



**Health
Policy
Solutions**

Impact of the changing role of private health insurers on clinical autonomy

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Executive Summary

The Royal Australasian College of Surgeons (RACS) commissioned this report to better understand the changing role of private health insurers in Australia and New Zealand and to undertake a preliminary assessment of the impact of these changes on the clinical autonomy of surgeons.

At the core of this project are fundamental questions about the extent to which health insurers should actively engage in purchasing to influence the appropriateness, quality and safety of private health services and how such a role interacts with the traditional paradigm of clinical autonomy for medical practitioners. Should clinical autonomy be absolute and, if so, does this principle apply to all payers of both private and public health services? Or, if clinical autonomy is not absolute, what parameters should be used to determine the 'line in the sand' that defines the optimal balance between active purchasing and clinical autonomy?

In Australia the regulatory framework for private health insurance includes the concept of 'the medical practitioner's professional freedom, within the scope of accepted clinical practice, to identify and provide appropriate treatments'. This legislative protection only applies to services provided under medical purchaser provider agreements or practitioner agreements between private hospitals and health insurers. However, most medical practitioners have chosen not to participate in these agreements and instead medical benefits are paid by insurers either through non-contractual medical gap policies or as a flat 25% medical benefit outside medical gap policies. So, in practice, there is no effective legislative protection that guarantees clinical autonomy for most private medical services provided to hospital patients.

In New Zealand health insurance is regulated under general business legislation. As a result, most of the consumer protections that apply to Australian health insurance are absent. New Zealand health insurance is not community-rated so insurers can reject sicker applicants and charge higher premiums using risk-rating, while pre-existing conditions can be excluded from any future coverage. This environment fosters a very different dynamic between insurers, patients and medical practitioners. In particular, provision of clinical information about a patient's health condition and proposed treatment occurs routinely as part of pre-approval processes that allow health insurers to make determinations about whether the condition and treatment are covered under individual-specific health insurance policies.

These regulatory differences have a major impact on how insurers manage costs in the two countries. New Zealand health insurers can limit their financial exposure through upstream policies including denying insurance to high-risk people and not paying benefits for pre-existing conditions. In contrast, Australian health insurers use more downstream policies including selective contracting, product design, clinical certification and audit to manage their costs.

In addition to cost containment, private health insurers are implementing strategies to determine the medical necessity of recommended or provided services. In Australia there has been considerable focus on the role of insurers in assessing whether plastic surgery is being undertaken for medical or cosmetic reasons. However, due to the current requirement for insurers to pay 25% medical gap benefits for MBS services provided on an inpatient basis, Australian insurers have not implemented more comprehensive utilisation review processes to challenge the medical necessity of a broader range of medical services. This contrasts with the situation in New Zealand where Southern Cross Health Society (the dominant private health insurer) has developed prospective eligibility criteria for many procedures. These criteria usurp the role of medical practitioners in exercising clinical judgement for individual patients as they specify the circumstances in which benefits will be payable (including required clinical signs and symptoms, previous procedures that must have been undertaken and types of procedures allowed or excluded). While Australian private health insurers cannot retrospectively deny payment once medical services have been provided, there is scope for them to adopt a more interventionist role prior to treatment being provided, similar to their New Zealand counterparts.

Australian health insurers have also begun to implement payment policies linked to safety and quality objectives. This includes the non-payment of hospital services agreed by Bupa and Healthscope if any of 14 specified 'never events' occurs, as well as Medibank's agreement with some contracted hospitals to not pay for five categories of adverse events (pressure injuries, falls, healthcare associated infections, surgical complications and venous thromboembolism). Responses to such policies have been mixed, depending on factors including: views about the level of consultation or unilateral action by health insurers; the evidence-base and clinical input underpinning the policies; the extent to which specified events are preventable and under the control of hospitals or medical practitioners; and uncertainty about whether costs will be passed on to patients.

A systems framework has been developed to assess the changing role of private health insurers. This framework comprises four elements: governance; rationale for and against intervention; type, target and timing of interventions; and outcomes of interventions.

On the first issue of governance, interventions that may impact on clinical autonomy are being negotiated through hospital-purchaser provider agreements, rather than with medical practitioners. As these agreements are commercially confidential, there is limited information available to medical practitioners and the public about terms and conditions that might override clinical autonomy. In the absence of matching agreements between private hospitals and medical practitioners, there are real questions about the ability or inclination of private hospitals to be agents for health insurers who are seeking to influence the appropriateness, safety and quality of health services that are provided by independent medical practitioners.

Turning to the second issue of the rationale for and against intervention, the arguments used to justify purchasing by private health insurers include: promoting value for money; ensuring care is clinically necessary; and promoting improvements in safety and quality. Criticisms of such interventions focus on issues including: the emergence of 'managed care'; the lack of clinical expertise amongst health insurers; the for-profit motivation of health insurers; and the unwillingness of health insurers to pay more for improved performance. In examining these arguments, it is valuable to consider whether they apply only to purchasing by private health insurers or whether similar arguments (for and against) should be assessed for purchasing by other payers including Commonwealth and State governments and the Department of Veterans' Affairs.

The type, target and timing of interventions used by private health insurers are diverse. While much of the focus has been on non-payment of benefits after treatment has occurred, health insurers can achieve more systemic changes through policies that prospectively influence the recommendations for, or provision of, medical treatment. This includes selective contracting with hospitals, approval of designated programs at individual hospitals, and incentives for members to use provider networks.

Finally, the outcomes of purchasing by private health insurers will vary depending on the specific intervention deployed. There may be immediate negative impacts including: denied or delayed access to care for patients; and non-payment or reduction in benefits by health insurers. Longer-term risks include: deterioration in continuity of care; shifting of some care to public hospitals; reductions in health insurance membership; and worsening of health outcomes for patients. However, if interventions achieve their stated objectives, potential benefits include: zero or reduced co-payments for patients; cheaper health insurance premiums; increase in health insurance membership; and the provision of high-quality health services in accordance with clinical guidelines.

This systems framework provides a preliminary tool to consider the extent to which health insurers should actively engage in purchasing to influence the appropriateness, quality and safety of private health services and how this can be balanced with a contemporary view on the effective operation of clinical autonomy.

1. Introduction

The Royal Australasian College of Surgeons (RACS) commissioned Health Policy Solutions to map and assess the changing role of private health insurers and the potential impact of any changes on the clinical autonomy of surgeons.

The context for this review is the gradual shift in behaviour as private health insurers move from passive purchasers of private health care services to a more interventionist role. Recent examples of increased intervention by Australian private health insurers include:

- The October 2014 agreement between Bupa and Healthscope where Healthscope will forgo payment for a defined list of 14 'never events';
- The contract negotiations in 2015 between Medibank and Calvary Health Care relating to the potential non-payment for a list of 165 'adverse events';
- The incorporation by some private health insurers (such as nib and HCF) in provider agreements of provisions authorising audit of medical practitioners' records including patient treatment records; and
- The introduction in 2014 of pre-approval authorisation schemes by some private health insurers (such as Medibank and Bupa) to determine the medical necessity of cosmetic surgery procedures.

This review has been undertaken through a desk-top based analysis, supplemented by targeted consultations with some expert informants in the private health sector. While the triggers prompting this review occurred in Australia, this review compares and contrasts developments in the Australian and New Zealand private health insurance sectors. In addition, the report examines the preliminary implementation of pay for performance schemes in some Australian state public hospital systems. Developments in both the New Zealand private health insurance sector and the Australian public hospital sector provide insights into future changes that might be introduced by Australian private health insurers.

