Australian
Private Hospitals
Association

APHA Budget Submission 2022-23

JANUARY 2022

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Key budget measures in this submission

THE HEALTH WORKFORCE

1. **Reform skilled migration regulations** to reduce the cost and complexity involved in recruiting experienced clinicians to positions Australian graduates cannot fill:
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    - Restore pathways to permanent residency for highly skilled employees.
    - Align government investment, including investments through the Skilling Australians Fund to reduce Australia's reliance on skilled migration.
2. **Bring forward national commitments to workforce planning** and **include a rapid assessment of the impact of COVID-19 taking account of local and global factors.**
3. **Identify and implement strategies to address urgent workforce shortages:**
    - Fast track pathways to graduation and registration for students/early career professionals whose training has been interrupted by COVID-19.
    - Fund expanded training opportunities including training opportunities in the private sector
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THE VALUE OF PRIVATE HEALTH

4. **Continue work on the reform of the Prostheses List** including implementation of reference pricing across the list as a whole and development of mandatory minimum bundled benefits to ensure funding of items and categories removed from the PL as a result of the reform process from 1 July 2023.
5. **Introduce a default benefit that supports ambulatory care in mental health and rehabilitation.**

HEALTH SECTOR RESILIENCE

6. **Introduce a mechanism to recognise the ongoing increase in private hospital operational costs due to pandemic related factors**
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    - Improve management and coordination of the National Medical Stockpile to ensure that essential supplies are secured, managed and distributed to support system-wide responses and protect consumers are protected from sudden demand side pressures
    - Continue support for domestic manufacture of essential medical supplies.
8. **Retain temporary MBS COVID-19 telehealth items on a permanent basis** so that they can be available for immediate access in any future pandemic outbreaks where public health measures are invoked that prevent clinicians from personally attending on a patient in a private hospital.
9. **Provide funding and financial incentives for the improvement of information technology compliance and digital health capacity building** recognising the role of digital technologies in a fully integrated and responsive health system and role of both public and private sectors in providing critical infrastructure.

Private health – the essentials

The private hospital sector provides around 40 percent of all hospital admissions. Since the start of 2020, the industry has demonstrated its integral role within the health sector as a whole in addressing both the immediate and longer-term consequences of the COVID-19 pandemic.

The outlook ahead for 2022-23 remains dominated by continuing health and economic impacts of the pandemic within Australia and internationally. This challenge on top of the underlying issues facing the Australian health sector will mean that private hospitals remain crucially important in providing timely access to health services for all Australians. In this context, APHA proposes that there are three crucial priorities for the 2022-23 Federal Budget:

- Skill shortages in the health workforce need to be urgently recognised and addressed.
- Consumers and taxpayers need to be assured of the value of private health.
- The resilience of the health sector to future shocks must be ensured by action on key learnings out of the COVID-19 pandemic.

THE HEALTH WORKFORCE

As we enter a new phase in Australia's response to the COVID-19 pandemic, the health workforce remains crucial in protecting Australians against the longer-term consequences of the pandemic and addressing a significant backlog in demand for treatment. At the same time the impact on this workforce and skill shortages demand attention.

The proportion of businesses reporting vacancies in the "health care and social assistance" industry increased from 8.2 per cent to 26.7 per cent between February 2020 and November 2021.[1] The top two reasons for those vacancies were replacement of staff due to resignations and increased workload.

The private hospital sector employs 140,000 people[2]. From the outset of the COVID-19 pandemic, the private hospital sector proved itself ready, willing and able to partner with the Commonwealth and with states and territories in meeting unprecedented challenges. The sector's clinical workforce has been at the heart of this effort.

Private hospital sector staff and expertise proved essential to the COVID-19 response on multiple levels:

- Long-term secondment of staff to contact-tracing teams and other non-clinical roles,
- Provision of training to aged care providers in the use of PPE and infection control and specialised training in COVID-safe practices
- Supporting services in the aged care, drug and alcohol and disability sectors with expertise in planning and training and the delivery of services in high-risk environments.
- The private hospital sector also made staff available as part of the whole of sector response to the high levels of community transmission and the need to backfill vacancies as the number of cases and requirements for isolation increased within the health and aged-care workforces.

[1] ABS, Job Vacancies Australia, January 2022 https://www.abs.gov.au/statistics/labour/employment-and-unemployment/job-vacancies-australia/latest-release

[2] People employed as at the end of June ABS, Australian Industry, 2019-20.

- Private hospital sector staff were deployed in teams to address COVID-19 outbreaks in aged care services by providing in-reach services and to receive transfers of aged-care residents and COVID patients.
- Private hospitals beds and staff were placed at the disposal of the public sector to receive surgical, medical and mental health patients.
- Where the number of COVID-positive hospital admissions surges, private hospitals treated both COVID-positive and non-COVID patients.

These contributions are ongoing in the majority of Australian states.

Even though the Australian Government took prompt action at the start of the pandemic to increase the workforce capacity of the health sector, skill shortages that existed before the pandemic have now become acute as:

- Clinical staff, many exhausted from the efforts of the last two years, elect to reduce hours or in some instances leave their profession.
- Skilled migration levels remain suppressed with the provision of temporary skilled migration visas to nurses in 2020-21 standing at only 6,810, 20 percent less than for 2018-19[3].
- Graduate numbers are down: 15,000 midwives and nurses graduated in 2020[4] compared with 17,178 in 2019.

