28 January 2022

The Hon Michael Sukkar MP
Assistant Treasurer
House of Representatives
CANBERRA ACT 2600

Pre-Budget Submission 2022–23

Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services accounting for around 15 per cent of hospital-based healthcare in Australia. Our members provide around 30 per cent of private hospital care, 5 per cent of public hospital care, 12 per cent of aged care facilities, and 20 per cent of home care and support for the elderly. CHA not-for-profit providers promote the ministry of health care as an integral element of the mission and work to fully provide health care to the sick, the aged and the dying. This ministry is founded on the dignity of the human person, giving preference to the needy, suffering and disadvantaged.

CHA welcomes the opportunity to make a submission concerning priorities for the 2022–23 Budget. As with our 2021–22 pre-budget submission, this submission is made in the context of private healthcare reforms that are already underway as well as the ongoing impacts of the COVID-19 outbreak.

Critically, the ongoing negotiations around the implementation of Prostheses List (PL) reform in the 2021–22 Federal Budget must result in a solution that avoids the arbitrary removal of items from the PL without a **credible** and **mandatory** alternative benefit payment from insurers. Without this, it is inevitable that private hospitals will be faced with reduced clinician and patient choice, reduced and in some instances shuttered services.

The 2022–23 Federal Budget is an opportunity to demonstrate Australia's commitment to universal, high-quality palliative care. This is of particular importance given it is our community's most vulnerable people who are at risk of receiving lower standards of health, aged and palliative care. This includes those without the financial means, health literacy or advocates to help them access and navigate our country's complex care systems.

CHA is engaging with the Department of Health's study to explore the current landscape of risk equalisation in the private health insurance industry, and incentives for private health insurance uptake. It is important that as reforms are considered, the government is cognisant of the affordability and equitability of private health insurance of those already disadvantaged Australians who have faced the brunt of the impact of the COVID-19 pandemic, including young Australians and minority groups.

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More broadly, these same groups now require a significant investment in their health and wellbeing. Young people, women and socioeconomically disadvantaged Australians have borne the brunt of the COVID-19 pandemic's impacts. This has included the mental health burden of public health orders, near-term financial insecurity brought about by job losses and long-term financial insecurity resulting from lost career opportunities and superannuation.

Key budget recommendations:

The following recommendations are provided as CHA's priority recommendations, extracted from the complete submission which follows:

1. Implement public sector reference pricing for the Prostheses List (PL), particularly the General Miscellaneous category. No item should be removed from the PL without a rigorous clinical review determining that the item is no longer useful in clinical practice.

2. Ensure any alternative to the PL, including bundles, represent a mandatory minimum payment by insurers.

3. The Commonwealth Government should play a leading role in ensuring consistent high quality palliative care is available across Australian jurisdictions, including by establishing a common definition of and minimum standards for acceptable palliative care.

4. Require take up of a Bronze-tier private health insurance product in order to avoid incurring the Medicare Levy Surcharge.

5. Mandate out-of-hospital digital mental health care for all PHI tiers and abolish waiting periods for mental health services.

6. Mandate out-of-hospital cover as an inclusion in all Bronze, Silver and Gold private health insurance products, providing hospital-equivalent services in out-of-hospital locations.

Implementing sensible prostheses reform

The 2021–22 Federal Budget included a provision to "modernise and improve the administration of the Prostheses List". In practice, this has resulted in short-sighted reform focused on the removal of items from the PL to ease the Department's administrative burden without regard to the significant reduction in services and out of pocket expenses such an approach will impose on consumers. In some instances, the expense incurred by private hospitals may threaten their viability. This runs counter to the intent of the reform, which is to achieve savings for private health consumers without limiting their care options or quality.

CHA recognises that the PL is not working as originally intended and that reform is needed. However, this reform should focus on providing value to consumers through the promotion of affordable procedure prices, clinician and patient choice.

Central to CHA's proposal is the significant savings that can be achieved through reference pricing. Key stakeholders including the Australian Medical Association, private health insurers, the Australian Private Hospitals Association and the Medical Technology Association of Australia have expressed support for a reference pricing approach. CHA is supportive of the Independent Hospital Pricing Authority (IHPA) developing and overseeing a reference price list, using whatever domestic or international reference prices may be available.

CHA notes that for the broader PL, the Government is pursuing a reference pricing model that closes the gap between private prices and the to-be-developed reference price by 40% in the first year (commencing in the 2022–23 financial year), and a further 20% in each of two subsequent years. CHA is supportive of this approach in principle.

