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Department of Health

Palliative Care & Private Health Insurance

Focus of Presentation

1. Legislation
2. Early Review of Changes
3. Trends in Palliative Care
 - Mandatory Coverage
 - Coverage by Insurers
4. MBS & Palliative Care
5. Role of PHI in Primary Care
 - Innovative Programs



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1. Legislation

Legal Framework

- The *National Health Act 1953* (Health Act)
 - Requires all hospital cover products to provide a benefit for palliative care
- *Private Health Insurance Act 2007* (the PHI Act) - Continues the coverage requirements of the Health Act.
 - Section 72-1 (2) *“The Act requires that each policy that covers hospital treatment must cover any part of hospital treatment that is psychiatric care, rehabilitation or palliative care if the treatment is provided in a hospital and no Medicare benefit is payable for that part of the treatment.”*
 - Maximum waiting period of 2 months for palliative care

Hospital Substitute Treatment

- Under the PHI Act hospital substitute treatment means general treatment that substitutes for an episode of hospital treatment
 - Allows PHI to provide out of hospital coverage for palliative care (Section 69-10 the PHI Act)
- Is any combination of services or goods intended to manage a disease, injury or condition, including but not limited to;

nursing
medical
podiatric surgical
therapeutic
pharmacological

diagnostic
surgical
prosthetic
pathology



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2. Early Review of Changes

Industry Input

- The Department hosted a **Palliative Care Roundtable** in early 2008 to assess the use of hospital substitute treatment by insurers for palliative care
- Invitees included;
 - Palliative Care Australia
 - Clinician craft groups
 - Australian Medical Association
 - Insurers
 - Provider organisations (including Catholic Health Australia)
 - Consumer group representatives

Palliative Care Roundtable

- Found:
 - Arrangements between insurers and palliative care providers were taking time to develop
 - The need to actively promote arrangements between insurers and palliative care providers
- Considered the Cabrini model, Community based palliative care service pilot (St Frances Xavier Cabrini Hospital 1997) - Noted its success
 - Established separate palliative care units that do not require hospital beds
 - Provided comprehensive support in medical, nursing, pastoral counselling, physiotherapy and dietetics services



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3. Trends in Palliative Care

Mandatory Coverage

Why Mandatory Coverage is Needed

- In 2010-11, 37.2% of patients who died as an admitted patient had been a palliative care patient during their final separation
- Palliative care is multidisciplinary - insurers have found it difficult to value services like;
 - home based care
 - equipment to enable home based care
 - nutritional support
 - pastoral care
 - complementary therapies
 - bereavement care
- Presents challenges in balancing benefits against outlays and product development

Challenges for Insurers

- Defining palliative care episodes with agreed admission and discharge criteria
- The variability in the nature and duration of treatment
- Assessing patient functionality in planning for end of life care
- Lack of private palliative care providers to improve competitive pricing arrangements for insurers
- Access to a mix of public-private palliative care services is varied and navigation can be difficult
 - Fear of cost shifting from public to private sectors

Impact on Patients

- Service providers limit expansion
 - If consumers know a service is not covered in some way under a private health insurance product they are less likely to access it
- This limits
 - competition and downward pressure on cost of services
 - access to services for patients

Benefits for Insurers

- Savings from reductions in acute care admissions
 - Cost of hospital beds
 - Overall cost of out of hospital treatment far lower than in hospital treatment
- Increased value to health insurance products
 - Persuades existing members to retain policies
 - Encourages new members to join



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3. Trends in Palliative Care

Coverage by Insurers

Trends in Palliative Care

In 2012, 30,405 patients accessed specialist palliative care services - an increase of 11.8% from 2011 (27,201)

Coverage of Palliative Care

- In 2010-11 private health insurance funded
 - 15.6% of all palliative care in public hospitals
 - 58.3% of all palliative care in private hospitals
- In 2012-13 private health insurance funded
 - 20.0% of all palliative care in public hospitals
 - 49.5% of all palliative care in private hospitals
- Increase in coverage for public hospitals but decrease in coverage for private hospitals