At the same time, the demand for health care workers is greater than ever. Some of the increased demand is directly related to the COVID-19 pandemic. This demand will remain in the immediate term and may be required again if future waves of infection occur. Other sources of increased demand include permanent changes to clinical practice as a result of the pandemic and pent-up demand for services deferred during the last two years. The health care sector also faces increased competition for skilled staff from the aged care sector (due to regulatory changes) and the disability sector (in the wake of expansion in the National Disability Insurance Scheme (NDIS)).

APHA advocates three immediate responses:

- **Skilled migration regulations need to be reformed** to reduce the cost and complexity involved in recruiting experienced clinicians to positions Australian graduates cannot fill:
    - A 12-month moratorium on charges to employers for health care related skilled migration.
    - Pathways to permanent residency for highly skilled employees should be restored.
    - Government investment, including investments through the Skilling Australians Fund[5], in training and workforce development needs to align with skill shortages.

- **National commitments to workforce planning need to be brought forward** to include a rapid assessment of the impact of COVID-19 taking account of local and global factors.

- **Strategies to address urgent workforce shortages need to be identified and funded** including:

[3] https://data. gov. au/dataset/ds-dga-2515b21d-0dba-4810-afd4-ac8dd92e873e/details?q=
[4] Minister Greg Hunt quoted the number of graduates in 2021 in a media statement on
[5] https://www.dese.gov.au/skilling-australians-fund/resources/skilling-australians-fund-factsheet

- Fast track pathways to graduation and registration for students/early career professionals whose training has been interrupted by COVID-19.
- Funding for expanded training opportunities including training opportunities in the private sector.
- Development and implementation of training pathways for people seeking to re-enter the health workforce or re-skill from other occupations.

THE VALUE OF PRIVATE HEALTH

In December 2021, the Federal Government delivered the lowest average premium increase for private health insurance in twenty years. Lower than usual levels in benefit outlays have also led to private health insurers being placed under an obligation to ensure that any 'windfall' profits arising from the COVID-19 pandemic are returned to consumers.

At the same time work must continue to deliver value to consumers of private health insurance in both the immediate and longer term by:

- **Continued work on the reform of the Prostheses List** (PL) including the implementation of reference pricing across the list as a whole and development of mandatory minimum bundled benefits to ensure funding of items and categories removed from the PL as a result of the reform process from 1 July 2023.
- **Introduction of default benefits that support ambulatory care in mental health and rehabilitation.**

HEALTH SECTOR RESILIENCE

As already discussed the health sector's resilience has been significantly tested over the last two years and it remains under pressure. The close collaboration of both public and private sectors remains crucial in meeting both the immediate and longer-term impact of the pandemic. In light of this challenge APHA has identified four key priorities:

- **Introduce a mechanism to recognise the ongoing increase in private hospital operational costs due to pandemic related factors.**
- **Consolidation of coordinated guidelines and learnings from the pandemic.**
- **Retention of temporary MBS COVID-19 telehealth** items to ensure continuity of care where clinicians are prevented from personally attending on a patient in a private hospital due to public health measures.
- **Funding and financial incentives for the improvement of information technology compliance and digital health capacity building.**

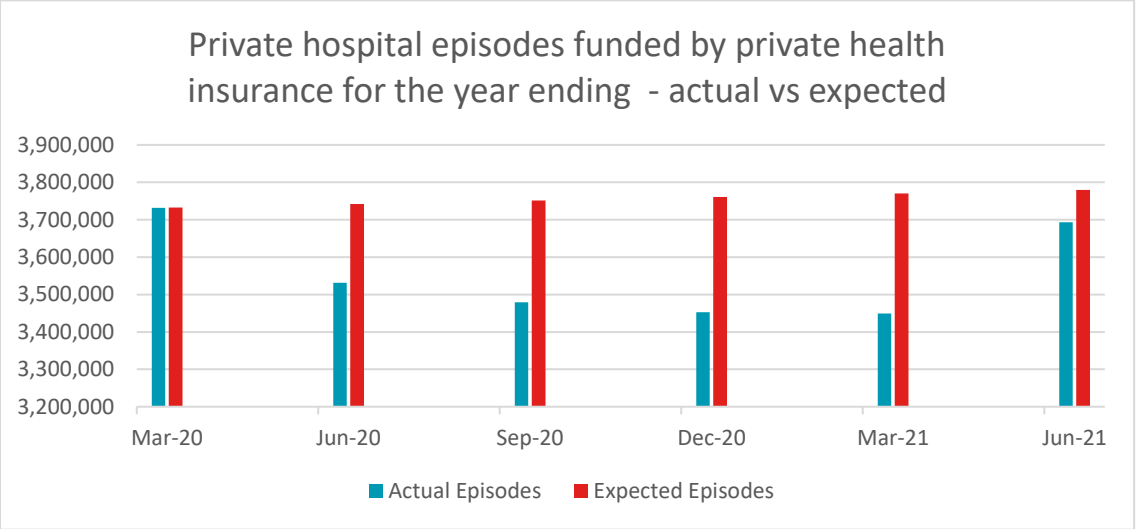
These measures will not only support the immediate COVID response, they will also strengthen the resilience of the health sector overall, support the intent of the recently passed *Security Legislation Amendment (Critical Infrastructure) Bill 2021* and position the sector as a whole to meet systemic threats.

The impact of COVID-19 on the Private Hospital Sector

In 2020, the sector was directly impacted by the COVID-19 pandemic as the Federal Government imposed restrictions on elective surgery and consumers deferred non-emergency services. Impacts have continued through 2021 and into 2022. Even where there have been no formal restrictions imposed by states and territories on elective surgery, service levels have been suppressed due to:

- Consumers choosing to defer seeking treatment.
- Shortages in personal protective equipment and other supplies.
- Difficulties accessing COVID testing options for both staff and patients.
- Changes in clinical practice and use of facilities as a result of COVID safety requirements.