For the General Miscellaneous (GM) category, CHA notes that reference prices are likely to vary significantly by product. In financial year 2019–20 the GM category attracted benefits of approximately $250 million. Estimates for cost savings from this category alone in introducing reference pricing range from $60-100 million annually.

CHA proposes that:

- Reference pricing be introduced across the GM category, using the most affordable prices IHPA is able to identify as a baseline. This should occur as soon as feasible.

- Any gap between the identified baseline and the prices paid by insurers in the private hospital system should be minimised. CHA acknowledges in some instances private prices may be set slightly higher due to factors including Australia's relatively low volume compared to some other markets.

- Maintain these items on the GM category of the PL at their reduced prices to ensure clinicians are able to continue to provide the highest possible care.

This approach will deliver the fastest, largest savings to health insurers and consumers in a way that maintains services, clinician and patient choice, and quality of care.

CHA notes proposals for bundling of GM items. CHA has expressed support for IHPA developing a series of bundles for GM items. However, by definition, bundles will limit patient and clinician choice, increase system complexity and threaten the delivery of some valuable but high-cost services. Additionally, bundles will provide extremely limited scope for savings once reference pricing is in place, for three reasons:

- Hospitals are already incentivised to use GM items efficiently, given the costs of stocking and dispensing these items.

- Items that are opened but not used are not billed to an insurer, those costs are incurred by the hospital.

- Anecdotally, doctors in private hospitals have not widely understood that some GM items are listed on the PL and can be claimed. Private hospitals would catalogue the use of these items and ensure they are captured in the development of bundles.

Any small savings from a bundling model beyond reference pricing will need to be weighed against the significant drawbacks, including the risk of reduced services and clinician choice. It is imperative that bundles developed by IHPA and implemented as part of PL reform are mandatory for insurers to pay.

Most importantly, bundles developed in place of GM items must be a mandatory minimum benefit paid by a patient's insurer. Without this assurance, the viability of services will be threatened, and out of pocket costs for patients will skyrocket.

Providing for consistent palliative care across Australia

Catholic services are collectively the most significant providers of palliative care in the private health system. We support the highest standards for aged care and palliative care. It is at the core of human dignity to value the lives of all people, including those at the end of their lives. We are concerned by the propagation of laws that support and legislate the notion that a human being's life is no longer of value. This is particularly dangerous given that it is our community's most vulnerable people who are at risk of receiving lower standards of health, aged and palliative care. This includes those without the financial means, health literacy or advocates to help them access and navigate our country's complex care systems.

There is an urgent need for a clearer definition of palliative care, and a dedicated commitment to ensuring uniformly high funding, standards and availability for these services in both the private and public health and aged care systems. Provision of high quality, timely and equitable end-of-life care must be the starting point for any effort to improve the final stages of people's lives.

One of the key findings from recent Catholic advocacy is the profound lack of understanding among legislators of the benefits of palliative care, and advances in effective pain mitigation techniques. The Commonwealth Government should play a leading role in ensuring consistent high quality palliative care is available across Australian jurisdictions, to ensure no Australian is left to choose assisted suicide because high quality palliative care was not made available to them.

CHA notes Palliative Care Australia's recent election statement. We specifically draw the Commonwealth Government's attention to the following, promising proposals:

- $2.5 million over two years to develop a national palliative care workforce plan with all sector stakeholders:
    - Both the health and aged care sectors are facing challenges in addressing their skills shortage. Work is needed to understand how the workforce shortages being faced across all care sectors will specifically impact the provision of high quality palliative care in all settings.
- $8.7 million over 18 months for a project to trial palliative care registered nurses in residential aged care facilities (100 full time equivalent palliative care nurses):
    - This important initiative will enable the study of a potentially viable option for improving palliative care in residential aged care facilities, which the Commonwealth Government is responsible for regulating.

Improving the value and affordability of private health insurance

CHA understands the Department of Health is conducting a study in to whether the current risk equalisation settings and the Medicare Levy Surcharge (MLS) are fit for purpose. CHA welcomes this work, noting that affordable, high-value health insurance is a key driver of sustainable growth of the private health sector. That said, any adjustments to risk equalisation settings and the MLS need to be considered as part of a broader package of reforms. Consideration should be given to ensuring that all policies offer meaningful benefit to consumers, and that any punitive incentives do not disproportionately discriminate against vulnerable groups.

