Australian
Private Hospitals
Association

SUBMISSION NO. 24
AUTHORISED: 25-05-05

Mr James Catchpole
Secretary
House of Representatives Standing Committee on Health and Ageing
Parliament House
CANBERRA ACT 2600

Dear Mr Catchpole

On behalf of the Australian Private Hospitals Association (APHA) I have attached a submission to the House of Representatives Standing Committee on Health and Ageing's Inquiry into Health Funding.

APHA is the peak national body representing the interests of the private hospital sector, with a diverse membership that includes large and small hospitals and day surgeries, for profit and not for profit hospitals, groups as well as independent facilities, located in both metropolitan and rural areas throughout Australia. The range of facilities represented by APHA includes acute hospitals, specialist psychiatric and rehabilitation hospitals and also free-standing day hospital facilities.

Please contact me if APHA can further assist the Committee's inquiry.

Yours sincerely

Michael Roff
Executive Director
10 May 2005

Level 3, 11 National Circuit, Barton ACT 2600. PO Box 7426, Canberra BC ACT 2610. [T] 02 6273 9000 [F] 02 6273 7000 [E] info@apha.org.au [W] www.apha.org.au
ABN 82 008 623 809

SUBMISSION BY THE AUSTRALIAN PRIVATE HOSPITALS ASSOCIATION TO THE HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING'S INQUIRY INTO HEALTH FUNDING

Background

The contribution of the private hospitals sector

According to the latest data from the Australian Institute of Health and Welfare[1] and the Australian Bureau of Statistics[2]:

- There are 296 private hospitals in Australia with around 25,000 beds (approximately 32% of all hospital beds) and 248 free standing day hospital facilities
- the private hospitals sector treats almost four in every ten patients (39 per cent of all hospital separations), with 2.5 million separations in 2002-03

The private hospitals sector provides:

- 56 per cent of all surgery
- 77% of knee procedures
- 71% of Major wrist/hand/thumb procedures
- 68% of sameday mental health treatment
- 55% of hip replacements
- 52% of chemotherapy
- 46% of all cardiac valve procedures
- 42% of all coronary bypass operations

In 2002-03, private hospitals admitted 2,563,000 patients, up 37.5% on the previous four years. Public hospitals admitted 4,091,000, up 6.0% on the previous four years.

The changing role of the private hospitals sector in the provision of complex, high-end acute care was even recognised in a report prepared for Health Ministers, which noted that:

---

[1] Australian Institute of Health and Welfare, *Australian Hospital Statistics 2002-03*, AIHW 2004
[2] Australian Bureau of Statistics, *Private Hospitals 2002-03*, ABS, 2004

"Over the past twenty years, there has also been growth in the capacity of the private sector, both in offering dedicated day procedure facilities and in offering a more complex range of services. With the exception of some super speciality services (such as transplantation), some large metropolitan private hospitals now offer comparable services to the major teaching hospitals"[3] (AHCA Reference Group report)

Indeed, according to the Australian Institute of Health and Welfare[4], of the total 654 different procedures performed in Australian hospitals, private hospitals perform 647. The seven exceptions are liver transplants, multiple organ transplants, heart transplant, lung transplant, cardiothoracic/vascular procedures for neonates, severe full thickness burns, and HIV with catastrophic complicating conditions.

Myths about the private sector

The private hospitals sector often seems to be regarded as a bit like a ninth jurisdiction, which is misleading and does not take account of the diversity of services, the range of hospitals of different sizes and variety of ownership models in the sector. In particular there are a wide range of myths, misrepresentations and misunderstandings about the work of the private hospitals sector. These include:

Myth No 1: 30% rebate is poor value for money

The first myth to be challenged is that the 30% rebate on private health insurance is not good value for money. It is quite remarkable that some 6 years on, and notwithstanding the raft of data presented earlier, that publicly funded "research" continues to pretend that the rebate is "poor value" or "bad public policy".

In a report released in 2003, the Melbourne Business School's Professor Ian Harper found that:

"If private health insurance were to disappear entirely, the cost of providing public hospital treatment to all who were not prepared to pay directly for private hospital treatment (predominantly those in a financial position to self-insure) would escalate dramatically.