The impact of these factors is evident in the data reported by the Australian Prudential Reporting Authority (APRA) which shows that activity has remained below expected levels. It should also be noted that the chart below takes no account of the additional activity that will be required to address deferred demand for hospital services. APHA estimates that as at 30 June 2021, the pandemic has resulted in private hospitals treating 290,000 fewer privately insured patients (cumulative) than would ordinarily have been expected.



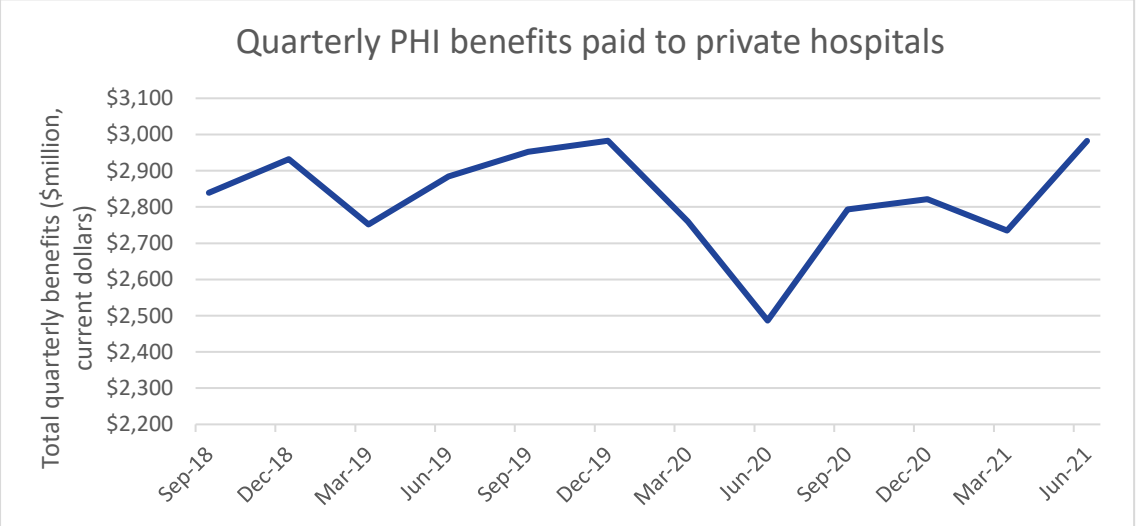
Source: APRA

Private hospital operators have responded repeatedly to requests to rapidly divert resources in readiness for forecast scenarios of the pandemic impact and in response to changing clinical priorities and these demands have continued into 2022.

In ordinary circumstances, the sector has a turnover of $19 billion[6] and operates with an overall profit margin of just 4.5 percent[7]. As admissions were cut either as a result of government decisions to restrict elective surgery or as a result of changes to operational procedures and consumer behaviour, revenues were directly impacted.

Although the Federal Government moved swiftly in 2020 to put in place measures to support the financial viability of the private hospital sector and ensure its ability to participate in the pandemic response, operators have held beds and staff on standby at their own cost and returned government viability payments to offset any profits from ordinary activities within the same quarter. Until late in 2021, these offsets were calculated at operator level (as opposed to individual hospital level) meaning that operators of multiple hospitals were substantially cross-subsidising their contribution to the COVID response from their own earnings.

In 2019-20 total revenues (all sources) in the private hospital sector declined in real terms by 3.4 percent when compared with 2018-19. Although the contribution of the Australian Government increased in real terms by 14.5 percent, state/territory government contributions declined by 1.6 percent and non-government contributions declined by 9.2 percent[8]. Although health expenditure data for 2020-21 is not yet available, data reported by APRA shows a second year of low revenues from the sector's primary revenue source, private health insurance (PHI)[9]. Note that in the second half of 2021 "second wave" outbreaks in NSW and Victoria saw the imposition of significant surgery restrictions in the two most populous states which should be expected to result in reductions in benefits paid when subsequent quarterly data is released.



Source: APRA.

[6] Sales and service income for 2019-20, ABS, Australian Industry, 2019-20.
[7] Ratio of operating profit before tax to Sales and service income for 2019-20.
[8] AIHW, Health expenditure Australia 2019-20. Private hospital spending by source of funds, constant prices,
[9] APRA, Private Health Insurance Statistics, September 2018 to June 2021.

The impact was particularly severe for operators in jurisdictions subject to prolonged and repeated cycles of restriction on elective surgery. Even though activity rebounded once restrictions were eased in most locations, successive cycles of localised restrictions and suppressed levels of activity are evident. Adverse financial impacts are expected to continue into 2021-22 as a result of severe restrictions in most states and territories.

In addition to a decrease in revenue, operational costs increased as a result of the pandemic as the price of items essential to the COVID-19 response suddenly rose and international supply chains came under pressure. These cost increases also impacted the cost of non-COVID activity as many of the same supplies are also essential for standard hospital services. Although most acute shortages have moderated with time, the vulnerabilities of supply chains have been exposed and many ongoing costs have increased because of sustained upward as pressure on price and changed operational requirements. The enduring impact in the medium and longer term is expected to be material with initial estimates of increases in operational costs ranging from five to ten percent.