This report is structured as follows:

- Chapter 2 outlines relevant aspects of the regulatory framework for Australian private health insurance, including the 'clinical autonomy' provisions relating to agreements between health insurers, hospitals and medical practitioners. Key differences between the operation and regulation of private health insurance in Australia and New Zealand are identified.
- Chapter 3 examines three case studies of purchasing approaches used by private health insurers in Australia and New Zealand that potentially impact on clinical autonomy. This includes selected contracting with affiliated providers, reviews of medical necessity and non-payment for adverse and never events.
- Chapter 4 develops a systems framework that can be used to assess the impact of the changing role of private health insurers. This framework comprises four elements: governance; rationale for and against intervention; type, target and timing of interventions; and outcomes of interventions.

2. Regulation of private health insurance in Australia and New Zealand

The Australian Government's *Private Health Insurance Act 2007* requires that medical purchaser-provider agreements and practitioner agreements 'must not limit the medical practitioner's professional freedom, within the scope of accepted clinical practice, to identify and provide appropriate treatments'.¹

Section 2.1 examines the legislative basis of these clinical autonomy provisions and existing commitments by health insurers to clinical autonomy in their medical gap policies. Section 2.2 examines health insurance regulation more broadly to understand the environment in which the private health market operates.

2.1 Regulatory framework for private health insurance contracting in Australia

The clinical autonomy provisions that underpin contracting by Australian private health insurers were introduced in April 1998. Their context and rationale are relevant. In 1996 the Commonwealth Government had legislated to encourage health insurers to contract with health providers. These contracts took three forms:

- Hospital purchaser-provider agreements (HPPAs) are contracts between health insurers and private hospitals;
- Medical purchaser-provider agreements (MPPAs) are contracts between health insurers and medical practitioners; and
- Practitioner agreements are contracts between medical practitioners and hospitals.

The AMA expressed concern that such contracts would diminish the clinical independence of medical practitioners and result in the introduction of US-style 'managed care'. The 1998 clinical autonomy provisions were one response by the government to allay medical practitioner concerns and achieve its objective of reducing medical gaps experienced by consumers.

However, participation by medical practitioners in contracts continued at very low rates (less than 10% in December 1999).² Accordingly, the Commonwealth Government legislated to remove the need for medical practitioners to contract with health insurers in order to receive medical gap payments under so-called 'no or known gap' arrangements.

Today, most medical practitioners simply register for eligibility to be paid benefits under each insurer's medical gap cover scheme. They do not enter into MPPAs with health insurers or practitioner agreements with hospitals. There is, in fact, no data reported on the participation rate by medical practitioners in MPPAs or practitioner agreements. (While the industry regulator reports on 'agreements' with providers in regard to gap or known gap arrangements, these data include the non-contracted medical gap cover policies).³

In the years since the introduction of the more informal (non-contractual) medical gap cover policies, and in response to the continuing opposition by some doctors to agreements, the Commonwealth Government removed almost all references to MPPAs and practitioner agreements in its legislation and regulation. The only remaining inclusion are the clinical autonomy clauses.

So, the somewhat unusual outcome is that currently:

- Most medical practitioners register for medical gap policies, which are not covered by the clinical autonomy provisions in the *Private Health Insurance Act 2007*;
- The clinical autonomy provisions in the Act apply to the largely superseded MPPAs and practitioner agreements. While there is no data on the number of medical practitioners covered by these agreements, it is expected that participation would be low, given the existence of the non-contracted medical gap policies; and

- There are no clinical autonomy provisions in the Act relating to contracts between private health insurers and private hospitals. As will be examined subsequently, many of the interventions that may impact on the clinical autonomy of medical practitioners are being introduced indirectly through these hospital contracts.

Despite this mismatched regulatory framework, the reality is that most health insurers do include protections related to clinical autonomy in their medical gap policies. Table 2.1 lists the clinical autonomy provisions of the five largest Australian private health insurers.

Table 2.1: Clinical autonomy provisions in medical gap policies, Australian private health insurers

Private health insurer	Policy document that refers to clinical autonomy	Wording of clinical autonomy provision
Medibank	Gap Cover Provider Guide ⁴	You retain complete clinical independence.
Bupa	Medical Gap Scheme: Practitioner's Guide ⁵	You maintain complete clinical independence.
	Medical Gap Scheme: Terms and Conditions ⁶	Bupa acknowledges that medical practitioners are to exercise their independent clinical judgement at all times in relation to the provision of services to eligible Bupa members. Bupa will preserve medical practitioners' professional freedom and will not interfere in the autonomous relationship between medical practitioners and their patients. Bupa accepts no responsibility (other than paying benefits) for the medical treatment of members.
HCF	Medicover Terms and Conditions ⁷	As a recognised provider and when you use HCF Medicover, you can expect us to acknowledge your freedom to identify and provide within the scope of accepted clinical practice the appropriate form of clinical treatment for HCF members in your care.
HBF	Medical Gap Provider Guide ⁸	Under no circumstances are any of the conditions associated with HBF's Medical Gap cover arrangements to interfere with the clinical decision-making of a medical practitioner or in any way affect the confidentiality between the patient and the medical practitioner.
nib	MediGap Scheme Terms and Conditions (9 September 2015) ⁹	<i>There are no clinical autonomy provisions.</i>

2.2 Comparing Australian and New Zealand health insurance regulation

The clinical autonomy provisions only tell one part of the story when it comes to understanding the incentives or disincentives on private health insurers to operate as active purchasers. Equally important are the broad regulatory framework for private health insurance and the mix of public and private financing and health service provision models.

This is illustrated by comparing the environment in which Australian and New Zealand private health insurance operates. Some of the key differences across the two countries that are potentially relevant to the purchasing role of private health insurers are outlined below.

Private health insurance penetration and market concentration

New Zealand has a much smaller private health insurance market than Australia.

In terms of its contribution to total health spending, the Australian private health insurance sector plays a larger role than the New Zealand sector. In New Zealand private health insurance accounted for 4.9% of total recurrent health spending in 2009/10, compared to 6.0% a decade earlier in 1999/2000.¹⁰ Australian private health insurers accounted for 8.3% of recurrent health spending in 2013/14. It has increased from 7.4% in 2011/12, coinciding with changes to income testing arrangements for rebates that have resulted in a declining contribution by the Australian Government.¹¹

Turning to population coverage, just under half (47.4%) of all Australians had hospital insurance membership in June 2015¹², up from a low of 30.1% in December 1998¹³. The trend in New Zealand is almost the mirror opposite. The peak industry association, the Health Funds Association of New Zealand (HFANZ), estimated that only about 30% of the New Zealand population had health insurance in March 2013.¹⁴ This represents a significant decline from 47.8% of the population in 1990.¹⁵

The smaller New Zealand health insurance market is highly concentrated. While HFANZ has 10 member associations that represent 97% of private health insurance policies in New Zealand¹⁶, one health insurer dominates. In 2014/15, the Southern Cross Health Society had 61% of the health insurance market and met 73% of health insurance claims in New Zealand.¹⁷ This not-for-profit health insurer is part of a vertically integrated group that also has a separate Health Trust that operates hospitals, travel insurance and primary health care clinics.