"For instance, in 2000-01 alone, private hospitals in Australia performed procedures which it would have cost the public hospital system around $4.3 billion to perform.

"In other words, had the private sector not carried its share of the hospital load in Australia in that year, public hospital outlays would have been around one third higher in real terms."

What this means is that far from being poor value for money, the 30% rebate has a leveraging effect, with an investment of $1.8 billion actually purchasing more than $4.3 billion worth of care.

---

[3] It should be noted that such services and facilities exist also outside the capital cities.
[4] Australian Institute of Health and Welfare, *Australian Hospital Statistics 2002-03*, AIHW 2004

Myth No. 2: Private health insurance membership is declining

The second myth under challenge is that despite the 30% rebate, membership of private health insurance is declining. Since the dramatic (50%) increase in private health insurance membership following the introduction of the 30% rebate in 1999 – taking membership from 30% to 45% of the population – private health insurance membership has proven remarkably resilient.

Today, despite four years of premium increases, private health insurance membership is at 43.0% of the population - hardly a dramatic decline. Indeed, in the December quarter 2004, the number of people insured increased by its highest level since December 2002.

Myth No 3: Costs increase only in the private sector

There is a very dishonest "debate" in Australia regarding increasing costs, with which APHA takes issue. Every year, around this time, premiums increase for private health insurance. From the chatter and headlines, one could be excused for thinking that the private sector is the only area of the health system where costs increase. The fact is that increased utilisation actually accounts for the lion's share of cost increases paid through private health insurance. For example, privately insured episodes in the private hospitals sector increased by 9.8% over the last 2 calendar years, from 1.82 million to 2 million episodes.

It should be noted that in addition to guaranteed, indexed, annual increases under the Australian Health Care Agreements, the States and Territories will jointly receive from the Australian Government an estimated extra $10 billion over the next 4 years from the GST – extra because this is over and above what the States and Territories could have expected to receive under the old (pre-1999) revenue sharing arrangements.

According to data from the Australian Institute of Health and Welfare[5] and the Federal Treasury[6], the facts are:

- In 2002-03, public hospitals received a total $15.6 billion from taxpayers (federal and State). In 2002-03, the 30% rebate delivered a total $1.8 billion from taxpayers to meet the cost of private hospital care.

- With this $15.6 billion in 2002-03, public hospitals admitted 4,091,000 patients. With $1.8 billion, private hospitals admitted 2,563,000 patients.

- State Governments received an 'extra' $380 million in 2002-03 from the Federal Government for public hospitals, and public hospitals admitted 125,000 more patients than in 2001-02. Meanwhile, private hospitals admitted 130,000 more patients in 2002-03 than 2001-02.

Taxpayers are clearly getting value and efficiency from the private sector.

---

[5] Calculated from Australian Institute of Health and Welfare, *Australian Hospital Statistics 2002-03*, AIHW 2004

[6] Department of the Treasury, *Final Budget Outcome*, various years

Myth No. 4: The private sector only does the "profitable" work, while the public sector treats the oldest and sickest patients

This myth continues to persist, despite the evidence from the Australian Institute of Health and Welfare showing that:

- Private hospitals treat 900,000 patients aged 65+ each year and growing. This age group represented 34.3% of all private hospital admissions in 2002-03, commensurate with public hospitals at 34% over the same period.

- In 1995-96, patients aged 75 years and older comprised 14.6% of total admissions in private hospitals, compared to 13.9% in public hospitals. In 2002-03, patients aged 75 years and over comprised 19.1% of total admissions in private hospitals, but only 18.3% in public hospitals.

- In 2002-03, 4.0% of total private hospital treatments were for patients aged 85 years and older. In public hospitals, 4.8% of total treatments were for this age group.

In addition, and not to imply that all veterans are older patients, but they are often very sick:

- In 2002-03 private hospitals treated 204,892 DVA patients (up 11.6% on 2001-02), while public hospitals treated 137,696 DVA patients (up 4.6% on 2001-02).