Throughout 2020 and 2021:

- The private hospital sector responded swiftly reducing volumes of admissions and elective surgeries to reduce demand for intensive care beds and the drugs, equipment and personal protective equipment essential to the pandemic response.
- Private hospitals provide 35 percent of Australia's standing intensive care capacity[10] and negotiated with states/territories to contribute additional surge capacity in beds, equipment and clinical personnel.
- Private hospital operators demonstrated agility in responding to specific requests from the Commonwealth and individual states/territories to assist with the treatment of COVID and non-COVID patients.
- At local level private hospitals assisted other services in health, aged care and disability sectors by sharing PPE resources and expertise.
- Private hospitals have accepted residents transferred from aged-care homes where outbreaks have occurred and treated COVID-19 patients requiring hospitalisation.

As and when restrictions on elective surgery have eased, the private hospital sector has focussed on ensuring services were delivered to consumers safely and efficiently so backlogs in deferred demand could be addressed. The private hospital sector did this by:

- Implementing additional infection control measures to protect patients, staff and the wider community.
- Bringing capacity for elective surgery back on-line as quickly as possible.
- Addressing the surgical and medical care needs of patients whose health conditions were exacerbated as a result of the pandemic.
- Providing acute psychiatric care to patients requiring hospital admission throughout the course of the pandemic.
- Establishing alternative models for the delivery of care including delivery of care in the home and in community settings and using virtual health technology.

The private hospital sector is and will remain central to meeting Australia's health challenges in 2022-23 and in the years ahead.

[10] AIHW, Admitted Patient Care, 2018-19.

The health workforce

REDUCE THE COST AND COMPLEXITY OF SKILLED MIGRATION ARRANGEMENTS.

Prior to the COVID-19 pandemic, skilled migration was an essential tool in meeting health sector skill shortages that could not be met by new graduates. Skilled migration will continue to be of significant importance to the Australian hospital sector in both the short and longer term. Highly skilled health care workers on skilled migration visas bring capabilities and experience that cannot be provided by new graduates. They are essential to the depth of skill and expertise required for the provision of hospital services and for training the future workforce.

International health care workers and international students who have remained in Australia have played an integral part in the response to the COVID-19 pandemic. In 2019-20 the number of temporary visas granted to registered nurses surged to 8,217 but this declined to 6,743 in 2020-21. Skilled migration levels remain suppressed with the provision of temporary skilled migration visas to all nursing occupations in 2020-21 standing at only 6,810, 20 percent less than for 2018-19.

The Department of Jobs and Small Business reports internet vacancies are now at an all-time high and APHA member hospitals are experiencing pervasive and persistent difficulties in recruiting experienced nurses to take on specialised roles including:

- Surgical.
- Critical care.
- Peri-operative.
- Cancer care.
- Mental health.
- Midwifery.
- Nursing manager roles.

In 2018, the Federal Department of Education, Skills and Employment predicted employment in the health care and social assistance industry (also a major employer of health professions) will expand at double the pace of all industries over the five years to May 2023; this was before the added demands arising from the pandemic are taken into account[11]. On top of this projected demand, the Federal Government's response to the Royal Commission into Aged Care has already led further demand for skilled and experienced clinicians, particularly nurses, across both sectors.

In the first year of the pandemic, onshore applicants accounted for the majority of visas granted. Off-shore applicants were limited because of restrictions on entry to Australia. Those that were admitted were predominantly government sponsored migrants filling essential roles as part of the COVID-19 response.

Australia must compete globally for a clinical workforce that is in high demand, now more than ever. Consequently employee-sponsorship is now more important than ever. However, the financial impacts of the last two years, leave the private hospital sector with a severely diminished capacity to afford the costs of sponsorship. Furthermore, because the public health sector is exempt from the charges

[11] Labour Market Research, Health Professions, Australia, 2017–18, September 2018 https://docs. jobs. gov. au/documents/health-professions-australia

imposed by the Federal Government on private sector employers, private hospitals are further disadvantaged.

Reforms to skilled migration in 2018 dramatically increased the cost to employers of sponsoring skilled employees' migration. While acknowledging the Federal Government needed to act to address damaging unintended consequences in some sectors, APHA contends the impact on the health sector has been detrimental.

There is no longer the possibility of retaining skilled and valued employees beyond the initial visa period. Consequently, not only employers but the health sector as a whole, loses the benefit of several years' investment in these individuals; personnel essential to the provision of high-quality healthcare.

The loss of highly skilled and experienced employees also reduces the capacity of private hospitals to train the next generation of Australian healthcare professionals. Without a ready supply of well-trained and experienced clinicians, consumers will inevitably face challenges in accessing timely and affordable high-quality care. Furthermore, the sectors' ability to train and mentor Australia's future workforce will be constrained.

The cost to an employer of sponsoring a single employee is now many thousands of dollars. The Skills Levy included in these charges does nothing to reduce the reliance of the Australian health sector on immigration. Therefore, we call for a temporary 12-month moratorium on charges to employers for health care related skilled migration.

Pathways to permanent residency for highly skilled employees need to be restored so that Australia benefits from the huge made by health sector employers in temporary skilled migrants. Not only do employers meet the costs of sponsorship and on-boarding, they also invest in supporting the employees' adjustment to life in Australia; both personally and professionally. The health sector requires staff who are familiar with Australian clinical practice and standards in healthcare. The skill shortages which are met by skilled migrants are not short term and this investment is lost if successful candidates are not able to access a path to permanent residency.

Finally, government investment in education and training, including investments through the Skilling Australians Fund, must be targeted to reduce Australia's reliance on skilled migration. Under current arrangements the Skilling Australians Fund is directed towards training in the vocational education and training sector. This investment does nothing to reduce Australia's reliance on skilled migration to meet health sector skill shortages which predominantly require undergraduate and post-graduate training in the university sector and upskilling of the existing workforce.