The former Australian regulator, the Private Health Insurance Administration Council (PHIAC), assessed that the Australian health insurance market is significantly concentrated.¹⁸ In 2012 Medibank and Bupa accounted for 54% of all health insurance policies, while three other insurers (HBF, HCF and nib) accounted for about one-quarter of the market. Although there has been considerable market consolidation in the Australian industry over the last two decades, there were still 24 small private insurers in 2012 (some of which are regionally based) that accounted for about 8% of all private health insurance policies.

PHIAC also identified a major shift in the mix of for-profit and not-for-profit companies in the Australian private health insurance market. As a result of demutualisation and public listing of private health insurers, the market share of for-profit health insurers in Australia grew rapidly from 12.5% in 2000 to 68.6% in 2012.¹⁹ This contrasts with New Zealand, where, as already noted, the dominant health insurer is not-for-profit, as are most of the other smaller health insurers.

Market share data in the private hospital sector are not published by governments in either Australia or New Zealand. According to financial publications, Ramsay and Healthscope had 25% and 17% market shares respectively of the Australian private hospital sector in 2014.²⁰ The ownership trend in the Australian private hospital sector has been towards for-profit ownership (similar to the trend in the private health insurance sector). In 2012/13 just over half (54%) of beds in Australian overnight private hospitals were owned by for-profit organisations, 37% by religious or charitable organisations and 9% by other not-for-profit groups.²¹ Ownership data are not available on private day hospitals. The market concentration is expected to be much lower in private day hospitals than private overnight hospitals. Many private day hospitals specialise in particular procedures or services and some of these hospitals may be owned by groups of doctors. For example, of the 319 Australian private day hospitals, 56 were endoscopy centres, 42 were eye surgery clinics, 29 were plastic and reconstructive surgery clinics, 16 were fertility clinics or reproductive health centres, 14 were dialysis clinics, 13 were oral and maxillofacial procedure centres and 11 were haematology and oncology clinics.²²

Private health insurance products and regulation

The overarching regulatory framework for private health insurance is very different across Australia and New Zealand.

The New Zealand government has very limited involvement in the private health insurance market. Private health insurers are regulated as insurance businesses (rather than via health insurance specific legislation) and there are no rebates or tax deductibility of health insurance premiums. This is significantly different to Australia where the Commonwealth Government has used incentives (health insurance rebates) and disincentives (Lifetime Health Cover to encourage younger members and higher Medicare Levy surcharges for non-insured, high-income people) to encourage growth in private health insurance membership. The Australian government is moving towards broader industry regulation, with recent changes including the abolition of two health insurance specific regulatory bodies (the Private Health Insurance Administration Council and the Private Health Insurance Ombudsman) and the transfer of their functions to broad regulatory agencies (the Australian Prudential Regulatory Authority and the Commonwealth Ombudsman).

In Australia private health insurers are required under the *Private Health Insurance Act 2007* (and associated regulations) to provide community-rated products that do not price discriminate on the basis of age, gender or health status. (This is being examined as part of the recently announced Commonwealth Government review into private health insurance). Australian health insurers are required to accept anyone who wishes to join and they must provide the same benefits to all members after waiting periods relating to pre-existing conditions have been served.

The health insurance market in New Zealand is risk-rated so premiums vary according to underwriting criteria based on factors such as age and health status.²³ Health insurers in New Zealand can reject potential members. They also routinely require potential members to disclose all information relating to any pre-existing conditions. These conditions are then identified and excluded in individual membership policies, although some health insurers may allow members to seek a review of excluded pre-existing conditions after several years.²⁴

In principle, these regulatory differences create more 'downstream' pressure on Australian private health insurers to manage their costs through their contracting, product design and policy terms and conditions. New Zealand health insurers, in contrast, can reduce their financial exposure upfront through rejecting high-risk members or limiting coverage of pre-existing conditions.

3. Recent developments in health insurance purchasing

This chapter examines three case studies of purchasing approaches used by private health insurers that potentially impact on clinical autonomy comprising:

- The Southern Cross Health Society's selective contracting approach where it only pays for specified services if they are provided by Affiliated Providers and it determines eligibility criteria before patients will be assessed as eligible to receive certain procedures;
- The agreements between the Australian Society of Plastic Surgeons, Medibank and Bupa that will replace pre-approval processes used by Medibank with a specialist eligibility authorisation process coupled with a post procedure audit model; and
- Medibank's contracts with some private hospitals where it will not pay the hospital for the additional hospital costs related to any of 165 adverse events.

3.1 Selective contracting with affiliated providers

Since 1997 Southern Cross Health Society has been using its dominant market position in New Zealand (61% market share) to moderate health spending through its Affiliated Provider program. Affiliated providers include both facilities (hospitals, medical centres) and individual specialists. (They do not include GPs, pharmacy services, optometrists and other primary health care services).

Members are encouraged by Southern Cross Health Society to use the services of affiliated providers with an online directory that lists facilities and specialists by location, service speciality and name. While members may still face co-payments depending upon their level of cover, Southern Cross uses three arguments with its members to encourage the use of affiliated providers:

1. *"It's easy. The Affiliated Provider organises prior approval for the member's healthcare service and claims on their behalf.*
2. *It keeps future premiums more affordable by helping us to manage the cost of claims.*
3. *Agreed prices mean members know up-front how much their contribution will be (if any)."*

As is evident, the Southern Cross approach shifts the relationship between the medical practitioner and the patient to one where the medical practitioner is now responsible for discussing and 'agreeing' with the health insurer the service to be provided and its price. (In effect, agreement means that the medical practitioner agrees to accept the Southern Cross schedule of fees/benefits payable to Affiliated Providers).

The claimed benefits for members are, however, counterbalanced by the reduction in choice of both hospitals and medical practitioners. This is given real effect through Southern Cross's requirement that members will not receive any benefits for certain procedures unless they are provided by an Affiliated Provider. (The exception is members on the most expensive plan (Ultracare) who will be paid benefits for treatment by any provider including those who are not Affiliated Providers).

Southern Cross is expanding the range of services for which it will only pay benefits through Affiliated Providers. It phases in the introduction of new 'Affiliated Provider-only health care services' so that it continues to pay other providers until, in its judgement, there are 'sufficient Affiliated Providers in place'. As at October 2015, the list of Affiliated Providers covers the following number of medical practitioners by speciality: cardiac surgery (1), cardiology (120), clinical neurophysiology (3), gastroenterology (199), general surgery (206), gynaecology (6), imaging (16), internal medicine (14), interventional radiology (14), ophthalmology (114), oral/maxillofacial surgery (41), orthopaedic (200), otolaryngology (76), peripheral angiography (23), plastic surgery (51), radiotherapy (24), respiratory and sleep medicine (36), skin (435), urology (121), varicose veins (180) and vascular surgery (5).²⁵

Issues include:

- To what extent does the Affiliated Provider program represent highly selective or broad contracting by Southern Cross? What is the proportion of medical practitioners for each speciality covered by these arrangements?
- Do any differences in the coverage rate of individual specialties reflect decisions by individual medical practitioners not to participate or decisions by Southern Cross on its judgement as to what constitutes a 'sufficient number' of specialists?

