiation between service types.

On 1 April 2015, after a period of discussion with representatives of private health insurers, facilitated by PHA, a revised set of service descriptors for physiotherapy were implemented by the private health insurers.

It is important to note that this set of service descriptors did not reflect the entire of the NPSDs. It did not have a set of resource relativities incorporated (i.e. it did not describe the relative quantum of resources needed for the different services, though some are more resource intensive than others); and it did not include a set of indicative fees.

Thus, the current private health insurance industry schedule is a service schedule, rather than a pricing schedule.

Following the adoption of this schedule, we were alerted to the fact that some private health insurers did not fund a service for lymphoedema care in the community setting under general/ancillary cover while others did. We found this out only after patients insured with different private health insurers reported quite different experiences when they sought to claim rebates for the equivalent services. We discovered that one fund, at least, wanted to adopt a particular competence threshold (that of a third party, not the APA) for recognising which physiotherapists could provide this service whereas others did not.

Thus, the schedule adopted through the PHA is like a menu from which private health insurers can pick. It provides little certainty to consumers that a service described by the physiotherapy profession will be the subject of a rebate under general cover (for example).

Our discussions through PHA have strongly suggested that the private health insurers want the range of service descriptors to be constrained. We understand the need for a reasonable range of service descriptors, as too many descriptors can be confusing and add to the transaction costs in the system.

In August 2016, following advice from feedback from physiotherapists whose patients claim on private health insurance that some of the 1 April 2015 changes were working against the interests of their policy-holders, we wrote to each private health insurer asking if the insurer would adopt new service indicators for Group Consultations and Class Consultations. The responses we got generally indicated that the private health insurers would prefer for the issue to be managed through the PHA.

No resolution has been reached on the issue, despite the fact that the proposed model appears to add only one different service to that in the range used by private health insurers prior to 1 April 2015.

In contrast to the view that the industry would like a constrained range of service descriptors that would, by necessity, cover a number of clinical areas, in May 2017, following a request to the private health insurer, nib, for clarification about the coverage of a physiotherapy service called ‘bike fit’, nib advised that

> “There is no physiotherapy industry code that explicitly covers bike fit. Bike fit services have been claimed under item code 500 Assessment Consultation and nib only became aware of this after an investigation of claims that were a magnitude higher than what is to be reasonably expected for an Assessment Consultation. A bike fit service does not fall within the definition of what would be covered under Assessment Consultation (item 500).”

This suggests that at least some private health insurers want a differentiated set of service descriptors – where an assessment for one presentation (e.g. recurrent and persistent pain) is differentiated from an assessment for another presentation (e.g. pelvic floor problems).

The private health insurers have indicated that one of their challenges is the changes required in their internal business processes and information systems. It has been suggested that we need to meet a rigid timeline for the insurers’ annual cycle and even if we do, that the timing of the implementation of any changes could vary by insurer.

We appreciate that the adoption and use of service schedules for physiotherapy is best seen as a complex co-regulatory arrangement in which the physiotherapy profession needs to negotiate with private health insurance funds through PHA. We are committed to doing this.

We believe that policy-holders:

- are unaware of this ability of private health insurers to include (or exclude) particular, evidence-based physiotherapy services from general cover

- find out about the exclusions only after they have been provided the service
- cannot be expected to choose policies based on this degree of detail, especially when they may not be able to predict the particular sorts of physiotherapy services they would need.

It would be useful, however, for policy-holders to have a greater degree of certainty about the provision of rebates for services described by the physiotherapy profession as best practice. This would reduce inequitable treatment of policy-holders, some of whom (all other things being equal) would get a rebate for a service, when others would not.

Recommendation 15:

We recommend that the Senate Community Affairs References Committee consider mechanisms that would ensure that policy-holders can have confidence that a physiotherapy service described within the National Physiotherapy Service Descriptors which meets the legislated definition (currently one which is intended to manage or prevent a disease, injury or condition and is not hospital treatment) be included in the schedule of physiotherapy services fundable by each private health insurer.

7. The current government incentives for private health

We appreciate the active discussion occurring about the private health insurance rebate.

It is our view that the rebate plays a number of important roles. In the context of both the 'incremental fixes' that we support, and a more searching appraisal of the way in which the value of private health insurance can be maximised, we support the ongoing funding of this rebate by the federal government.

8. The operation of relevant legislative and regulatory instruments

8.1 The intent of the legislation with respect to supporting primary and secondary prevention must be made clear

Although section 121-10 of the Private Health Insurance Act 2007 defines general treatment as treatment that is intended to manage or *prevent* a disease, injury or condition (emphasis added), we are consistently told by private health insurers that the legislation precludes them from funding primary prevention activities nor fund services where there is the absence of an active health condition.

We repeatedly hear the notion that private health insurance is paid to treat a condition and the desired outcome from the insurer's viewpoint is discharge from care.