BRING FORWARD NATIONAL COMMITMENTS TO WORKFORCE PLANNING

APHA welcomes and strongly supports the commitments already made by the Federal Government to strategic planning with respect to major segments of the health workforce. However this work now needs to be urgently brought forward to include a rapid assessment of the impact of COVID-19 taking account of local and global factors.

All of the primary channels of workforce supply: domestic education and training, international students and skilled migration, have been significantly disrupted. Clinical practices have changed and trends in workforce participation are also likely to have been affected in both the near and longer term.

There is a substantial lag in the publication of national data and in the meantime, there is every reason to expect that historical trends and assumptions need to tested and re-evaluated.

All of these factors require an urgent reassessment taking account of the views and experiences of all stakeholders.

IDENTIFY AND IMPLEMENT STRATEGIES TO ADDRESS URGENT WORKFORCE SHORTAGES.

The COVID-19 pandemic not only radically impacted the provision of clinical services, it also disrupted the provision of training to students and early career clinicians. The Federal Government urgently needs to address these issues by:

- Fast tracking pathways to graduation and registration for students and early career professionals whose training has been interrupted by COVID-19.
- Funding expanded training opportunities including training opportunities in the private sector.
- Implementation of training pathways for people seeking to re-enter the health workforce or re-skill from other occupations.

The private hospital sector has an essential role to play in partnering with government to meet these challenges.

APHA estimates in 2014-15, private hospitals provided:

- 40,400 days of clinical placement for medical students.
- 304,800 days of clinical placement for nursing and midwifery students.
- 28,900 days of clinical placement for allied health students[12].

These figures demonstrate the private hospital sector has a vital role in meeting Australia's clinical workforce challenges by:

- Providing placements for university and vocational education and training students.
- Providing graduate placements for nurses and allied health professionals.
- Providing internships and junior doctor positions for medical graduates.
- Providing registrar positions to train future medical specialists.
- Supporting staff to acquire postgraduate and research qualifications.
- Providing training opportunities not readily available in the public sector.

In fact, the private sector plays a particular role in providing training in health areas not readily available in the public sector, including many areas of surgery, mental health and rehabilitation[13]. If the private sector is to play an even greater role in meeting these future challenges when it is also committed to keeping the cost of hospital care as affordable as possible while at the same time shouldering the tremendous impact of the COVID-19 pandemic, it will need financial support from Government to provide additional quality clinical training opportunities.

[12] Australian Private Hospitals Association and Catholic Health Australia, Education and training the private hospital sector, Canberra 2017.
[13] Ibid.

The value of private health

During the last decade, private hospitals have driven efficiencies, just at the time when the age and complexity of patients has been increasing. Data prior to the COVID-19 pandemic shows:

- The average length of stay in the private hospital sector has decreased by eight percent[14].
- The complexity of overnight patients in private hospitals has increased by eight percent[15].
- Total expenditure per separation has increased in real terms by less than five percent over the decade a as whole and has, in fact, decreased in five of those years[16].
- In the year ending 31 March 2020, private health insurance benefits paid to private hospitals increased 3.8 percent, but this was entirely due to increased utilisation. The benefit paid per separation actually decreased in real terms[17].
- Expenditure growth in the public hospital system was 4.1 percent in real terms over 2015-16 to 2018-19. In the private hospital system it was only 2.6 percent[18].

Marginal cost increases over the last decade have been outweighed by improved health outcomes for patients.

The private hospital sector plays an essential role in the health sector as a whole. Forty percent of hospital services are delivered by the private hospital sector.

In surgery, the private hospital sector provides around 60 percent of all services including:

- 72 percent of eye procedures.
- Almost half of all heart procedures.
- 76 percent of procedures on the brain, spine and nerves.
- 60 percent of all musculoskeletal procedures.
- At least 30 percent of all chemotherapy.

Each year, private psychiatric hospitals treat around 43,000 people living with acute mental health conditions[19]. These hospitals provide 32 percent of acute specialist mental health beds and 45 percent of acute adult general psychiatric beds[20].

Private hospitals provide 79 percent of all in-patient rehabilitation[21].

[14] AIHW Admitted Patient Care, 2009-10 and 2019-20.
[15] AIHW Admitted Patient Care, 2009-10 and 2019-20.
[16] AIHW Admitted Patient Care, Health Expenditure Australia, 2018-19.
[17] APRA, Private Health Insurance Statistics.
[18] AIHW Health Expenditure Australia, 2018-19.
[19] PPHDRAS Report, 2019-20.
[20] AIHW, Mental Health Services in Australia, 2018-19.
[21] AIHW Admitted Patient Care, 2019-20.

CONTINUE WORK ON THE REFORM OF THE PROSTHESES LIST

In May 2021, the Federal Government announced a major program of reform for the PL to be implemented over a five year period. These reforms included:

- Alignment of PL benefits with prices in competitive markets such as the public hospitals system
- Better defining the scope and purpose of the PL.

In December 2021, the Minister again affirmed the Federal Government's intent to progress implementation of reforms in the first half of 2022[22].

Since 2005, the PL has provided a basis for determining the benefits payable for implantable medical devices used in surgery where the treatment is covered by private health insurance. This mechanism has protected consumers from out-of-pocket costs, while ensuring they have access to technologies recommended by their treating surgeon. The PL has also provided stability within the sector allowing insurers, hospitals and medical technology manufacturers to manage their respective financial risks. At the same time this approach has a number of limitations, particularly with respect to assuring consumers these technologies are available at a transparent and competitive price.