Table 3.1 identifies the established services that are Affiliated Provider-only health care services, as well as the new services that will become Affiliated Provider-only once agreements have been signed with a sufficient volume of providers.²⁶

Table 3.1: Southern Cross – Affiliated Provider-only health care services

Existing services	New services that will transition to Affiliated Provider-only status
Balloon sinuplasty Catheter based cardiology procedures Cholecystectomy Computer Axial Tomography Corneal crosslinking CT angiogram CT coronary angiogram Endoscopic modified lothrop Eye surgery Gastrointestinal endoscopy GDx retinal scanning Heidelberg retinal tomography Hernia repair Hip joint replacement Intravitreal injections Knee joint replacement Laparoscopic renal cryotherapy Mohs surgery MR angiogram Magnetic resonance imaging Optical coherence tomography Peripheral angiography Positron emission tomography/Computed tomography Prostate treatment Radiotherapy Varicose veins (legs)	Adenoidectomy Carpal tunnel release Eye surgery Grommets Laser eye treatment Prostate treatment Sacral nerve stimulation Skin lesion removal Tonsillectomy Tooth extraction Vasectomy

Southern Cross then uses its Affiliated Provider program to limit the payment of benefits for certain procedures through the use of 'eligibility criteria'. These eligibility criteria are comprehensive, specific to individual procedures and identify a range of clinical issues that must be satisfied before benefits are payable including:

- The **type of procedure**: for example, hernia repair by abdominoplasty will not be covered;
- The **previous procedures that must have been undertaken**: for example, removal of submucosal fibroids using Myosure requires that the pre-operative trans vaginal sonography demonstrates that more than 50% of the submucosal fibroid projects into the uterine cavity;

- The **exclusionary conditions** that rule out payment of benefits: for example, balloon sinuplasty will not be covered if extensive sino-nasal polyps or allergic fungal rhino-sinusitis is present; and
- The **clinical signs and symptoms** that must be present: the eligibility criteria for paediatric colonoscopy define a range of conditions, at least one of which must be present or diagnosed, for benefits to be payable.

As at October 2015, Southern Cross had eligibility criteria for 37 groups of procedures. There is no transparency as to how these eligibility criteria are developed and the evidence base on which they rely. Only two of the 37 sets of eligibility criteria include any external referencing, namely:

- The criteria for adult colonoscopy are taken from the NZ Guidelines Group publication on the surveillance and management of groups at increased risk of colorectal cancer; and
- The criteria for radiography use elevated PSA levels based on Trans Tasman Radiation Oncology Group guidelines.

Commentary and Issues

The regulatory framework in Australia discourages the Southern Cross approach of selective contracting with only some hospitals and some medical practitioners to achieve 'preferred provider' networks. In particular, the option of non-payment for certain conditions unless they are provided by 'Affiliated Providers' is not allowed as private health insurers must pay at least the 25% medical gap for in-hospital medical services for all medical practitioners. Similarly, second-tier default benefits mean that Australian private health insurers cannot exclude hospitals from receiving any benefit payments. Nonetheless, Australian private health insurers can provide incentives for their members to use certain providers through promoting information on 'members' choice' networks that is based on lower co-payments when members access network services. This is occurring more frequently with insurance for allied health services, including the situation where health insurers also operate services such as dental clinics through separate businesses.

Choice of hospital and medical practitioner is valued as one of the main benefits of private health insurance. Health insurers, such as Southern Cross, must tread a fine line in establishing preferred provider networks so that their members believe that there is still sufficient choice of private health providers. In New Zealand the public is already primed to accept less choice – private health insurers do not have to accept all members and can reduce cover to exclude pre-existing conditions. In this environment, further restrictions on choice of health providers may be accepted more readily than in the open and community-rated Australian private health insurance sector.

In the less concentrated Australian private health insurance market, insurers can also compete against each other on the basis of their breadth of provider coverage. In theory, this would limit insurers from offering coverage that is highly selective in terms of provider coverage. However, health insurance does not operate as a well-informed market and there is relatively limited 'switching' by consumers across health insurers. Given the market power of the two major insurers (with Medibank and Bupa each having over 25% market share), the emergence of more restricted 'preferred provider networks' could occur in Australia, particularly if the current private health insurance review results in greater deregulation of minimum benefits for hospitals and medical practitioners.

3.2 Pre-approvals, eligibility authorisations and audits

Australian private health insurers have always followed the lead of Medicare which does not provide coverage for cosmetic surgery. However in recent years, there has been considerable debate about the boundary between cosmetic and plastic surgery and the role of private health insurers in determining when benefits should be payable.

In June 2014 Medibank decided to introduce a pre-approval process for plastic surgery to determine if it was being undertaken for medical or cosmetic reasons. Medibank noted that this new pre-approval process was in response to an audit it had undertaken of 1000 plastic surgery claims, 25% of which were identified as being for cosmetic reasons.²⁷ The pre-approval process was contested by plastic surgeons and the Australian Society of Plastic Surgeons (ASPS) as introducing delays for patients, creating uncertainty and signalling the introduction of ‘managed care’ tactics with health insurers intervening in clinical decision-making. Bupa announced that it would introduce eligibility criteria, commencing in September 2014, for procedures including blepharoplasty and specific nose, stomach and breast-related plastic surgeries.²⁸

Following protracted negotiations (and input from other stakeholders including private hospitals and the Commonwealth Government), the ASPS announced in late 2014 that it had reached agreement with Medibank and Bupa to replace their respective pre-approval and eligibility criteria processes with new ‘eligibility authorisations’ and audit processes.

The eligibility authorisation shifts the responsibility for medical necessity decision-making back from insurers to individual medical practitioners. Rather than a process involving approval by an insurer, the eligibility authorisation process is based upon the medical practitioner certifying that:

“I believe my colleagues would regard the surgery or treatment as clinically necessary for the appropriate treatment of the patient”.

The eligibility authorisation form must be completed for specific procedures/MBS items relating to surgery on the face, eyes, nose, breasts or abdomen, as well as revision of scars. As part of this certification, the medical practitioner is required to provide information on the applicable MBS codes, the underlying medical condition including the severity and duration of signs and symptoms, and advice on how the surgery or treatment is expected to address these signs and symptoms. Under this process, private health insurers are not involved in approving or rejecting applications prior to the conduct of surgery. The locus of decision-making about medical necessity remains with medical practitioners.

However, this upfront automatic authorisation process is partnered with independent audits subsequent to the provision of surgery or treatment to the patient under what is described by ASPS as a self regulation audit model. This model allows up to 16 ASPS members annually to be nominated by either Medibank or Bupa to participate in a ‘voluntary post-procedural audit model’. A three-person audit panel (comprising a medically qualified representative of one of the insurers, a Commonwealth Government representative and a member of ASPS) review 5-10 cases of each audited ASPS member. Depending upon the outcomes of this initial audit, the ASPS member may be the subject of a special audit with additional cases reviewed.

The process is ‘voluntary’ in that ASPS members may choose not to complete the eligibility authorisation form or to participate in the audit process. However, the medical practitioner implicitly accepts the potential for audit if he/she participates in the eligibility authorisation process. The eligibility authorisation form:

- Provides written advice to the medical practitioner that ‘audits are periodically undertaken subsequent to surgery or treatment’; and
- Requires the written consent of the patient for the surgeon to provide any supporting documentation (including referral letters, investigations and photographs) to the health insurer for the purposes of audit.

Commentary and Issues

This case study illustrates some of the options that may be used by health insurers seeking to challenge the medical necessity of certain procedures or hospital admissions. In particular, it highlights the potential trade-offs between the timing of interaction with a health insurer (prior to /after a hospital admission), the impact on patients (non-provision of a service, delays, non-payment of benefits) and the nature of the intervention by insurers (pre-approval, self-certification by the medical practitioner, audit).