Discharge from care can be an appropriate outcome in many situations. However, there are a range of research studies which argue for a structured and planned 'light-touch' model, especially where there are patient-related or environmental factors likely to predict relapse.

There appears to be an important difference between the way in which the intent and text of the legislation is interpreted by private health insurers and by the physiotherapy profession. In the view of the physiotherapy profession this undermines its ability to provide high value care.

Recommendation 16:

We recommend that the Senate Community Affairs References Committee consider ways that the intent of the legislation to facilitate the provision of primary and secondary prevention physiotherapy be clarified and strengthened.

8.2 We need to explore the model of 'choose and review'

Private health insurers can set longer waiting periods for high cost general treatments to protect themselves against the 'hit and run' phenomenon.[46]

The 'hit and run' policy-holder is aware of a coming need (e.g. hip replacement or pregnancy). They take out a policy for the minimum period (usually a year under the pre-existing condition rule). They then drop the cover after making a large claim.

Protecting themselves against 'hit and run' behaviour reduces the outlays of private health insurers and reduces upward pressure on premiums.

In the context of chronic conditions, we think that it is possible that informed policy-holders may wish to *choose* to forego a degree of freedom in movement across insurers, in order to benefit from higher cost investments in their care. For example, they may choose to remain if they can access conservative treatment that reduces the risk of surgery.

This is different to the tendency of consumers to select a private health insurer and remain with their insurer on a 'set and forget' basis.[47]

The choice of 'set and review' could allow policy-holders to make different choices about higher cost consumables (e.g. the garments required for lymphoedema care) on the basis that the cost was amortised across the number of years over which they chose to remain with the insurer.

Recommendation 17:

We recommend that the Senate Community Affairs References Committee consider whether private health insurance policy-holders could be provided with the *choice* of foregoing a degree of freedom in movement across insurers in situations where private health insurers are making comparatively high investments in the policy-holders' out-of-hospital health care.

8.3 The risk equalisation arrangements need to promote improvements in the value provided

We support the intent of risk equalisation.

It has been argued that the approach to risk equalisation and its impacts on the evenness and fairness of the playing field among private health insurers is an important issue; and while there are advantages and disadvantages associated the current arrangements (and possible alternatives) there is comparatively little research or modelling that clearly enables assessments to be made of the implications of changes to the current system.[48]

As we understand the risk equalisation arrangements two risk equalisation mechanisms operate – an Age Based Pool (ABP) and a High Cost Claimants Pool (HCCP).

In the ABP, all people in any age group are considered to incur equal risk. In Ireland[49], by contrast, a policy measure standardises the health status of policy holders in a given age and gender group. This is a modification of the approach used in Australia.

The Irish approach means that people in a particular age/gender 'cell' who carry more risk (are less well) attract more 'compensation' for that risk.

Arguably, though more complex to administer, the Irish policy measure results in a more sensitive measure of risk than that which occurs in Australia where the policy does not allow for differences in policy-holder characteristics within age groups (apart from the role of the HCCP).

In Australia, should a strategy to enhance the wellbeing of older Australians be successful and reduce reliance of these policy-holders on their private health insurance, then the private health insurer would benefit. This incentive declines substantially as the population that might be targeted gets younger – reducing the incentive for measures in younger populations that might have long term health and economic benefits.

As a result, it may be preferable to offset the costs of rebates paid to policy-holders for participating in evidence-based prevention activities from the anticipated balancing transfer that a fund would make after the age-based contribution to the risk equalisation pool was calculated.

It has been suggested that the HCCP accounts for only 3% of claims equalised, and is thus much less material than the ABP.[50]

However, if a private health insurer were to reduce its own claim costs by investing in wellness programs, or substituting hospital rehabilitation with lower cost community-based rehabilitation, the lower costs would mean a lower gross deficit for the insurer and so that insurer would have to contribute more into the risk equalisation pool.[51]

We believe that this is an undesirable outcome of the risk equalisation measures. Arguably, after the impacts of the HCCP are calculated, and prior to re-distribution from the pool, the costs of evidence-based prevention measures (including conservative management of high-cost conditions likely to result in hospitalisation) could be deducted from any balancing transfer to be made to the risk equalisation pool by a private health insurer.

We consistently hear that the diffusion of incentives through the risk equalisation arrangements is a problem within the sector, leading to less innovation in service models for policy-holders.

The risk equalisation arrangements could also be amended in order to provide support for small rural and remote services that do not have a critical mass otherwise in order to maintain their ability to provide services funded under private health insurance. This sort of model already exists in the area of aged care through the Aged Care and Home Care Viability Supplements.[52]

Recommendation 18:

We recommend that the Senate Community Affairs References Committee propose a review of the risk equalisation rules with a view to making the age-based equalisation more sensitive and creating incentives for preventing hospitalisation.