Consultations carried out during 2021 have confirmed broad stakeholder support for a shift to public sector reference pricing, a move which APHA supports. This will deliver significant savings to consumers while assuring consumers of access to the technologies that meet their specific requirements, as determined by their treating clinician.

In a consultation paper released August 2021, the Department of Health proposed a change in the definition and scope of the PL which would result in the removal of around 400 items from the PL, equating to a value of more than $250 million in private health insurance benefits. The Department relied on a report by EY Consulting to justify this proposal however, EY Consulting noted such a move, a cost shift to the private hospital sector, should only be made once alternative funding mechanisms have been put in place. Notwithstanding significant consultation and discussion, the issue of an alternative funding mechanism has remained unresolved[23].

In late 2021, APHA has proposed a solution to this impasse. The proposal is that the 400 items be subject to public sector reference pricing from 1 July 2022, to give consumers access to these technologies at a fair price and that the Independent Hospital Pricing Authority be commissioned to assist the development of a bundled pricing framework that could then provide the basis for a mandatory minimum benefit for these items effective from 1 July 2023.

This approach will the substantially deliver on Federal Government's goal of improving value for consumers through reduced increases in insurance premiums. It will also provide immediate certainty for both health funds and hospitals while at the same time enabling consumers to be assured of access to the technologies recommended by their treating clinicians.

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[22] Minister Greg Hunt, Delivering Australia's lowest private health insurance premium change in 21 years, 23 December 2021. https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/delivering-australias-lowest-private-health-insurance-premium-change-in-21-years#:~:text=The%20Hon%20Greg%20Hunt%20MP&text=The%20Morrison%20Government%20understands%20the,change%20of%202.74%25%20in%202021.

[23] EY Consulting, A Review of the General Miscellaneous Category of the Prostheses List, 2020.

It is essential that this substantial reform program is implemented smoothly with minimal disruption to the sector at a time when there is substantial demand for elective surgery as patients seek treatments that were deferred during 2020 and 2021 as a result of the COVID-19 pandemic and all segments of the supply chain involved in delivery of private hospital services have withstood a significant period of financial stress.

APHA remains committed to supporting reform to the PL. APHA is of the view that the best way forward should be based on the recognition of the following principles

- Retaining the ability of clinicians, in partnership with consumers to select the most appropriate technology for each patient.
- Ensuring that the Prostheses List delivers certainty to consumers by minimising patient out-of-pocket costs.
- Ensuring that the process used to set benefits is transparent.
- Ensuring that the Prostheses List is responsive to changes in service delivery and changes in technology.
- Ensuring that the process of benefit setting delivers fair value to all stakeholders.
- Ensuring that this reform protects the financial sustainability of the private health sector.

This reform process also needs to be supported by investment in systems aligning information about the devices listed with data about their performance so that clinicians are better able to monitor utilisation and clinician outcomes and to access the information needed to make cost-effective choices.

INTRODUCE A DEFAULT BENEFIT THAT SUPPORTS AMBULATORY CARE IN MENTAL HEALTH AND REHABILITATION

Consumer-centred care involves the delivery of care in the most appropriate setting. Existing private health insurance regulations already recognise hospital services can include services provided in the community or home. However, the expansion of such services is impeded by a lack of support from private health insurers.

The Department of Health's Private Hospital Data Bureau (PHDB) reports 82,373 separations involving a charge for hospital-in-the-home care were delivered in 2019-20[24]. According to the same source, these separations account for two percent of all separations delivered in 2019-20. According to the Department of Health's Hospital Casemix Protocol Annual Report for 2019-20 only, 12,789 private sector hospital-in-the-home separations were funded (benefit reported) through private health insurance a reduction from 25,565 in 2017-18 [25].

Although this type of service has been increasing in the sector more generally, it is still only a tiny proportion of the services delivered by private hospitals and the contribution of private health insurance to funding such services remains minute and falling. Hospital-in-the-home services and other outreach services have many potential benefits for patients, particularly in relation to mental health and rehabilitation.

Unlike admitted overnight hospital care, there is no provision for minimum default benefits for day programs or home-based services in mental health or rehabilitation. Consequently, consumers can only access these programs if their insurer has contracted with the hospital to cover them, or if the

[24] Department of Health, Private Hospital Data Bureau (PHDB).
[25] Department of Health, Hospital Casemix Protocol Annual Report, 2019-20.

insurer has a financial interest in the service. The reluctance of insurers to support home-based services provided by private hospitals has retarded their growth.

Even when hospitals have put forward evidence-based proposals for outreach and home-based programs and participated in trials, these trials have not translated into ongoing programs because of lack of financial support from health insurers.

Providing default benefits for day programs, outreach and home-based programs in mental health and rehabilitation care would ensure consumers' care options are not restricted by choice of insurer and mean consumers could access the most efficient and clinically appropriate care pathway.

Providing default benefits for community-based and home-based programs would enable private hospitals to establish these programs on a sustainable basis, delivering consumers the services they require and reducing the risk of avoidable hospital readmission.

The Australian Government should remove barriers to private hospital providers delivering at scale contemporary models of care including delivery of care in the community and in the home and through virtual health by:

- Introducing a minimum default benefit for day programs and services delivered by hospitals in the home/community in mental health and rehabilitation.
- Introducing and retaining provision of MBS items for the use of virtual health in delivering consultations and case-conferencing for private hospital patients receiving care in community and home-based settings.