While this case study played out specifically in relation to whether plastic surgery was being undertaken for medical or cosmetic reasons, there is potential for the same models and issues to arise more broadly with any hospital admission payable by a private health insurer.

Indeed, New Zealand private health insurers routinely use pre-approval processes for all hospital admissions, not simply those suspected of being cosmetic in nature. In addition, the responsibility for navigating the pre-approval process in New Zealand is placed on the health insurance member / patient, rather than the medical practitioner. The general process is that the patient must submit a pre-approval form to their insurer at least five to seven days prior to surgery. Using Accuro health insurance as one example²⁹, the pre-approval form requires information including:

- Contact details for the patient's GP, together with a copy of the initial medical referral;
- Contact details for the specialist including the date of first specialist consultation and whether other treatment was offered;
- The procedure and reason for procedure;
- A history of symptoms; and
- A quote to be filled out with the assistance of the surgeon and private hospital detailing the fees for the surgeon, anaesthetist, theatre, diagnostics, hospital accommodation (number of days and rate/day), prosthetics and sundry expenses.

However, the rationale for pre-approval in New Zealand extends beyond the medical necessity issues that were at the core of the dispute between Australian private health insurers and plastic surgeons. In New Zealand pre-approval processes are the inevitable consequence of health insurance policies that can exclude pre-existing conditions. As health insurance benefits are only payable for new conditions, New Zealand private health insurers use the pre-approval process to determine whether the proposed hospital admission / treatment is in any way linked to pre-existing conditions for which coverage would be denied.

Other Australian health insurers that are not party to the agreement with ASPS may continue to use pre-approval processes. For example, HBF has a 'Limited Surgical Items List' for MBS item numbers which have been found to include 'a high cosmetic component'. Medical practitioners are required under HBF's medical gap cover arrangements to contact HBF prior to providing any services that include or are associated with items on the HBF Limited Surgical Items List to determine if MBS benefits are payable.³⁰

There are subtle but important differences between pre-approval processes, Bupa's previous proposal to introduce eligibility criteria and the new ASPS self-certified authorisation process, notwithstanding that all three models operate prior to the provision of the medical service. These differences concern the locus and transparency of decision-making, namely:

- Pre-approval – the insurer is the decision-maker, but there is no transparency as to the criteria used to determine whether an application is approved or rejected;
- Eligibility criteria – the insurer issues the eligibility criteria which provide transparency as to what services are or are not covered; and
- ASPS eligibility authorisation - the medical practitioner is the initial decision-maker, but his/her performance can subsequently be audited. There is limited transparency as to the basis of the medical practitioner's authorisation decision.

In theory, the use of published eligibility criteria would result in greater certainty (than the other two approaches), as they are available for upfront consideration by the medical practitioner. The critical issue for many medical practitioners will be whether such eligibility criteria should be accepted if they are developed unilaterally by private health insurers. As an outcome of the recent dispute, Bupa indicated that it would work with ASPS to develop more detailed clinical guidelines to support the new processes³¹ (although it is unclear whether this extends to eligibility criteria).

3.3 Non-payment for adverse events

In mid-2015 the hospital contract negotiations between Medibank and Calvary stalled on the proposal by Medibank to not pay for the hospital treatment costs of a list of 165 'highly preventable adverse events.' The contract negotiations also included penalties for specific circumstances involving complications or readmissions within 28 days.

The Australian Private Hospitals Association (APHA) criticised the approach, but particularly the specific list, arguing that it had been developed in isolation by Medibank, was not based on accepted clinical standards and had not been validated by any safety and quality body. While denouncing the list as an example of managed care, the APHA also stated that:

"Hospitals are not opposed to quality measures in contracts with health funds provided they are:

- *Based on evidence;*
- *Likely to lead to improvements in healthcare delivery;*
- *Relate to risks that hospitals can manage."*³²

Medibank countered that its list was based on evidence and that the starting point for its list was:

- The Australian Classification of Hospital Acquired Diagnoses (CHADx)³³; and
- The National Set of High Priority Complications developed by the Australian Commission for Safety and Quality in Health Care (ACSQHC) and the Independent Hospital Pricing Authority (IHPA).

Medibank indicated that its final list was based on review of Australian and international evidence and discussions with healthcare partners. It also noted that about 40 other private hospitals had already agreed to the inclusion of the adverse events list in their contract negotiations.

At the end of August 2015, Medibank and Calvary announced that they had signed a new three-year contract, the terms of which would not be disclosed publicly due to confidentiality (this is standard practice for all HPPAs negotiated between private health insurers and private hospitals). However, Medibank did release its list of 165 adverse events and also indicated that it would establish an independent clinical review process³⁴. This process is intended to allow hospitals "to put forward evidence in seeking to demonstrate that responsibility for the event is unclear and that everything possible has been done to prevent the hospital acquired complication". Further information on the membership and operation of the independent clinical review process is not yet available.

Commentary and Issues

Context matters.

Much of the criticism of Medibank's approach focussed on claims around the evidence base for the adverse events list and views that the list had been developed and imposed by Medibank on private hospitals without sufficient consultation or clinical input.

In contrast, Bupa and Healthscope's October 2013 decision around non-payment of 14 'never events' was generally welcomed. Both the Commonwealth Minister for Health and the CEO of the ACSQHC offered their support for the broad Pay for Quality initiative rolled out by Bupa and Healthscope in June 2014 (that built upon and incorporated non-payment for never events).³⁵ The Pay for Quality initiative was characterised by Bupa and Healthscope as comprising two main streams:

- **Payment for participation** – this links funding to participation in key benchmarking activities, clinical quality registries and clinical indicators; and
- **Payment for performance** - this links funding incentives and/or disincentives for a certain level of safety and quality processes and outcomes.

At the 2013 launch of the non-payment for 'never events', Healthscope stated that:

"If a never event occurs in a Healthscope hospital, and it is due to hospital error, then we do not expect to receive payment from Bupa. We are prepared to stand by our commitment to quality and safety, it's the right thing to do".³⁶

Clearly, linking payment and quality is seen as acceptable by at least some private hospitals if this occurs in partnership with private health insurers.

On the second issue of the content / evidence base of Medibank's adverse events list, Table 3.2 shows:

- The 14 'never events' agreed by Bupa and Healthscope for non-payment in October 2013;
- The December 2013 'draft' national set of 15 high-priority hospital complications under development by the ACSQHC and IHPA; and
- A summary of Medibank's list of 165 adverse events.

Table 3.2 has been bolded to highlight similarities and overlaps across the three lists. There are several issues worth noting in relation to Medibank's list of adverse events. First, while the Medibank list was widely reported as comprising 165 adverse events, the list is actually based on five broad types of adverse events (pressure injuries, falls, healthcare associated infections, surgical complications and VTE). The 'full' listing of 165 adverse events arises as Medibank disaggregated out each of the individual ICD-10-AM codes that contributed to the five types of adverse events. Second, Table 3.2 indicates that the Medibank list of adverse events is considerably narrower than the draft ACSQHC list, comprising a subset of only five of the 15 adverse events on the ACSQHC list.