Myth No 5: Private hospitals don't provide any education and training

APHA has commissioned an independent analysis of the contribution of the private hospitals sector to the education and training of medical, nursing and allied health professionals. Preliminary results indicate that more than 7 out of 10 private hospitals provided some form of education and training in 2004. The research also found that 62 private hospitals are Approved Teaching Facilities, formally affiliated with a University. Most importantly, the research found that some $36 million worth of education and training was provided by respondents in the private hospitals sector, however, only $1.3 million of this was funded. Private health insurance company payments to private hospitals do not include a component for training our health workforce. Therefore, the majority of the training costs incurred in private hospitals must be met from operating surplus. This has been identified as a major barrier to expansion of the training role undertaken by private hospitals.

The health workforce is highly mobile across the public and private sectors. A funding model based on the trainee rather than the sector in which the training is provided is suggested as a more effective way of allocating training funds.

The private sector provides a vital role in the training of the health workforce. Without this commitment the public sector would not have the capacity to cope with the increased training requirement – a fact that receives little if any acknowledgement.

Some examples of the courses and training with which private hospitals are involved include:

✍ Medical	International Postgraduate Training Fellowship in Hand Surgery
✍ Nursing	Bachelor of Nursing Master of Nursing Health Post Graduate Certificates in Nursing Science
✍ Allied Health	Clinical Master of Psychology Master of Manipulative Therapy

Myth No. 6: All the high-tech, cutting edge work is undertaken in the public sector

Australia's private hospitals are at the cutting edge of health care, pioneering treatments and developing new surgical procedures and interventions for the benefit of patients - often for the first time anywhere in the world.

In addition, they are leaders in bringing the latest international advances and newest techniques to Australians for the first time. Some local examples include:

- ✍ The introduction of robotic surgery for radical prostatectomy and mitral valve repair procedures.
- ✍ The use of intra-aortic stents in the treatment of aortic aneurysms.
- ✍ The use of 3 dimensional cardiac electrophysiological studies for the diagnosis of cardiac arrhythmias.

Term of reference (a)

Examining the role and responsibilities of the different levels of government (including local government) for health and related services

Term of reference (b)

Simplifying funding arrangements, and better defining roles and responsibilities, between the different levels of government, with a particular emphasis on hospitals

Due to their similarities, this submission addresses these two Terms of Reference together.

There is tremendous scope for improvement in the areas encompassed by these Terms of Reference. However, it should be emphasised that a considerable obstacle to improvement is the silo-based perspective that is almost always adopted when the health system and, in particular, health funding arrangements, are examined. Even the way in which the inquiry's Terms of Reference are framed underlines the challenges facing the efficient delivery of care to ensure optimum outcomes for patients.

Three of the Inquiry's Terms of Reference address the public sector and the remaining two deal with the private sector. Examining health funding in this way, the Committee's Inquiry runs the risk of perpetuating the myth that Australia operates a dual health system, whereas the reality is that Australia has a single, balanced health care system, which in the main is publicly funded and in the main sees services delivered by the private sector (medical practitioners, hospitals and allied health professionals).

Simplifying funding arrangements, and better defining roles and responsibilities are not only about government. As can be seen from the data presented earlier in this submission, there is a vigorous and effective private hospitals sector that is providing a very wide and growing range of quality services.

The Productivity Commission recently reported that Australia faces a great many challenges in the near to medium term in the sustainable delivery of health services to an ageing population. Meeting these challenges will require a vigorous private hospitals sector that continues to complement the work of the public hospitals sector within Australia's balanced health care system. The APHA Board has identified that potential may exist for the expansion of services offered by the private hospitals sector in the future, including boosting the sector's capacity to deliver care across the continuum.

The Productivity Commission has identified jurisdictional issues as a key inefficiency in the delivery of public hospital services. It is worth noting that the private hospitals sector doesn't suffer from Federal/State jurisdictional problems and is therefore an appropriate model for consideration of options for improvements in the delivery of health care, particularly around the continuum of care.

Available data on the ageing of the population, increasing acuity of patients and lack of appropriate step down facilities in either the public or private sectors together indicate a current and future need for the private hospitals sector to give consideration to its capacity to expand further into delivery of care across the continuum.