Health sector resilience

The COVID-19 pandemic saw the Australian health sector as a whole put to the test to an extent not seen in more than a century. Moreover, the sector experienced the impact of a truly global event as the pandemic spread rapidly around the world.

In response to this crisis, governments, health care providers, clinicians and scientists in both public and private sectors demonstrated a capacity for agility and collaboration, and discovered new ways of working together.

Pre-existing pandemic plans and sources of expertise provided a valuable starting point for national and local responses, but opportunities to improve the health sector's future resilience were also quickly exposed as the clinical, social and economic dimensions of the pandemic unfolded.

Now, after two years, a valuable pool of knowledge and practical experience has accumulated informing effective responses to both immediate and longer-term impacts of the pandemic as it moves through successive stages. International experience suggests that the outlook for the medium term remains uncertain, with the potential for further challenges.

It is essential that public and private sectors pool and consolidate learnings so that Australia's capacity to respond to future challenges is consolidated. Experience over the past two years has shown that it is essential to:

- Recognise increase private hospital operating costs due to COVID related factors
- Consolidate guidelines and learnings from the pandemic.
- Retain temporary MBS COVID-19 telehealth items.
- Provide funding and financial incentives for the improvement of information technology compliance and digital health capacity building.

RECOGNISE INCREASED PRIVATE HOSPITAL OPERATING COSTS DUE TO COVID-RELATED FACTORS

As previously discussed, private hospitals have been negatively impacted by significantly reduced revenues due to surgery restrictions and providing the Commonwealth and state governments with significant assistance in the pandemic response. At the same time, the sector has also had to deal with COVID-related increases in operating costs in the order of 5 to 10 percent (remembering that the average margin in "normal" times is just 4.5 per cent).

At the same time, the health insurance sector has benefitted financially during the pandemic by continuing to collect premiums for services that could not be provided.

The ongoing viability of the private hospital sector will be essential in addressing the significant backlog in essential elective surgery that has developed in both the public and private sectors over the last two years. Therefore, APHA proposes the Government consider options to ensure that funders recognise the increased hospital operating costs due to COVID-related factors, for as long as these cost increases are present.

CONSOLIDATE LEARNINGS FROM THE COVID-19 PANDEMIC

The last two years have demonstrated an unprecedented level of cooperation between public and private hospital sectors. However there have been many challenges along the way highlighting the importance of:

- Retention of the ability to rapidly activate contractual arrangements with private hospital sector operators in the event of future emergencies.
- Improved management and coordination of the National Medical Stockpile
- Continued support for domestic manufacture of essential medical supplies.

The National Partnership Agreement on COVID-19 Response signed by the Australian Government and all states/territories ensured the resources, facilities and staff of the private hospital sector were available to assist in the national response to the COVID-19 pandemic. Hospitals and day hospitals contracted by states/territories were supported by Commonwealth funding which enabled them to retain clinical staff and operational readiness.

In initial stages, a lack of prior experience in large scale contracting of services with the private sector led to longer timeframes than would have been ideal. Negotiations were also hampered by a lack of knowledge regarding the capacities of the private sector (including the capacities of smaller providers) and a disconnect between the objectives of the Commonwealth and state/territory governments in relation to the NPA. Much has been learnt over the past two years about the diversity of ways in which the private hospital sector has been able to contribute to successive stages of the pandemic and associated responses.

The other crucial challenge has been to manage the balance between COVID-19 response activities and provision of mainstream health services. The last two years has shown the flexibility that is required to enable both public and private sectors to cooperate effectively. Both sectors need to operate to optimal capacity particularly as medium and longer-term consequences of the pandemic unfold.

It is important that learnings at national, jurisdictional and local levels are documented now so that they can inform decision making and policy for the future. Policies, practices and agreements that have been developed over the last two years need to be documented so that guidelines and templates can be readily accessed when future needs arise.

It is essential that the private hospital sector have a direct role in contributing to the evaluation and refinement of policies and guidelines developed as part of the COVID-19 response.

Early in the pandemic, it quickly became apparent that many essential supplies were in high demand globally. The private sector was immediately impacted as governments moved swiftly to place orders in market conditions where only nation states had the resources and powers necessary to secure supply. Federal and state/territory governments moved quickly to establish stockpiles of essential supplies, however, the bidding wars which quickly broke out exposed the necessity of a more co-ordinated response.

These challenges were most evident in relation to personal protective equipment – this problem was eventually given limited recognition when the Minister of Health advised that private hospital sector access to the National Medical Stockpile (NMS) could be granted in limited circumstances. However, in late 2021, similar issues resurfaced in relation to rapid antigen tests. Lack of a coordinated national

response to such market pressures have hampered the capacity of the private hospital sector to fulfil its role both in relation to general hospital services as well as services essential to the pandemic response. It imperative that learnings from the recent experience are captured and used to inform improved management and coordination of the NMS.

Australia's lack of on-shore manufacturing capacity in essential medical supplies quickly became apparent in 2020 as overseas manufacturers were subject to emergency shut-downs, surges in demand and disrupted transportation. While Australian manufacturers and government were quick to respond, it is essential that the learnings from this experience are used to improve future responsiveness and address underlying points of vulnerability.

The Federal Government needs to continue support for domestic manufacture of essential medical supplies. Initiatives taken so far need to be sustained and extended in recognition of the importance of such capacities and the enhance understanding of the vulnerabilities of global supply chains that has arisen in the last two years. This support needs to extend to purchasing policies in recognition of the scale required to establish domestic manufacture on a sustainable basis.