9. Other related matters

9.1 Private health insurers be allowed to provide a limited range of incentives to providers

We appreciate the role of well-designed incentives for high quality health services.[53] [54] The physiotherapy profession, unlike general practice in Australia, has not been the beneficiary of substantial financial incentives to embrace electronic health records. As a result, there is a material trade-off for many physiotherapists between providing affordable and accessible services for private health insurance policy-holders and adopting digital technologies that would improve the quality and safety of care.

We appreciate that the adoption of digital health records would be in the interests of policy-holders and private health insurers. In this context, we would be concerned if constraints on incentives for the adoption of such technologies were put in place, even as a perverse outcome of other policy measures.

9.2 The intersection of private health insurance and other funding schemes needs to be considered

Although the focus of this Inquiry is on the value and affordability of private health insurance and out-of-pocket medical costs, we believe that it is important that the Committee's considerations occur in context.

Australia's health system is a complex set of structures and services, in which all levels of government are involved. Australia's health system is comprised of a number of health financing and funding arrangements in addition to private health insurance. These arrangements include those in Aboriginal and Torres Strait Islander Health, aged care, and disability (e.g. the National Disability Insurance Scheme).

We are keen for the Inquiry to take a broad approach to the issues such that the outcome minimises the chance that Australians will 'fall through the gaps' between the schemes, and that there is equity in the way Australians are treated, as a whole. The challenges are illustrated in Ernie's story.

> Ernie's story
>
> Ernie is 85 and lives in rural NSW and recently entered assisted care six months ago. When he 'retired' he was a keen bowler.
>
> Ernie has a history of Parkinson's disease, Diabetes, and low back pain. He suffered a stroke in January 2016, requires one nurse to walk with him at all times and has some short term memory problems. Ernie's problems make him a high risk for falls and potential harm from falls. If he fell he may require hospitalisation. That would increase the cost of his care to government.
>
> Despite his stroke Ernie really wants to be able to walk so that he can still visit his family and go to the bowls club with his friends.
>
> Ernie experiences low back pain each time he stands and walks a short distance. The Aged Care Funding Instrument (ACFI) gives funding to the nursing home to provide a weekly massage by the registered Nurse (RN) – a passive treatment. Massage gives Ernie short term pain relief but does treat the underlying cause of his back pain – muscle weakness and poor posture.

> The contract physiotherapist has assessed Ernie as requiring a different type of pain management that ACFI does not fund – active treatments. Ernie's pain would be best managed by improving his posture and muscle strength in his back and legs through various exercises and walking practice. This type of active treatment would also increase his balance and overall strength which are key components to reducing the risk of falls.
>
> Ernie can pay for this through his private health insurance.
>
> This exercise program which is individually designed by his physio gives Ernie a better chance of walking. It improves his circulation, reduces his risk of falling and his risk of developing a pressure sore. In turn, he has a higher quality of life.

9.3 We support a 'best practice regulation' model

We appreciate that some of the approaches we recommend be explored suggest that there is a failed market in private health care. It has been suggested that the more reliance that occurs on 'rule-following' to shore up trust, the less likely it is that trust will be based on the assumed integrity of the person or institution.[55] We appreciate that market failures, inefficiencies and inequity are primary reasons for government intervention in markets.[56]

However, it has been suggested that the more reliance that occurs on 'rule-following' to shore up trust, the less likely it is that trust will be based on the assumed integrity of the person or institution.[57] As a result, our profession pursues an active self-regulatory role. Our preference for building real trust includes a recognition of the need for a range of rules to protect people from malpractice – that there are 'no barrels without some bad apples'.

Thus, we strongly support a 'best practice regulation' model should any intervention be required. A 2014 paper from the Department of Prime Minister and Cabinet signals the intent of such a model:

> The Government has a clear approach to regulation: we will reduce the regulatory burden for individuals, businesses and community organisations. … Every policy option must be carefully assessed, its likely impact costed and a range of viable alternatives considered in a transparent and accountable way against the default position of no new regulation.[58]

Recommendation 19:

We recommend that the Senate Community Affairs References Committee consider best practice regulation models when considering how to address the structural and systemic barriers that prevent maximum value in private health insurance being captured.

10. Conclusion

The APA is committed to improving the value of the health system and to maximising the value and affordability of private health insurance.

We would welcome the opportunity to provide evidence to the Committee and to work with the Committee and other stakeholders on the reforms that emerge.

Australian Physiotherapy Association

The APA vision is that all Australians will have access to quality physiotherapy, when and where required, to optimise health and wellbeing.

The APA is the peak body representing the interests of Australian physiotherapists and their patients. It is a national organisation with state and territory branches and specialty subgroups. The APA represents more than 23,000 members who conduct more than 23 million consultations each year.