Commercial Arrangements

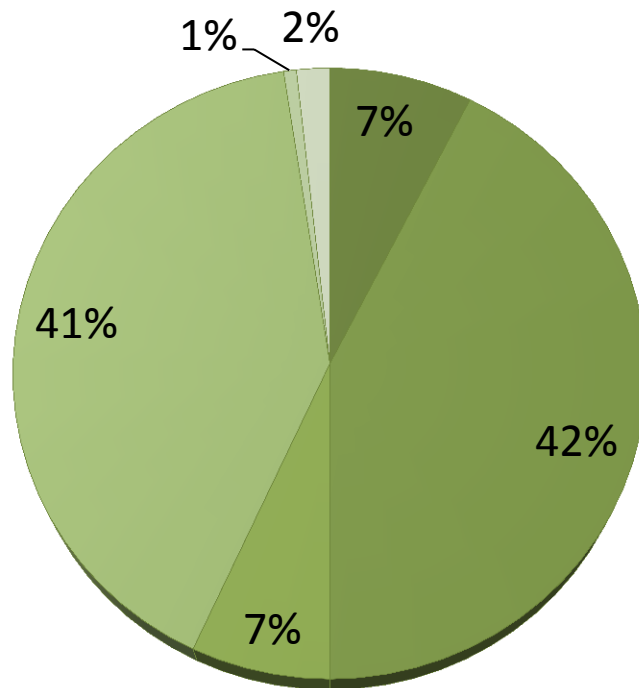
- Commercial decision for private hospitals to cover palliative care
- Better arrangements between public hospitals and palliative care providers
 - Increases the number of patients relying on the public system
- Insurers can only cover drugs not covered under the Pharmaceutical Benefits Scheme (PBS)
 - it remains a commercial decision for insurers as to what drugs are covered

Source of Funds 2012-13

- For public hospital
 - Public patients funded - 24,590 separations
 - Private health insurance funded - 6,660 separations
 - Department of Veterans' Affairs funded - 1,721 separations
- For private hospitals
 - Public patients funded - 2,250 separations
 - Private health insurance funded - 2,971 separations
 - Department of Veterans' Affairs funded - 484 separations

Cost in Admitted Hospital Treatment

Separations involving palliative care – all hospitals (2012-13)



- Medical Charges - \$3,128,005
- Hospital Charges - \$17,600,690
- Medical Benefits - \$2,851,322
- Hospital Benefits - \$16,874,962
- Medical Gap - \$276,683
- Hospital Gap - \$725,728

Source: Hospital Casemix Protocol



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4. MBS & Palliative Care

MBS and Palliative Care

- MBS coverage for palliative care patients includes;
 - rebates available for GP attendance services
 - creation of GP management plans
 - team care arrangements
 - multidisciplinary care plans
- In 2011-12, the MBS subsidised 9,600 patients receiving palliative care
 - Approximately \$3.5 million was paid in benefits
- In 2013-14, MBS expenditure on consultations and case conferencing specialist services was \$5.2 million

MBS and Palliative Care

- For consultations and case conferencing MBS rebates are provided by palliative medicine specialists
- Includes provision for home visits and the organisation of community case conferencing and discharge case conferencing
- Specialist palliative medicine physicians made up nearly 4 in every 1,000 (0.38%) employed medical specialists in Australia, with an estimated 92 working in Australia in 2011

Medical Services Advisory Committee (MSAC)

- In April 2014, MSAC considered an application to expand palliative medicine specialist services on the MBS
- MSAC referred the matter to the Department for further consideration due to lack of evidence
- The Australian and New Zealand Society of Palliative Medicine are aware of this outcome



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5. Role of PHI in Primary Care

The Department's Role

- To encourage commercial arrangements and facilitate discussions between key stakeholders where required
- To remove barriers to these arrangements
 - E.g. Introducing broader health cover services
 - Need for industry input

PHI Role in Primary Care

- Health reform agenda
 - Reducing barriers to competition and unnecessary regulation
- PHI expansion in to primary care
- Medibank/Independent Practitioner Network (IPN) North Brisbane
 - 24-hour appointment guarantee
 - Streamlined access to after-hours GP service
 - No out-of-pocket costs



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5. Role of PHI in Primary Care

Innovative Programs

Medicare Locals

- Intended to provide improved care coordination, case management and reducing avoidable hospitalisation (National Primary Health Care Strategic Framework 2013)
- Scope for Medicare Locals to facilitate connections between insurers and (palliative) care service providers
- Medicare Locals offer established connections for the provision of multidisciplinary services

North Sydney Medicare Local (NSML)

- Looking at models around hospital in the home services for end of life care
- Acute care nurses are not specifically trained for palliative care
 - Palliative care providers better suited for provision of care
- Care coordinator working with GPs and service providers
 - Assessing medical requirements, capacity for family support and social needs
- Insurer coverage through broader health cover arrangements
 - E.g. Certain non medical care services a point of contention

Aged Care Transition & Hospice NSML Models

- 54,466 palliative care related separations in all hospitals
 - Patients aged 75 years and over accounting for nearly half (49.5%) of these separations (2010-11)
- Numerous studies suggest out of hospital care is less expensive for insurers and patients
- Working with GPs to formulate a care plan including pain management, home health aids, safety assessments and pastoral care
 - Reduces multiple admissions to hospitals

Aged Care Transition & Hospice NSML Models

- Limits to what services fall under broader health cover
 - More work needed to understand what services are covered
- Relationships with hospitals need to be improved to foster access to the wide range of services on offer
 - Medicare Locals act as a single point of contact
- Insurers need to see value in this relationship
 - lower hospital costs for them and patients

Questions