Australian Society of Anaesthetists®

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Reform Opportunities and Committee Support Section
MBS Policy and Specialist Programs Branch
Australian Government Department of Health, Disability and Ageing
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To whom it may concern,

Private Health Sector Reform – Consultation Paper 1

Thank you for this opportunity to provide a written submission regarding *the Private Health Sector Reform – Consultation Paper 1*. We would also like to thank the Department for providing us with an extension to the submission close date.

Set out below is the ASA's feedback on the following questions and initiatives presented for stakeholder consideration:

1.1. Mental Health Care Initiative 1: Allowing overseas-trained psychiatrists to practice in private hospitals,

1.2. Maternity Care Initiative 1: Sector Education (a – b); Initiative 2 (c); Initiative 3 (d); Initiative 4 (e); Initiative 5; and Initiative 6

1.4 Type C Certification requirements: exemption criteria (a)

2.1. Improving Access to regional private hospitals (a, b, c, d and e)

2.2. PHI product simplification (a, b, c)

2.3. Risk Equalisation: Initiative 1 and Initiative 2 (b and c)

About the ASA

The ASA was formed in 1934 and is a member-funded organisation dedicated to supporting, representing and educating specialist anaesthetists to ensure the safest possible anaesthesia for the community. We have proudly supported specialist anaesthetists for over 90 years and continue to support members and advance their skills while advocating for the anaesthesia specialty to ensure safe and high-quality patient care for the Australian public.

1.1 Mental Health Care

The ASA supports this initiative as a targeted measure to help address significant workforce pressures in mental health care, provided robust safeguards are in place. Overseas-trained psychiatrists should only be eligible where their training, qualifications and clinical experience are comparable to those expected of the Australian specialist workforce.

Any exemption mechanism must preserve existing requirements for specialist registration, credentialling, scope of practice and patient safety. The policy should also be monitored and reviewed regularly to assess its impact on workforce capacity, patient access and quality of care.

The ASA does not support extending this approach to other medical specialties without a separate and equally rigorous assessment of workforce need, clinical risk, regulatory safeguards and potential impact on patient care.

The ASA also emphasises that processes to assess, support and integrate international medical graduates into the Australian health care system must be adequately resourced and focused on areas where service delivery is demonstrably failing to meet patient demand.

1.2 Maternity Care

Initiative 1: Sector education

a) Do you agree or disagree that sector education about innovative models of maternity care would help to raise awareness of models and build a clearer understanding of regulatory enablers? Why do you agree or disagree?

More information is required to provide an appropriate response to this question. Specifically, the term "innovative models of care" is very broad and requires further definition before it can be meaningfully assessed.

The ASA does not support models of maternity care that increase risks for women and babies, such as free birthing. Care models should not be based on reducing, bypassing, or replacing access to specialist medical care with alternative service providers. Any proposed model should maintain access to appropriate specialist expertise and support safe, evidence-based maternity care.

b) What mechanisms should be used to educate the sector?

Sector education should draw on high-quality evidence, including peer-reviewed research, and prioritise the safety and wellbeing of mothers and babies. Any new model of care should have clear inclusion and exclusion criteria to support appropriate implementation and patient selection.

Education initiatives should also be supported by robust regulatory frameworks that promote collaborative, multidisciplinary care. This approach can help improve maternal and neonatal outcomes while optimising the effectiveness and efficiency of the healthcare system.

NASOG should play a central role in the development, delivery, and oversight of any education programs to ensure clinical accuracy, consistency, and alignment with evidence-based practice.

Initiative 2: Increased access and choice to different models of private maternity care.

c) Would you participate in the development and implementation of innovative models of care with other practitioners in the private maternity sector? Please provide details.

Anaesthetists play a significant role in private maternity care, including the provision of labour analgesia, anaesthesia for operative and assisted deliveries, support for the management of complications during labour, and care for post-delivery complications where anaesthetic expertise is required.

The ASA would participate in consultations on innovative models of maternity care where the issues are relevant to the safe, ongoing provision of anaesthesia services supporting women's health. However, the ASA considers that the overall clinical management and decision-making for admitted maternity patients in private hospitals should remain under the care of a specialist obstetrician. The ASA does not support any model in which admitted maternity patients are not under the responsibility of an appropriately qualified obstetric specialist.

Private hospitals providing maternity services must be appropriately resourced and have systems capable of supporting 24-hour emergency delivery care. Consideration must also be given to the way these services are funded and remunerated. In the private sector, maternity-related medical services are commonly provided on a fee-for-service basis, and patients may be required to make an out-of-pocket contribution depending on their level of private health insurance, Medicare eligibility and the doctor's fee. It should not be assumed that private maternity care will be provided on a no-gap basis.

Any changes to models of care should also consider whether new or amended MBS items are required where there is a clear need for additional consultation, labour analgesia or anaesthesia services. The ASA notes that there are existing issues where labour analgesia for private patients may need to be provided by a non-specialist anaesthesia provider, such as an anaesthesia registrar, due to the appropriate allocation of trainees and a specialist anaesthetist being unavailable because of competing clinical priorities. However, there is currently no clear mechanism under the MBS for anaesthesia trainees to be remunerated for this care.

