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File Ref: DG078971

11 DEC 2015

Ms Janet Quigley
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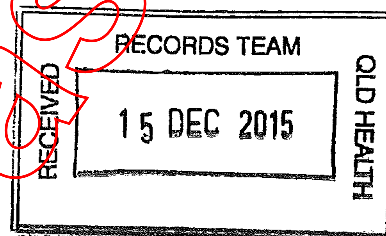
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QLD HEALTH

Dear Ms Quigley

I refer to a letter of the 13 November 2015, from the Secretary of the Department of Health inviting the Queensland Department of Health to make a submission to the Private Health Insurance (PHI) consultation.

I appreciate the opportunity to make the comments outlined in the enclosed submission.

I hope that State and Territory Departments of Health will be further consulted if and when specific changes to PHI arrangements are proposed.

In the interim, Mr Paul McGuire, Senior Director, Funding Strategy Unit, Department of Health, would be pleased to discuss any of the issues raised. I have arranged for Mr McGuire, on telephone (07) or via email at @health.qld.gov.au, to be available to assist the PHI consultation team.

Yours sincerely

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Private Health Insurance (PHI) Consultation Submission

The Queensland public healthcare system, collectively known as 'Queensland Health' (QH), comprises 16 independent Hospital and Health Services (HHSs), the Queensland Ambulance Service (QAS), and the Department of Health.

The Department of Health is responsible for managing the public health system, including purchasing services from the HHSs which are, in turn, largely responsible for delivering public healthcare services. QH provides a full range of acute and sub-acute inpatient hospital care, outpatient and emergency department services as well as an array of other community, dental, preventive health and health promotion activities.

As at 30 June 2015, QH had an estimated 73,980 full time equivalent staff. In 2014-15, these provided nearly 938,000 episodes of inpatient care and over 6.79 million outpatient appointments to the people of Queensland and catered for approximately 1.85 million presentations at emergency departments.

The QH budget for 2015-16 is $14.183 billion. Approximately 66% of QH's revenue in 2015-16 is estimated to derive from State resources, 25% from the Commonwealth and the remainder (9%) coming from other sources, including own source revenue relating to private patients treated in public hospitals.

QH is one component of the broader Queensland healthcare system. Other components include primary healthcare providers, community organisations, private hospitals and aged care services. Each sector has its own delivery, regulatory and funding profile. Notwithstanding this they are all inter-connected and need to operate together effectively to ensure the best possible health outcomes for Queenslanders.

It is difficult to directly compare activity between public and private hospitals due to differences in the service profile of each. However Queensland has traditionally had a strong private hospital sector. This is reflected in information published by the Australian Institute of Health and Welfare showing that Queensland had higher than average proportions of hospital separations (47.5% versus 41.1% nationally) and patient days (40.8% versus 32.5% nationally) in the private setting during 2013-14

At the same time, according to the latest information from the Australian Prudential Regulation Authority (APRA), Queensland has below national average rates of PHI membership. For the September 2015 quarter, 45.1% of the Queensland population was insured for hospital treatment compared to the Australian average of 47.3%. For the same period, 50.5% of Queenslanders had coverage for general treatment (sometimes known as ancillary or extras) compared to a national average of 55.8%.

The regulation and conduct of PHI is, in a narrow sense, the responsibility of Commonwealth agencies, Federal legislation and Commonwealth Government policy. However, changes to one part of the health system will have flow on impacts to others areas.

In this respect, the Queensland public hospital system has a unique and central role as the people of Queensland ultimately rely on it for care and treatment if other areas do not operate effectively or efficiently. While many cascade effects of a change in PHI arrangements are predictable, others may be unintentional or not immediately manifest. It is therefore critical that all changes are considered carefully, in particular:

1. Maintenance of an universal healthcare system

Medicare, public hospitals and the general principle of universal healthcare access have served Australia well over many decades. The public health system must be resourced adequately and

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equitably to ensure it can provide high quality health services on the basis of clinical need and within a clinically appropriate period.

Any changes to PHI arrangements that allow or encourage people to opt out of the Medicare system have the potential to drive a 'two-tiered' health system, where those who can afford PHI have access to high quality healthcare with the remainder of the community reliant on a poorly resourced residual public health system.

2. Integration of PHI changes with other health reform

The PHI consultation is just one of a number of health reform initiatives underway. These initiatives also include the White Paper on Reform of the Federation, various reviews of the Medicare Benefit Schedule, primary health services, personally controlled electronic health records as well as a range of other state and territory initiatives. In order to ensure any future and reformed health system is better integrated and aligned, these initiatives must be considered in tandem. Otherwise there is a risk that the current fragmentation will be perpetuated.

For example, the White Paper on Reform of the Federation discussion paper has proposed five options for the Australian health system. One of the options being considered proposes the establishment of a Commonwealth hospital benefits schedule. The new benefits would be funded in part through the discontinuation and redirection of the PHI tax rebate. It is not clear if and how this process relates to the current PHI consultation.

3 Impact on public hospital activity and funding

Queensland and other states and territories are already facing very significant health budgetary pressures as a result of the Commonwealth Government's decision to cease the National Health Reform Agreement funding arrangements from 2017-18 and introduce an indexation based methodology for calculating the Commonwealth contribution to public hospital services.

The Commonwealth Treasury has indicated this change will reduce health funding nationally by $57 billion over the period 2017-18 to 2024-25. The Queensland Department of Health has estimated the Queensland share of this reduction to be $11.8 billion over the same period.

Changes to the current PHI arrangements have the potential to increase significantly the demand for public hospital services by decreasing the proportion of the population that hold and/or choose to use PHI. Increased activity at public hospitals is not in itself a negative outcome. However, without commensurate additional resources it effectively amounts to cost-shifting to states and territories, further undermining the financial sustainability of the public system.

Currently PHI is community rated with the same coverage at the same price available to all regardless of risk factors. The alternative risk rated model could place the public hospital system under additional strain by deterring the less healthy from taking up PHI coverage leaving the care of this high need group to the public hospital system.

As the managers of public hospital services, states and territories should be fully consulted and compensated for any increased activity and loss of revenue resulting from changes to current PHI arrangements. Otherwise, there is a risk that public patients will have the quality of their care impacted, including for example through longer waiting times for health services.

4. Minimum benefit for private patients in public hospitals

Current PHI arrangements provide for a minimum benefit for private patients treated at public hospitals. Without this requirement, private health insurers would have little incentive to pay benefits

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DOH-DL 15/16-048 RTI Document No. 3

in respect of private patients treated in public hospitals, leading to higher out of pockets expenses for private patients.

Consequently fewer patients would choose to be treated privately in public hospitals. This would largely remove payments from private health funds as a source of revenue for the public hospital system. This outcome amounts to cost-shifting from private health insurers to states and territories. Indeed, not only should this minimum hospital benefit be retained, it should be raised to reflect true costs and ensure it is equitably aligned with benefits paid to private hospitals.

Queensland Health would be pleased to engage constructively with the Commonwealth Department of Health and other agencies to aid reforms that improve the value, efficiency and effectiveness of PHI for Queensland consumers. However, any changes should consider and take full account of their flow on effects to the broader health system and, crucially, avoid the development of a two tiered health system.

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