The APA corporate structure is one of a company limited by guarantee. The APA is governed by a Board of Directors elected by representatives of all stakeholder groups within the Association.

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Terms of reference and recommendations

Reference (c): Private health insurance product design including product exclusions and benefit levels, including rebate consistency and public disclosure requirements;

Recommendation 1:

We recommend that the Senate Community Affairs References Committee support the completion of the work of the Private Health Insurance Ministerial Advisory Committee on product design.

Recommendation 2:

We recommend that the Senate Community Affairs References Committee consider how constraints can be placed on the ability for private health insurers to subsidise therapies for which there is no clear evidence of clinical effectiveness.

Recommendation 3:

We recommend that the Senate Community Affairs References Committee consider ways to ensure that hospital-substitutable care is treated on an equivalent basis to the hospitalisation for which it substitutes.

Recommendation 4:

We recommend that the Senate Community Affairs References Committee explore mechanisms that would prevent a private health insurer from paying a differential rebate for the same service unless the payment is to reward reliably better value (better health and related outcomes).

Reference (d): The use and sharing of membership and related health data

Recommendation 5:

We recommend that the Senate Community Affairs References Committee consider requiring that private hospitals provide consumers with a range of information about safety, quality, and outcomes (including length of stay and costs), especially in areas of high variation in these factors across Australia, as a precursor to being funded through private health insurance.

Recommendation 6:

We recommend that the Senate Community Affairs References Committee consider ways in which private health insurers could be encouraged to report aggregate data on matters that affect the access to, safety and quality of health services in order to ensure that the public is aware of the variation and can participate in discussions about systems improvement.

Recommendation 7:

We recommend that the Senate Community Affairs References Committee consider separation between any role as a private health insurer and service provider can be ensured in order to ensure the privacy of policy-holders and providers, and a level playing field in the provider market.

Reference (g): Medical services delivery methods, including health care in homes and other models

Recommendation 8:

We recommend that the Senate Community Affairs References Committee explore mechanisms that will re-orient the private health insurance system towards a model that allocates resources to evidence-based early/conservative interventions, especially those which would reduce preventable hospitalisation and surgery.

Recommendation 9:

We recommend that, as a matter of priority, the Senate Community Affairs References Committee support the establishment of a government-facilitated industry working group on private health insurance funded rehabilitation to examine opportunities to improve the value provided in rehabilitation.

Recommendation 10:

We recommend that the Senate Community Affairs References Committee support the exploration of episode payments, including episodes which are funded separate to, but within a general cover product for the assertive management of specific conditions.

Recommendation 11:

We recommend that the Senate Community Affairs References Committee consider how the obligations under private health insurance policies could be better aligned with other schemes which provide aids.

Recommendation 12:

We recommend that the Senate Community Affairs References Committee consider requiring private health insurers to recognise, for funding purposes, that synchronous audio-visual communications where the provider and policy-holder are in different locations are equivalent to consultations in which the provider and policy-holder are collocated.

Recommendation 13:

We recommend that the Senate Community Affairs References Committee consider mechanisms that would ensure that all service providers are able to claim for services provided through any technologies used by private health insurers to provide services to policy-holders.

Recommendation 14:

We recommend that the Senate Community Affairs References Committee consider ways in which a level playing field in the provision of health services can be assured in the context of the corporate entities of private health insurers taking roles of both insurer and service provider.

Reference (h): The role and function of: (i) medical pricing schedules, including the Medicare Benefits Schedule, the Australian Medical Association fee schedule and private health insurers' fee schedules,

Recommendation 15:

We recommend that the Senate Community Affairs References Committee consider mechanisms that would ensure that policy-holders can have confidence that a physiotherapy service described within the National Physiotherapy Service Descriptors which meets the legislated definition (currently one which is intended to manage or prevent a disease, injury or condition and is not hospital treatment) be included in the schedule of physiotherapy services fundable by each private health insurer.

Reference (j): The operation of relevant legislative and regulatory instruments

Recommendation 16:

We recommend that the Senate Community Affairs References Committee consider ways that the intent of the legislation to facilitate the provision of primary and secondary prevention physiotherapy be clarified and strengthened.

Recommendation 17:

We recommend that the Senate Community Affairs References Committee consider whether private health insurance policy-holders could be provided with the *choice* of foregoing a degree of freedom in movement across insurers in situations where private health insurers are making comparatively high investments in the policy-holders' out-of-hospital health care.

Recommendation 18:

We recommend that the Senate Community Affairs References Committee propose a review of the risk equalisation rules with a view to making the age-based equalisation more sensitive and creating incentives for preventing hospitalisation.

Reference (k): Any other related matter.

Recommendation 19:

We recommend that the Senate Community Affairs References Committee consider best practice regulation models when considering how to address the structural and systemic barriers that prevent maximum value in private health insurance being captured.

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