Provided appropriate funding arrangements can be identified, future services may include, for example, the development of private step down facilities and the expansion of the current provision of private home-based care and private Emergency Departments so as to ensure the continued delivery of access and choice for privately insured consumers. Other possible options for consideration include an expansion of contracting with State and Territory governments for the treatment of public patients in private hospitals.

Term of Reference (d)

How best to ensure that a strong private health sector can be sustained into the future, based on positive relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in various levels of government; and

Term of Reference (e)

While accepting the continuation of the Commonwealth commitment to the 30 per cent and Senior's Private Health Insurance Rebates, and Lifetime Health Cover, identify innovative ways to make private health insurance a still more attractive option to Australians who can afford to take some responsibility for their own health cover.

Due to their similarities, this submission addresses these two Terms of Reference together.

In APHA's view, ensuring a strong private sector moving forward cannot and will not occur until fundamental reforms are made to the badly flawed regulatory arrangements that underpin the unfair contracting environment between private hospitals and private health insurance funds.

For the most part, private hospitals and day facilities receive the bulk of their funding via private health insurance funds under Hospital Purchaser Provider Agreements (HPPAs) which operate within a regulatory framework of the *National Health Act 1953*. It is the experience of many private hospitals and day facilities that this is a flawed framework that does not deliver a level playing field.

Medibank Private's RFP process

An excellent current example of the shortcomings of the contracting environment can be found in Medibank Private's Request for Proposal (RFP) process.

As part of this RFP process, Medibank Private has notified private hospitals that it will cut its contract base (contracts with private hospitals) by 10% in the major metropolitan markets of Sydney, Melbourne, Adelaide, Brisbane and the Gold Coast – as part of a selective tendering program which will restrict access to private hospital services.

APHA estimates up to 40 private hospitals in the specified markets could lose a contract with Medibank Private as a result of this process. This will mean Medibank customers are likely to face gap charges if they choose to seek treatment in a hospital not supported by Medibank. The effect will be to severely restrict choice and access

for Medibank members – cornerstones of health fund and Government marketing strategies.

Medibank has said that it will deliver increased volume to hospitals that gain a contract under its new tender process. However, as most major metropolitan private hospitals are already operating at full capacity, it is more likely that Medibank customers will find themselves waiting for treatment or having to pay extra to be treated in a non-contracted hospital.

In addition, Medibank has advised private hospitals that they will be financially penalised if they actually treat more patients. This is completely at odds with the aim of the Government to increase the contribution of the private sector.

There are two clear implications for patients of this process initiated by Medibank: patients will face limits on their choice of, and access to, private hospitals; and patient gap payments will be introduced for private hospital care

In addition to these problems that will be faced by patients, APHA is concerned about the tender process itself. A number of key elements are not transparent, including:

- Weighting of the criteria that will be used to assess whether a hospital is offered a contract (financial; market and services; quality and safety; compliance; and efficiency); and