In the most recent quarter for which private health insurance coverage statistics are available (September 2021), 44.7% of Australian's held hospital cover.[1] This means that more than 55% of Australians are entirely reliant on the public hospital system for all their hospital care needs – including for care types more efficiently delivered by the private hospital system.

CHA has outlined effective improvements that could be made to improve the affordability of high-quality health insurance products below:

Removing the 'Basic' product tier as a means to avoid the MLS

In order to avoid the MLS, younger people and some wealthy Australians who prefer to self-fund their private health care are choosing low value private health insurance (PHI) polices that offer minimal access to private health care and are rarely used. Known as 'Basic' tier health insurance, these products generally offer the option to be a private patient in a public hospital, while remaining susceptible to public sector waiting times. They exist solely to provide an option for the avoidance of the MLS – meaning that the Commonwealth

[1] https://www.apra.gov.au/quarterly-private-health-insurance-statistics

Government is subsidising insurance products that are essentially and deliberately worthless. Choice consumer group had this to say on Basic tier products:

Since you'll very rarely be able to use Basic policies (and they're overpriced for what you get in health cover) they're what's known as junk insurance.[2]

Evidence suggests that between 2015 and 2020, the number of consumers opting for these 'junk' policies increased significantly. It is unknown how many of these Australians are aware that their policy offers them virtually no private health care to speak of. Further, as the only 'benefit' these policies tend to offer is shared accommodation as a private patient in a public hospital, they increase the risk of public hospitals 'revenue-chasing' – that is, offering patients the option to be private patients where there is no real benefit (or via an excess, higher costs) to do so. This increases the Commonwealth Government's contribution to public hospitals artificially via the private health insurance rebate.

Removing the basic product tier would result in one of two outcomes for Australians with 'junk' policies:

- Some of these (single) Australians with a taxable income of greater than $90k per year would opt for Bronze insurance, putting more private money into products that actually offer some value to the patient and relieve pressure on the public system.

- The remainder of this cohort would opt to pay the MLS, providing more funding to enhance Medicare.

As the Medicare Levy Surcharge is not applicable to single Australians or families earning less than $90k and $180k respectively, this reform would capture more funding for both the private and public hospital systems, improve the quality of care offered to private patients, and have no negative impact on Australians in lower socio-economic brackets.

Improving the value of private health insurance for young Australians – mental health care

Private health insurance coverage among young Australians is dire, as low as 22% in recent years for those aged 20-29. That percentage is all the more severe when one considers that many of those young Australians hold 'junk' Basic tier policies. This is an immense challenge for the private hospital system, but also for the public hospital system and Medicare, which are entirely relied upon to fund the health needs of young Australians without health cover. Further, the risk pool is concentrated on older, less healthy adults, who are more likely to use their PHI to access health care. This drives up the cost of PHI, making it less affordable for younger people and reducing the likelihood that they will take it up in future. This is a vicious cycle.

[2] https://www.choice.com.au/money/insurance/health/articles/basic-health-insurance-policies-rip-off

The key to improving uptake of PHI among young people is improving the perceived and actual value of healthcare offered under the cheapest available policies. It is unfortunate that a growing number of young people do not see value in PHI, even those who can afford it.

One key area of concern for young people is access to quality, affordable mental health care. The leading causes of illness for younger Australians are anxiety disorders, depressive disorders, suicide and self-harm, alcohol misuse, and poisoning - all amenable to treatment through better access to mental health care services.

Australia's population faces a significant mental health burden with around one in five Australians experiencing a mental health illness in any given year. Broadly, this includes 2.3 million Australians with mild mental illness, 1.2 million with moderate illness and 800,000 Australians that will experience a severe episodic or persistent mental illness[3]. Half of all adults will have a mental illness in their lives. The highest prevalence of mental illness is in Australians aged 16 to 25.

Aside from the obvious health impacts that include high rates of suicide, shortened life expectancy and depression/anxiety, there are direct and indirect economic costs in the hundreds of billions of dollars resulting from care expenditure, work absenteeism, the cost of family/friend provided care and other productivity loses.

The Commonwealth Government notes in its National Mental Health and Suicide Prevention Plan that it continues to consult on reforms to expand home and community based mental health services funded by private health insurers[4]. This is broadly, in keeping with the Productivity Commission's 23rd recommendation relating to funding arrangements.[5]

To improve the availability of meaningful mental health care and uptake of PHI among young Australians, the Commonwealth Government must:

- Mandate coverage of community based private mental health care within all PHI hospital policies. The minimum requirement would be a specified period of follow up, post-discharge or community care linked to an episode of hospital admission and could include day stay or hospital substitution services.