RETAIN MBS ITEMS FOR COVID-19 TELEHEALTH

The MBS items introduced on 14 September 2021 and reinstated in January 2022 for a temporary period ending 30 June 2022 should be retained on a permanent basis so that they can be available for immediate access in any future emergencies where public health measures are invoked that prevent clinicians from personally attending on a patient in a private hospital.

The COVID-19 pandemic has demonstrated that disease outbreaks of this magnitude are complex and unpredictable. There is often little time to mount an effective response. APHA is grateful that the Federal Government moved in September 2021 to recognise the crucial role of telehealth in assuring continuity of care to hospital inpatients. While face-to-face consultation remains the norm in the treatment of inpatients, the pandemic has shown that when public health orders require clinicians themselves to be placed in isolation, telehealth can play an essential role in easing workforce pressures and ensuring continuity of care for patients.

This need has shown itself most acutely when large numbers of people in a particular location have been subject to isolation requirements – these circumstances arose in the "Indooroopilly Outbreak" in Brisbane in August 2021. It has also proven invaluable in specialties, such as psychiatry, where the therapeutic relationship between the clinician and patient are of central importance.

The cost of these provisions is negligible as they are a direct substitute for services which would otherwise be provided in a conventional face-to-face manner. Although these provisions should only be used when required, they should be retained in a form that can be immediately reactivated when such circumstances arise.

PROVIDE FUNDING AND FINANCIAL INCENTIVES FOR THE IMPROVEMENT OF INFORMATION TECHNOLOGY COMPLIANCE AND DIGITAL HEALTH CAPACITY BUILDING.

COVID-19 has demonstrated the critical importance of an integrated health system where all providers, public and private are able to work closely together. The importance of information technology in supporting critical health infrastructure across both public and private sectors was

recently recognised in amendments to the Security of Critical Infrastructure Act 2018. Amendments passed in late 2021 and further amendments foreshadowed in 2022 impose substantial additional costs on private sector operators of 'critical hospitals'. This legislation rightly recognises the importance of health sector infrastructure but the intentions of this important legislation will also require financial support from government if the security of critical infrastructure is to be assured.

Digital health capabilities, fundamental to an integrated and responsive health system are still lacking in significant parts of the private hospital sector when compared to the public sector. As at the end of April 2021, 97 percent of public hospital beds were registered to use My Health Record. These facilities are viewing an average of 292,000 records per month and uploading up to three million documents every month. No recent data has been reported by the Australian Digital Health Agency in respect of the private hospital sector[26]. As at June 2020 (the most recent information available), 67 percent of private hospitals and 16 percent of day hospitals were registered for the My Health Record system[27]. This level of registration must be significantly increased to realise the benefits to the health system as a whole.

Apart from a small number of pilot project grants made available to some private hospital groups, there has been virtually no support provided to enable the private hospital sector to participate in the rollout and implementation of My Health Record. It is notable that the uptake of access to My Health Record has focused on the corporate groups that accessed pilot project assistance. As a consequence further expansion of registrations to cover the remaining 33 percent of overnight hospital beds and 84 percent of day hospitals will be slow without government support.

Full engagement requires a major investment in software, training and information technology. While private hospitals could play a major role in uploading information to My Health Record, it can be difficult for private hospitals to demonstrate an internal return on the investment required. The benefit of hospitals registering with My Health Record is realised outside the hospital, not inside. This challenge is reflected in data produced by the Australian Digital Health Agency that demonstrates that public hospitals upload 10 documents for every one view accessed within the hospital[28].

The Federal Government has provided a generic portal-based service that allows private hospitals to access information on the My Health Record system. While this option provides an affordable point of entry, the utility for private hospitals and patients is limited because this option does not allow hospitals to upload information.

Funding and financial incentives are needed to progress investments that will benefit the health sector as a whole.

[26] Australian Digital Health Agency, My Health Record Statistics and Insights, April 2020 to April 2021 https://www.digitalhealth.gov.au/sites/default/files/2021-06/myhealthrecord_stats_apr21.pdf

[27] Australian Digital Health Agency, My Health Record. Private hospitals using the My Health Record system https://www.myhealthrecord.gov.au/about/who-is-using-digital-health/private-hospitals-using-my-health-record-system

[28] Australian Digital Health Agency, My Health Record Statistics and Insights, April 2020 to April 2021 https://www.digitalhealth.gov.au/sites/default/files/2021-06/myhealthrecord_stats_apr21.pdf

Private hospitals in Australia

The private hospital sector makes a significant contribution to health care in Australia, providing a large number of services and taking the pressure off the already stretched public hospital system.

The private hospital sector treats:

- 4.4 million hospitalisations a year.

In 2019-20 it delivered:

- 58% of all surgery
- 72% of eye procedures
- Almost half of all heart procedures
- 76% of procedures on the brain, spine and nerves.
- 60% of all musculoskeletal procedures
- At least 30% of all chemotherapy

Australian private hospitals by the numbers:

- In 2021, almost half (49%) of all Australian hospitals are private
- In 2021, there were 642 private hospitals made up of:
    - 292 overnight hospitals
    - 350 day hospitals
- In 2016-17 (the most recent data available), that amounts to: 34,339 beds and chairs (31,029 in overnight hospitals and 3,310 in free-standing day surgeries)
- Employs more than 69,000 full-time equivalent staff.

THE AUSTRALIAN PRIVATE HOSPITALS ASSOCIATION

The Australian Private Hospitals Association (APHA) is the largest peak industry body representing the private hospital and day surgery sector.