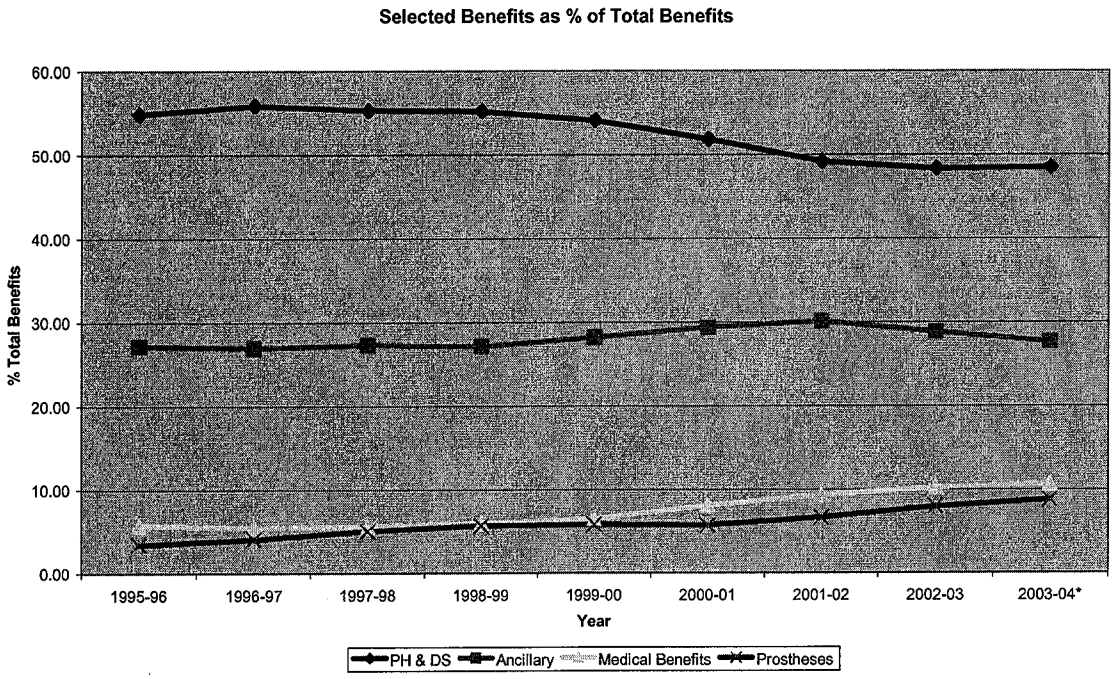
- Exactly how Medibank will compare one hospital with another

Medibank Private is owned by the Australian Government. As such, APHA has sought to work with it to help ensure Medibank does not undermine the Government's stated objectives in relation to the health system and the vital role played by the private hospitals sector.

Declining share of benefits

A further, and concerning, example of the shortcomings of the contracting environment can be found in the table[7] below which indicates the growth and decline of the proportion of benefits paid by private health insurance funds for different services under their 'hospital' tables.

[7] Calculated from Private Health Insurance Administration Council, Annual reports, various years.



More recent data[8] released by the Private Health Insurance Administration Council indicates that comparing calendar years 2004 and 2003:

- Episodes in private hospitals increased by 7.36% to 1.69 million episodes
- Benefits paid to private hospitals increased by 6.14% to $3.53 billion
- Episodes in day hospital facilities increased by 11.0% to 303,377 episodes
- Benefits paid to day hospital facilities increased by 11.63% to $160.4 million
- Benefits paid to public hospitals increased by 15.5% to $355.13 million

Capital expenditure decline

The capacity of the private hospitals sector to continue to deliver its existing level of services, let alone expand and assist the Government further, faces challenges. For example, the latest data from the Australian Bureau of Statistics[9] indicates that capital investment in the private hospitals sector fell substantially, by 35%, from 2001-02 to 2002-03. If this trend continues, the capacity of the sector to invest in new bed stock and replace equipment will obviously be severely constrained.

The reason for this concerning decline is simple: a flawed contracting environment between hospitals and private health insurance funds that continues to deliver unsustainably low rates of average benefit increases. This needs urgent attention as a prerequisite to any assessment of the capacity of the sector to continue to deliver improvements in the delivery of health care services.

---

[8] Calculated from Private Health Insurance Administration Council, Quarterly reports, 2003 and 2004
[9] Australian Bureau of Statistics, *Private Hospitals 2002-03*, ABS, 2004

Positive stakeholder interaction

However, despite the very concerning situation outlined above, private health stakeholders do work together constructively on a range of issues. Most recently a meeting was convened by APHA which also included representatives of the Australian Medical Association, Catholic Health Australia and the Australian Health Insurance Association. The group agreed on a statement for release following the meeting, which encompassed the following points:

- Doctor, hospital and health insurance representatives met informally on 17 February to consider ways to improve the value of private health in Australia. The Minister for Health and Ageing, Mr Tony Abbott addressed the meeting and encouraged the group to come forward with recommendations to improve private health.

- The meeting agreed to examine ways to improve patient services in the areas of psychiatric care, palliative care, appropriate use of office based surgery, out of hospital nursing and admission and discharge arrangements. The improvements could involve amendments to the *National Health Act 1953* and the *Health Insurance Act 1973*. It also includes the provision of step down, rehabilitation, transitional and alternative care options.