- Mandate inclusion of coverage for accredited, online mental health care in all PHI product tiers for people 30 years old or younger. This would include:

[3] https://www.pc.gov.au/news-media/speeches/mental-health
[4] https://www.health.gov.au/sites/default/files/documents/2021/05/the-australian-government-s-national-mental-health-and-suicide-prevention-plan-national-mental-health-and-suicide-prevention-plan.pdf
[5] https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume1.pdf pg 82

- 24/7 phone or online mental health crisis support
- Next day follow-up service from an accredited mental health service provider

- Removal of waiting periods for people aged under 30 to receive mental health care in all product tiers.

The benefits of these adjustments to product tiers would be profound, both in terms of outcomes for young people, and the appeal of PHI. Mandating mental health inclusions for young Australians will lead to:

- A more consistent private funding stream for mental health care which will result in the expansion of access to critical mental health services and support in the community.
- Improved retention of existing PHI customers, alongside increased uptake of PHI by currently uninsured and under-insured young people.
- Reduced likelihood of devastating and expensive unplanned hospital admissions and improved maintenance of good mental health.
- Reduced pressure on the public health system, which is already burdened by the majority of acute, emergency mental health care.[6]

Some Catholic hospitals are already offering high quality digital mental health services. These types of service are among those that would flourish given the consistency of funding provided by inclusion in all PHI product tiers.

Improving affordable, out-of-hospital care

Increasingly treatment and care which historically required the patient to have an extended overnight stay in hospital, can now be delivered through some form of out of hospital care. This is advantageous for a range of reasons, including:

- Reduced risks to patients associated with in-hospital care (iatrogenic illness).
- Lower costs of service delivery.
- Generally higher consumer satisfaction.

6 https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Former_Committees/mentalhealth/report/c12

In Australia, these improvements have been driven primarily by the public hospital sector and are increasingly baked into the public hospital funding model (for example, through price harmonisation under the National Health Reform Agreement). In contrast, current policy and regulatory settings for PHI have not kept pace with changing service models and are heavily skewed towards reimbursing established inpatient service delivery. Private health insurers are permitted to offer hospital substitute care including out of hospital care but are not required to do so. While some insurers have taken initiative in working with hospitals to develop out of hospital care models, service delivery is primarily designed around well-established reimbursement mechanisms. Where an insurer does offer out of hospital care, it is often restricted to providers with whom that insurer holds contracts, restricting consumer and clinician choice. The result of this is that some highly skilled out of hospital providers are shut out of the market, and the payer, rather than the treating doctor and their patients, call the shots.

Consumers need better, faster access to innovative out of hospital providers and the benefits they offer. This should be delivered by:

- Requiring all private health insurance product tiers to offer out of hospital care as part of their mandatory service offerings, with the range of clinical categories available to be varied across the tiers.

- Ensuring all qualified and accredited out of hospital care providers are able to provide services to any insured clients covered by their PHI policy for out of hospital care that is recommended by their treating doctor, irrespective of whether the out of hospital care provider has a contract in place with their PHI or not.

- Putting in place default benefit arrangements to ensure that consumers are not disadvantaged by their location (where choice of provider may be very limited) or the choice of provider as recommended by their treating doctor (where the provider may not have a precontract in place with their PHI).

Making these policy changes will lead to:

- Increased uptake of private out of hospital care for consumers with PHI.

- New Incentives for private health providers to provide innovative out of hospital care models.

- Reduced clinical risk and greater satisfaction for consumers.

- Reduced pressure on premiums through lower overall costs of care due to better quality, post-acute and sub-acute care being made available in the private sector.

- Better value, more comprehensive PHI products should improve membership retention and attraction.

As Australia's largest non-government provider grouping of health and aged care services, providing care to all those who seek it in fulfilment of the Catholic Church's mission, Catholic Health Australia and Catholic service providers have a vital interest in policies aimed at ensuring the sustainable provision of quality health and aged care services.

Thank you for considering our submission. If you or your staff wish to discuss matters we have raised, please contact our Health Policy Manager Alex Lynch, at alexl@cha.org.au or 0411 841 071.

I am copying this letter to the Minister for Health.

Yours sincerely,

Pat Garcia
Chief Executive Officer
Catholic Health Australia

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