The ASA will continue to represent its members, their expertise and their patients, and would welcome opportunities to provide meaningful input on matters that intersect with anaesthesia, perioperative care and the safe delivery of maternity services.

Initiative 3: Shorter PHI waiting periods for privately provided pregnancy and birth

d) Do you agree or disagree the maximum waiting period should be reduced for the 'Pregnancy and birth' clinical category? Please specify why.

The ASA strongly supports removing waiting periods for pregnancy and birth care in the private system. Pregnancy is not always planned, and even where it is planned, conception cannot be predicted with certainty. Prospective parents should not be excluded from, or disadvantaged by, eligibility requirements that limit timely access to this category of care. Removing these barriers would support greater patient choice and may help more women access care in the private system, reducing some pressure on public hospitals that continue to experience significant demand, as reflected in the AMA's *Clear the Logjam* campaign, public hospital report cards and public hospital waitlist data.

The ASA also considers that modelling should be undertaken to assess the potential impact of any proposed changes on premiums, insurer costs and broader private health insurance affordability, particularly in the context of Australia's declining birth rate. If cost recovery is considered necessary, this is a matter for government and private health insurers to address through appropriate policy and funding mechanisms. Any such approach should be applied consistently and transparently, noting that similar cost-recovery mechanisms do not appear to apply where a person takes up private health insurance to access other high-cost episodes of care, such as joint replacement surgery, and subsequently cancels or downgrades their cover.

Initiative 4: Review of product tier structure

e) Do you agree or disagree the 'Pregnancy and birth' clinical category should be a minimum requirement of a product tier other than Gold?

The ASA strongly agrees. See further under Section 2: Delivering better value for consumers.

Initiative 5: Review of risk equalisation arrangements

See response to Section 2: Delivering better value for consumers

Initiative 6: Review of MBS items for paediatricians

f) Do you agree or disagree that there should be consideration of an amendment to the MBS item for paediatricians? Please specify why.

The ASA strongly agrees that consideration should be given to amending the relevant MBS item for paediatricians. Paediatricians play a critical role in supporting the safety and wellbeing of newborns and should be appropriately remunerated for their expertise, training and clinical responsibilities.

Paediatrician attendance at deliveries may be planned, semi-scheduled or required at short notice, including for immediate neonatal care on the labour ward or during emergency deliveries in the operating theatre. In obstetric emergencies, timely responses for both the mother and newborn are critical to reducing the risk of morbidity and mortality. These responsibilities should be recognised as distinct from, and not transferred to, the role of the anaesthetist.

The current MBS arrangements are not contemporary and do not adequately recognise the time required for documentation, coordination of care, communication with parents and other clinical administrative responsibilities. These activities are recognised in the public hospital system, where salaried doctors are remunerated for clinical and administrative time, but are not adequately reflected in fee-for-service arrangements in the private sector.

Workforce shortages in paediatrics have also contributed to the closure of some private maternity services. This highlights the importance of maintaining a sustainable, appropriately supported and fairly remunerated paediatric workforce to ensure safe and reliable access to private maternity care.

1.4 Type C certification requirements: exemption criteria

a) Implementation of two 'exemption criteria' for the certification requirements for MBS items classified as Type C procedures, where:

- *a patient is ≥ 75 years of age, and*
- *the procedure is conducted under general anaesthesia, regional anaesthesia or IV sedation.*

The ASA supports the proposed exemption criteria for Type C certification requirements. Where a patient requires general anaesthesia, regional anaesthesia or intravenous sedation, care should be delivered in an appropriately resourced hospital setting, with corresponding recognition through appropriate MBS and private health insurance rebates.

The ASA queries the rationale for setting the proposed age threshold at 75 years. If this threshold has been determined primarily through mathematical or economic modelling, rather than clinical risk assessment, further justification should be provided. The ASA recommends consideration be given to reducing the threshold to 70 years, noting that age-related clinical risk and post-procedure support needs may arise well before the age of 75.

The ASA also notes that there are many practical and clinical reasons why a patient who may otherwise appear suitable for same-day discharge may require overnight admission following a procedure and anaesthesia. These include patients travelling from regional or rural areas, patients who live alone, patients who are carers for others, circumstances where family or other support is unavailable, changes to theatre timing, delayed recovery from anaesthesia, or situations where anaesthesia has commenced but the planned procedure does not proceed. These factors should be recognised in any exemption framework to ensure patient safety, appropriate post-procedure care and equitable access to private hospital services.

2.1 Improve Access to regional private hospitals

a) Should the proposed changes be implemented by government on a temporary or permanent basis? When should a post-implementation review be undertaken?

The increase in the second-tier benefit from 85% to 100% should be permanent, with reviews every two years or at similarly regular intervals. The policy should also monitor access and patient safety to identify any unintended consequences.

b) When should government commence the proposed changes, noting the current annual processes for second-tier audit, categorisation and rate calculation?