- The parties strongly support the early implementation of shared electronic systems for claiming and payment for all private inpatient medical services without exception. Such electronic systems will support high quality informed financial consent which helps patients and improve the value of private health insurance and may involve minor legislative change.

- The parties agreed to look at ways to expand Emergency Services in private hospitals and make recommendations to the Minister as necessary.

- The parties agreed to improve the way informed financial consent is achieved.

- The parties agreed to meet again soon after further joint work has been carried out to develop these broad ideas more.

Portability of private health insurance

While APHA welcomes positive interaction between stakeholders and, indeed, convened the above forum, it is concerned that the stakeholder for whom all activity and health policy development in this area is ultimately intended to benefit, the privately insured consumer, is often overlooked. There are two stark examples where the needs of privately insured consumers have been overlooked: the undermining of portability of private health insurance; and exclusions, limitations and restrictions on payment of benefits for private health insurance services.

The *National Health Act 1953,* which governs private health insurance, also provides for portability between health insurance companies for health fund members.

What this means is that once a waiting period is served with one health fund, if consumers chose to move to another health fund for the same level of cover, the waiting period does not have to be served again with the new health fund.

It has become apparent that the current portability provisions of the *National Health Act* are unclear and are therefore subject to differing legal interpretations. In a recent Discussion paper circulated to stakeholders, the Private Health Insurance Ombudsman (PHIO) acknowledged that:

"it is probable that the wording of the legislation does not prohibit the imposition of waiting periods for HPPA benefits in some transfer situations," although he does also note that *"it is my view (following appropriate research and discussions) that the intent of the drafters and the legislators was to prohibit the imposition of waiting periods in such circumstances."*

This uncertain legal situation has permitted several private health insurance funds to undermine portability for consumers.

In the most recent and concerning case, last year the Australian Government Department of Health and Ageing approved an application by the Australian Unity private health insurance fund to impose a 12 month benefit limitation period (**for psychiatric and rehabilitation benefits only**) on members of any other health fund who wish to transfer to Australian Unity, regardless of whether these members have already served a similar waiting period at another health fund.

What this means is that during this second, additional 12 month waiting period, benefits for patients who receive hospital-based mental health services will be paid by Australian Unity at only the basic default benefit.

This default benefit is basically a safety-net and is set well below the costs of providing quality private mental health services. This change has therefore placed affected patients at risk of substantial out-of-pocket costs, regardless of their level of private health cover.

This vital protection mechanism for patients receiving care and treatment for a mental illness is now gone for health fund members transferring to Australian Unity. This is unfair and discriminatory. What is even more concerning is that there is nothing to stop any other health fund from introducing a similar benefit limitation at any time.

Exclusions, Limitations and Restrictions on Benefits

Limitations on benefits can take several forms. The most obvious, and public, example is Australian Unity, with its additional 12 month Benefit Limitation Period imposed only on patients receiving psychiatric and rehabilitation services. While very concerning, this example is at least transparent and is included on the fund's website.

Other limitations on benefits are not transparent because they are included within the contracting arrangements between health funds and private hospitals. Health funds generally do not seem to alert their consumers to these limitations on the benefits paid for mental health services. Some examples include:

- Health funds are prohibited by law from excluding benefits for mental health services. However, some funds have found very creative ways around this by, for example, imposing a limitation on how many occasions a patient may receive benefits for a particular type of service in a calendar year (see ECT example below).

- Another widely used way around this ban is for health funds to pay benefits for private mental health services at only the default, safety net rate, which is set well below the cost of providing patients with the care they need. The result is patients either facing large out-of-pocket costs or seeking care in an overburdened public health system.

- In addition, a recent survey of member hospitals by the APHA Psychiatry subcommittee indicates that it is the policy of many private health insurance funds to limit in some way the benefits paid for ECT services.

- A concerning finding of the survey is that even within the one health fund, caps on ECT treatment may be imposed in some HPPAs and not others and/or are set at various levels in different HPPAs. So, regardless of the level of the contributor's cover, it may depend on where a particular patient lives or which hospital is attended, as to whether the patient requiring treatment with ECT may have a cap of 12 treatments, or 15 treatments or 18 treatments or indeed no cap at all in a 12 month period for which benefits will be paid. It is unclear whether contributors have been made aware of these caps on ECT services for which benefits are paid by some health funds.