Third, and most importantly, Medibank has been criticised for using its 'own' list that is non-evidence based, rather than waiting for the development of a national list. In fact, Medibank's list was directly based on the draft ACSQHC list that was developed through a clinician-led, evidence-based review of the literature. Both public and private health sector representatives have been critical of the slow pace of the ACSQHC work which has been underway for over three years. The objective of the work, which commenced in September 2012, was to explore how potential approaches to pricing for safety and quality could be incorporated in IHPA's pricing framework for public hospital services.

One of the key outcomes of the joint ACSQHC / IHPA work was the 2013 KPMG report that specified a national set of high-priority complications.³⁷ The next stage in its development was to have been a proof of concept in four Australian hospitals to test the accuracy and completeness of these measures within routine hospital data collections, as well as to identify their usefulness for clinicians as a local resource for monitoring and supporting improvements in the safety of healthcare. As at October 2015, the ACSQHC website continues to report that this proof of concept 'will conclude in June 2015'. However, following Medibank's implementation of what is essentially a cut-down version of the draft list of high-priority hospital complications, the Commonwealth Minister for Health directed ACSQHC to fast-track this work so that it was finalised by the end of 2015.³⁸ However, a report on an ACSQHC convened roundtable on 30 September 2015 indicated that the ACSQHC would 'soon commence accuracy and utility testing of a draft list'.³⁹ In summary, while Medibank's use of the draft list has been highly criticised by some groups, others suggest that this intervention provided a badly-needed spur to expedite national agreement and action.

In a final note on the significance of context, it is important to recognise that in New Zealand the issue of non-payment by health insurers of adverse events or complications cannot arise. This is because the Accident Corporation Commission (ACC) as part of its no-fault compensation scheme is legally required to meet the costs of what were initially described as 'medical mishaps' and are now known as 'treatment injuries'. The ACC funds the treatment injury component of all health care services, irrespective of whether the original treatment was publicly or privately funded. In 2014/15 the ACC spent \$139 million on the costs of medical treatment injury comprising about 7,000 new claims and about 13,000 active claims in that year.⁴⁰

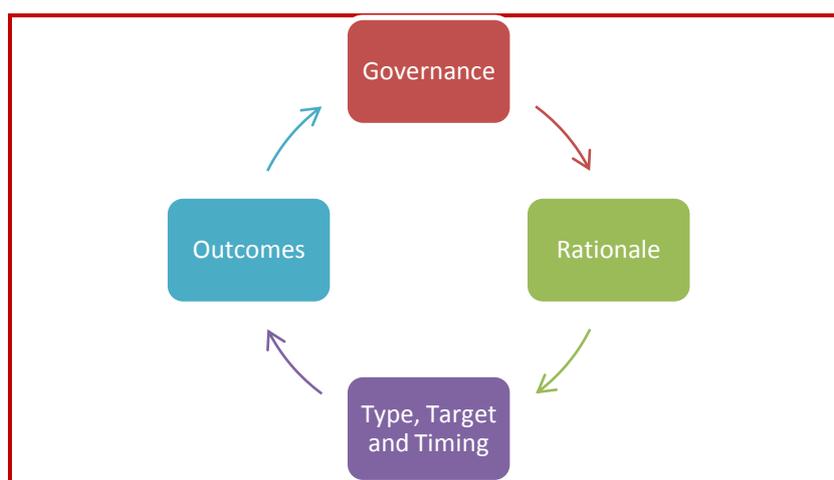
Table 3.2: Comparison of ‘complications’ lists in use or development by health insurers and the ACSQHC

Bupa and Healthscope list of 14 ‘never events’	ACSQHC draft national set of 15 high-priority hospital complications	Medibank summary list of 165 adverse events
<ol style="list-style-type: none"> 1. Procedures involving the wrong patient or body part resulting in deaths or major permanent loss of function 2. Retained instruments or other material after surgery requiring re-operation or further surgical procedure 3. Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs (excluding prescribing errors) including: 4. Maladministration of potassium-containing solutions; and 5. Wrong route administration of chemotherapy; and 6. Maladministration of insulin. 7. Haemolytic blood transfusion reaction resulting from ABO incompatibility 8. Suicide of a patient in an inpatient unit 9. Intravascular gas embolism resulting in death or neurological damage 10. Patient death or serious disability associated with a fall 11. Infant discharged to the wrong family 12. Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility 13. Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility 14. Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility 	<ol style="list-style-type: none"> 1. Pressure injury 2. Falls resulting in fracture and intracranial injury 3. Healthcare associated infection 4. Surgical complications requiring unplanned return to theatre 5. Unplanned intensive care unit admission or medical emergency team call 6. Respiratory complications 7. Venous thromboembolism 8. Renal failure 9. Gastrointestinal bleeding 10. Medication complications 11. Delirium 12. Persistent incontinence 13. Malnutrition 14. Cardiac complications 15. Iatrogenic pneumothorax requiring intercostals catheter 	<ol style="list-style-type: none"> 1. Pressure injury (Stage II and IV ulcers) (2) 2. Falls resulting in fracture and intracranial injury <ol style="list-style-type: none"> a. Intracranial injury (23) b. Fracture neck of femur (19) c. Other fracture (89) 3. Healthcare associated infection <ol style="list-style-type: none"> a. Urinary tract infection (1) b. Surgical site infection (2) c. Blood stream infection (2) d. Prosthesis associated infection (10) 4. Surgical complications <ol style="list-style-type: none"> a. Post-operative haemorrhage and haematoma (1) b. Other surgical complications (8) 5. Venous thromboembolism <ol style="list-style-type: none"> a. Pulmonary embolism (2) b. Venous thrombosis (6)

4. A systems framework to assess the impact of health insurance purchasing on clinical autonomy

Chapter 3 identified some of the ways in which private health insurers in Australia and New Zealand are increasingly becoming involved in influencing clinical decision-making. However, these recent examples need to be considered within a broader framework that moves beyond individual case studies. Figure 4.1 provides a systems framework, with each of the components of this systems framework used to assess the impact of the changing roles of private health insurers.

Figure 4.1: A systems framework for assessing private health insurance and clinical autonomy



4.1 Governance – roles and responsibilities of private health market participants

The regulatory and financing framework in which Australian private health insurance operates results in a set of roles and responsibilities that are not always well-aligned on the issue of clinical autonomy.

At one level, the Commonwealth Government is the ‘arbiter’ in determining when services are medically necessary through making decisions about inclusion of services on the MBS. In theory, the regulatory requirement that private health insurers cover the 25% gap up to the MBS fee removes any role for private health insurers in second-guessing medical practitioners on medical necessity grounds. However, this simple statement does not fully capture the complexity of the roles of each of the market participants and how they may diverge. For example:

- The MBS Review Taskforce⁴¹ notes that the Commonwealth’s compliance program (involving the Department of Health, the Department of Human Services and the Professional Services Review) includes a focus on inappropriate practice, incorrect billing and deliberate fraud. The outcomes of these Commonwealth activities do not automatically flow through to benefits paid by health insurers for the matching medical and hospital services.
- In recent years, some new items on the MBS have included specification as to the patient group or clinical conditions that determine the clinical and cost-effectiveness of the service. If this trend continues, it could be assumed that both the Commonwealth and private health insurers might seek clinical documentation to verify that the conditions in the MBS item have been satisfied before benefits were payable.