As soon as possible, using the financial calendar year.

c) Provide feedback on the criteria for determining what should constitute an established regional hospital eligible for a higher second-tier default benefit (i.e. MM2 to MM7).

Eligibility for the higher second-tier default benefit should be based on more than geographic classification alone. It should consider the hospital's location, the needs of the surrounding community, and its capacity to provide a broad range of services, including acute care, surgery and access to relevant specialist services.

Eligible regional hospitals should be able to demonstrate that they provide, or support access to, the core specialist services required by their region. This should be underpinned by appropriate workforce distribution, service coverage and capacity to meet local demand.

The ASA is concerned that the current Modified Monash Model may no longer be sufficiently fit for purpose as the primary basis for determining eligibility. Financial support should be better aligned with local service need, patient demand, workforce availability and the role of the hospital in maintaining access to essential regional health services.

d) Comment on the level of the proposed increase to the second-tier rate for established regional hospitals and estimated impact on private health insurance benefit amounts (e.g. should caps or other limits on out- of-pocket costs be applied under second-tier arrangements?).

The proposed increase would help support the viability of regional private hospitals and assist in maintaining access to essential private hospital services in regional communities.

The ASA does not support the imposition of caps or limits on patient out-of-pocket costs under second-tier arrangements. There is insufficient evidence to support an assumption that regional patients have less capacity to pay than non-regional patients, and geographic location alone is not an appropriate proxy for capacity to pay.

The key driver of increasing medical fees is healthcare cost inflation and the failure of MBS and private health insurance rebates to keep pace with the real cost of providing care. The widening gap between the AMA List of Medical Services and Fees and MBS rebates demonstrates the growing pressure created by inadequate indexation of patient rebates. For anaesthesia services, the MBS rebate now represents less than 22% of the AMA Relative Value Guide unit value.

Applying caps on out-of-pocket costs would not address the underlying cause of rising patient contributions. Instead, it would risk further undermining the viability of specialist medical practice in regional areas and could reduce patient access to private care. For these reasons, caps or other limits on out-of-pocket costs should not apply.

e) Are there any additional arrangements to support the effectiveness of the proposed changes that the department should consider, including audits of calculations and the publication of second-tier rates?

Yes:

- Publication of fees and charges.
- Provision of clearer, more comprehensive information to patients regarding billing arrangements and available services.
- Improved informed financial consent processes, including information provided by private health insurers.

2.2 PHI product simplification

a) Do you agree or disagree with (or are you unsure about) each of the reform initiatives below:

i. Initiative 1: simplifying PHI product structure: **Agree**

ii. Initiative 2: standardising the age threshold and associated eligibility for dependants: **Agree**

iii. Initiative 3: excess and co-payment standardisation, and associated eligibility for dependants: **Neither agree nor disagree**.

iv. Initiative 4: ensuring consistency across premium structures: **Agree**

b) Do you have any specific comments on each of the reform initiatives raised?

Private health insurance should provide a level of transparency comparable to other major consumer insurance products. Members should be able to clearly understand what they are covered for, what excess or co-payment applies, and when they may face additional out-of-pocket costs. Consumers should also be able to make informed choices about the trade-off between premiums and upfront costs, including the option of accepting a higher excess or co-payment in exchange for lower premiums.

c) Are there any other options or solutions that the department should consider?

Private health insurance terminology should be simplified and standardised to make products easier for consumers to understand and compare. Insurers should be required to present key product information in a consistent, plain-language format, including:

- included and excluded clinical categories
- waiting periods
- excesses and co-payments
- other restrictions and exclusions
- hospital network limitations
- circumstances in which out-of-pocket costs are likely to arise
- the distinction between hospital, general treatment and ancillary benefits.

A consistent presentation format would support greater transparency, improve consumer understanding and allow members to make more informed choices about the cover that best meets their needs.

2.3 Risk Equalisation

Initiative 2: Recalibration of existing mechanisms for younger age cohorts covered by Gold tier

b) Do you agree or disagree with the reform initiatives raised:

i. create new specific risk pools for maternity and mental health: **Agree**

ii. exclude maternity and mental health claims from existing aged-based pool (ABP) and high- cost claims pool (HCCP). **Neither agree nor disagree**

iii. extend existing ABP claim eligibility criteria to younger gold tier members, and: **Agree**

iv. redefine Single Equivalent Units (SEUs) to exclude younger gold tier members, possible exceptions to corporate products. **Neither agree nor disagree**.

c) Do you have any specific comments on the proposed reform initiatives? This may include required lead times for implementation, required information, transparency and ease of calculation etc.

The ASA does not have a specific position on the detailed technical design of risk equalisation arrangements. However, as a matter of principle, the ASA supports reforms that improve access to private health insurance, promote fairness across policyholders and reduce unintended disincentives for insurers to provide appropriate coverage for services such as maternity and mental health care.

Contact the ASA

Thank you for this opportunity to provide a written submission regarding *the Private Health Sector Reform – Consultation Paper 1*. Should you require any additional information from the ASA, please contact:

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