- Health funds generally have very restricted benefits for the provision in private hospitals of high cost pharmaceuticals not available under the PBS. These pharmaceuticals include chemotherapy and high cost anti-infective agents. In addition to the limited benefits the funds do not allow hospitals to charge patients for these drugs.

- Health funds have very restrictive policies in relation to the funding of new technologies and devices which provide proven beneficial outcomes to patients. For example the funding of catheters used in electrophysiological studies of the heart for the detection and repair of cardiac arrhythmias.

A further area that has frustrated the development of positive relationships between the various parties within the private sector has been the transfer of risk from health insurers to healthcare providers. Some of the already cited examples in this section are indicative of this. Other more overt risk transfer activities include:

- The bundling of pharmacy into the overall payment system to include drugs intrinsic to the episode of hospitalisation, discharge medications, patient co-payments and the provision of drugs not intrinsic to the episode.

- Capping inpatient days and critical care days through the use of aggressive step downs in benefits or case payments. Such downward pressure on the length of

stay of patients transfers the risk of caring for the sicker patients directly to the hospital.

- The proposal by Medibank Private to establish volume thresholds with discounted benefits over that threshold (as previously discussed) transfers the risk of patients seeking care in particular hospitals from the health fund to the hospital. Hospitals then become the defacto rationers of services for the health funds.

- The collection by hospitals, rather than by the health fund, of patient contributions from those health fund members who have a front end deductible product is a direct transfer of risk to hospitals. This practice has increased hospital administrative costs and also increased the risk of bad debts for hospitals when health fund members do not pay. This risk is further exacerbated where health funds do not have 24/7 verification facilities thereby not enabling hospitals to verify patient entitlements prior to discharge following after hours or emergency admissions.

- Delaying contract negotiations well beyond the date of expiry (in some cases by 12 months or more) with no ability for retrospective payments. The result is that hospitals receive no indexation for significant cost increases beyond their control (e.g. nursing wage increases, medical supplies and technology costs and professional indemnity premiums).

What can be done?

Health funds have very wide discretion to introduce at any time benefit limitations and restrictions on benefits such as those outlined above. Many of these benefit limitations and restrictions on benefits are targeted at privately insured patients requiring treatment for mental illness.

Ideally, legislative change is required to reaffirm the rights of consumers to portability of their health insurance and to prohibit covert discrimination through the imposition of limitations and restrictions on benefits against patients seeking care and treatment for mental health services in the private sector. These two issues are examined in detail in the papers "Enshrining Portability of Private Health Insurance" and "Should Exclusionary Products be Excluded?" prepared by Access Economics for APHA in March 2005 and attached as Appendices A and B.

In advance of appropriate legislative change, immediate courses of action to overcome this discrimination against people with mental illness include:

- A public statement by the Minister for Health and Ageing that health funds may not discriminate against any class of patient, including those requiring treatment for mental illness. Note that this is already a requirement under the *National Health Act 1953* but creative ways around this requirement have been found by at least some health funds. The statement should prohibit the use of Benefit Limitation Periods and should also prohibit within HPPAs all restrictions and limitations on the payment of benefits by health funds for mental health services that are outside of clinical guidelines issued by the RANZCP.

- The Reinsurance Pool is the appropriate mechanism for spreading the claims for benefits of patients who exercise their choice of moving between health funds under the portability provisions. Where these movements occur on a large scale and/or unduly impact on an individual health fund, the reinsurance arrangements need to be modified so that the Pool can make adjustments accordingly.

- A major cause of the imposition of Benefit Limitation Periods is the very large number of different types of health fund products, many of which differ only very marginally from other products. As a way forward, all health fund hospital table products should be categorised by the industry regulator, the Private Health Insurance Administration Council, so that patients will have certainty in their movements between funds. Once implemented, this process should also be administratively simpler for health funds.

Appendices

A. Enshrining Portability of Private Health Insurance, APHA, March 2005
B. Should Exclusionary Products be Excluded?, APHA, March 2005