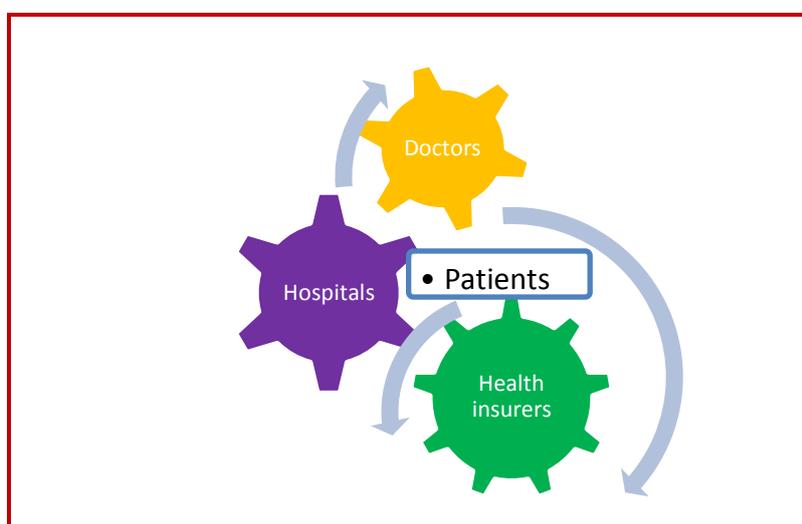
These examples illustrate the tension, and potential for divergent outcomes, when there are multiple payers involved in paying for the same service.

Similar issues arise in relation to the separate payment of benefits by health insurers for hospital services and for the private medical services that generated the hospital episodes. When the regulatory framework for private health sector contracting was introduced in the mid-1990s, it was assumed that the incentives would be aligned if health insurers had similar conditions in their HPPAs and MPPAs, or if hospitals entered into practitioner agreements with doctors that mirrored the conditions in the overarching agreement between the hospital and the health insurer. This did not eventuate with most doctors choosing not to enter into either MPPAs or practitioner agreements, but instead participate in non-contractual medical gap arrangements.

The outcome is that Australian private health insurers have increasingly gone around medical practitioners to include conditions in HPPAs that can have a significant influence on clinical autonomy. It is much easier for health insurers to negotiate contracts with a limited number of hospitals and hospital groups than with thousands of individual medical practitioners. The non-payment of adverse and never events was introduced through HPPAs and related to non-payment of benefits to hospitals. It did not affect payment of medical benefits as health insurers are still required to pay 25% gap medical benefits and the Commonwealth has no policy of not paying MBS benefits in this situation.

Health insurers have a strong expectation that private hospitals will act upon the conditions in HPPAs to influence the clinical practice of private medical practitioners. Doctors and the general public are not aware of the conditions and incentives included in HPPAs as these are confidential commercial documents. Private hospitals are increasingly being provided with benchmarking data by health insurers, often on input and process measures such as rates of readmission, number of minutes in theatre and length of hospital stay, with 'outlier' hospitals required to change their practice patterns. Some private hospitals reject the concept of being 'doctor police' on behalf of private health insurers. They argue strongly that doctors are independent practitioners, that doctors exercise their clinical judgement and are legally responsible for the medical care provided to patients, and that private hospitals are accountable only for the hospital services component of care (including nursing, allied health services, consumables and hospital facility services). In the centre of this non-aligned set of incentives are patients (Figure 4.2).

Figure 4.2: Lack of aligned incentives in Australian health insurance contracting



The ability or inclination of private hospitals to influence the behaviour of doctors is tempered under the dominant business model where medical practitioners bring in patients, and hence revenue, to private hospitals. This is changing somewhat in some independent private hospitals that are moving to directly employ medical practitioners. Outside of direct employment, private hospitals use accreditation and credentialing to indirectly influence the quality of medical services provided through the hospital. Some health insurers want private hospitals to take a more aggressive approach including 'super credentialing' that incorporates credentialing down to the level of specific procedures and/or requiring evidence on minimum

volumes and outcomes of care. (This is also occurring in some state public hospital systems for credentialing doctors with rights of private practice).

In New Zealand there is much closer alignment of interests and incentives across health insurers and private hospitals. As has been previously noted, this arises partly due to vertical integration with the Southern Cross Health Society group directly operating hospitals and primary health care clinics, as well as running a health insurance business. The ability of New Zealand health insurers to screen out high-risk members and to deny benefits for pre-existing conditions has created very different expectations about the role of insurers in effectively overriding medical decision-making. (While doctors can still recommend and provide medical treatment in this situation, the high costs for patients of 'uninsured' services would generally preclude this occurring).

The market power of Southern Cross in New Zealand has also created what is essentially a 'perfect storm' in fostering a growing spiral of influence over medical decision-making. Southern Cross has been able to sign many doctors up to its affiliated provider programs (presumably through initially generous medical benefits); it has then used those affiliated provider programs to restrict who provides certain medical services; and finally it has issued clinical guidelines that dictate to which patients, and in what circumstances, medical care will be provided.

Some believe that Australia is on a similar trajectory with an increasingly concentrated and for-profit private health insurance sector. Rather than affiliating medical practitioners, Australian health insurers are more likely to use their market power to specify acceptable clinical practice through hospital purchaser provider agreements. Private hospital representatives caution that the risk for clinical colleges and professional associations is that the opportunity offered by private health insurers to use data mining and predictive analytics to study and benchmark clinical practice may evolve from the relatively benign option of 'information to guide local decision-making' into the more intrusive option of 'rigid payment models to deny benefits through clinically supported guidelines'. Even without this development, a commonly held view is that some private health insurers have essentially done an end-run around clinical autonomy, with all the key levers now being exercised through hospital contracts, not doctor contracts.

4.2 Rationale for and against intervention by private health insurers

Another important dimension to consider in assessing interventions by private health insurers is the rationale or policy objective underpinning the intervention. The Chapter 3 case studies illustrate three major reasons that health insurers commonly cite to justify intervention, namely:

1. To ensure value for money and moderate health spending in order to keep premiums affordable for their members (the Southern Cross Affiliated Provider program);
2. To ensure that care provided is clinically necessary (the Medibank and Bupa approaches involving pre-approval and the introduction of eligibility criteria to determine the medical necessity of some surgical procedures); and
3. To promote improvements in safety and quality of health care services (the Bupa and Medibank initiatives to not pay for never and adverse events respectively).

The key question is whether these are legitimate reasons for intervention by private health insurers, and if so, how this interacts with the concept of clinical autonomy.

One way to assess these reasons for intervention is to consider whether they would be considered legitimate if they were undertaken by other payers. In other words, how much is it the 'messenger' rather than the 'message' that is seen to be problematic? In Australia other payers including Commonwealth and State Departments of Health / Human Services, the Commonwealth Department of Veterans' Affairs and third party

workers / transport accident compensation agencies have each used similar interventions with similar justifications to the private health insurers. For example:

- State governments are strongly focused on technical efficiency in their funding models for public hospitals. Many of these funding model decisions impact on clinical autonomy. For example, state governments may only fund certain procedures if they are performed on a same-day basis. They also constrain the choices of inputs such as prostheses, stents and pharmaceuticals through central purchasing arrangements and clinical guidelines that specify the conditions of provision for some of these inputs to care.
- DVA has operated a Pay for Performance scheme under which private hospitals are able to be paid bonuses according to their participation in a range of processes designed to improve the quality of care. For example, 30% of the P4P score in 2014 was based on results of DVA patient satisfaction surveys, with hospitals also required to achieve minimum levels of survey distribution to be eligible for the bonus. DVA has also used tendering to selectively contract for specified services. In 2014 it reviewed over 200 mental health outpatient day programs to identify those which were evidence-based, safe and supported the transition of veterans back to the community. DVA developed a set of clinical guidelines for mental health outpatient day programs which it used as the assessment basis in selecting providers with whom it would contract.⁴² Outside this example, DVA mandates that contracted private hospitals and other facilities report on their processes and outcomes of care including re-admissions, adverse events, infection control, medication safety, rehabilitation medicine and discharge planning processes. This reporting is based on the Australian Council on Healthcare Standards (ACHS) Clinical Indicator program.⁴³
- Queensland Health specifies annual 'purchasing intentions' which involve applying financial levers to drive the provision of efficient and effective care. In its 2014/15 funding model, Queensland Health has adopted a range of funding approaches to improve safety and quality including:
 - Incentive payments to hospitals that achieve a reduction in patients with chronic conditions being readmitted as an emergency with a chronic condition within 28 days;
 - Discounted DRG payment by 20% if surgical treatment of fractured neck of femur is not within two days (in previous years this was encouraged through an incentive payment);
 - Payment limits to discourage mental health frequent re-admissions involving no payment for more than 10 admissions to acute mental health inpatient units within 12 months;
 - Disincentives for adverse events including blood stream infections, Stage 3 and 4 pressure injuries and hospital acquired injury associated with administration of psychotropic medication for mental health inpatients;
 - No payment for specified out-of-scope services including vasectomies, reversal of vasectomies and laser refraction; and
 - Zero payment for six never events (death or likely permanent harm as a result of haemolytic blood transfusion reaction resulting from blood incompatibility; death or likely permanent harm as a result of bed rail entrapment or entrapment in other bed accessories; infants discharged to the wrong family; death or neurological damage as a result of intravascular gas embolism; procedures involving the retention of instruments or other material after surgery; procedures involving the wrong patient or body part resulting in death or major permanent loss of function).⁴⁴
- Western Australia has had a strong emphasis on incentive payments to encourage best practice care through its Performance-Based Premium Payments Program. Under this voluntary program, hospitals may receive higher payments if they achieve high levels of evidence-based care for designated conditions and treatments. In 2014/15 the three designated areas for which payments are available are fragility hip

fracture treatment, stroke model of care, and acute myocardial infarction.⁴⁵ For example, the hip fracture payment was based on similar models in the English National Health Service and it sought to incentivise timely surgery and appropriate involvement of geriatricians. Prior to introducing best practice payments, WA Health provided data on practice variation back to clinicians, as well as working with stakeholders to identify best practice and key performance indicators. This strategy of providing data back to clinicians was then supplemented with premium payments to encourage hospital executives to drive quality improvements.⁴⁶

The above examples highlight the rapidly evolving landscape of interventions used by other Australian payers of health care services to influence quality and safety and to set clinical parameters for appropriate care and best practice care. It is not immediately self-evident why private health insurers should not adopt similar purchasing strategies in regard to private hospital care.

The mantra that any intervention by health insurers equates to ‘US-style managed care’ is not particularly helpful. It is commonly used to repudiate any purchasing role for private health insurers and effectively disavows any legitimate interest by health insurers in quality, safety, appropriateness or best practice in the health services provided to their members. Under this view, insurers are simply relegated to passive payers of claims under a fee-for-service benefits model.

Given the focus of this section on understanding potential justifications for intervention, it is also important to understand the arguments that may sit behind the blanket rejection by some groups of ‘managed care’. Some of the arguments against intervention by health insurers, together with likely rejoinders, include:

- *Private health insurers are motivated by profit and competition for market share.* While this assessment is correct in many cases, this claim is equally valid for many private hospitals and private medical practitioners. Attacking the motivation of health insurers is not sufficient to deny them a role as purchasers of private health services.
- *Australian Government legislation protects the clinical autonomy of medical practitioners in providing private health care services.* The reality is that this legislation only applies to the relatively few medical practitioners that have entered into MPPAs or practitioner agreements, not the majority who are instead covered by non-contractual medical gap arrangements. It could also be argued that these almost 20-year old clauses are out-dated and do not reflect the more complex accountability framework in which health care is now provided.
- *Health insurers have no medical expertise and so should not intervene in clinical decision-making.* This criticism could also be made of other payers in the public and private health sector. It could also be challenged to the extent that insurers and other payers draw on medical expertise through employing clinicians, using evidence on clinical effectiveness and outcomes in developing their purchasing policies, and/or consulting extensively with clinical experts in developing strategies to influence quality and appropriateness of health care services. Health insurers may also have a relative advantage in bringing to the table data that can shed light on the robustness of clinical decision-making.
- *Health insurers are intruding on the doctor-patient relationship; there should be clinical autonomy in decision-making by doctors for their patients, and doctors should not be accountable to health insurance bureaucrats.* Part of the challenge with this argument is that it only seems to be used for private patients. The same argument is not routinely mounted for public patients accessing public hospital services, nor does it seem to arise for DVA beneficiaries. Unfettered clinical autonomy appears to imply that health insurance members have an open-ended ‘entitlement’ to the payment of benefits by health insurers. The *Private Health Insurance Act 2007* refers to ‘professional freedom within the scope of accepted clinical practice’, but is noticeably silent as to whether there is a role for any individual or agency to review whether decision-making is ‘within the scope of accepted clinical practice’. Clearly, consumers are not likely to be well-placed to form a view as to whether their treatment meets this criterion. The question

then becomes whether other agencies have a role in assessing divergence from accepted clinical practice. The existence of the Professional Services Review indicates that the Commonwealth Government believes it has a legitimate interest in these issues. If one payer has a legitimate interest, this could be extended to other payers of the same service.

- *Health insurers only want to not pay for poor performance; they are not willing to pay more for improved performance.* This is a common criticism, regardless of whether P4P programs are introduced by public or private payers of health care services. It is also the case that some of the behaviours being targeted through funding levers may be more responsive to bonuses (such as rewarding best practice care in accordance with clinical guidelines), while others may be more suited to funding penalties (such as not paying for never events). The relative mix of incentives and disincentives might change over time. The experience of states such as Queensland and Western Australia in implementing P4P type programs in public hospitals highlights changes to the types of levers used over time (e.g. begin with benchmarking information, move to incentive payments and follow-up with disincentive payments).

In conclusion, it is vital to move beyond simple assertions of the primacy of clinical autonomy to develop a more nuanced position as to how clinical autonomy adds value and how it operates in a complex regulatory, financing and accountability environment where many groups can legitimately claim to have a valid interest in how clinical decision-making is exercised.

4.3 Type, target and timing of private health insurance interventions

Table 4.1 provides a typology of private health insurance interventions organised against the three related dimensions of the type of intervention, the target audience for the intervention and the timing of when the intervention has its impact. It illustrates the diversity of approaches currently in use by Australian and New Zealand private health insurers to influence the appropriateness, quality or safety of health care, as well as to limit benefits payable by health insurers.

There are a few features of this table that are worth highlighting. First, upstream interventions (which are listed first in the table) are likely to have a more significant impact than those that take effect closer to the interaction between the medical practitioner and the patient. Stakeholder and media focus is frequently on the downstream interventions that directly impact on whether benefits are payable, such as non-payment of adverse events. In comparison, upstream interventions can change the whole environment in which services are provided. Decisions to contract with only selected hospitals or to limit services to preferred providers influence the scope of what services are able to be recommended by GPs and/or specialists, well in advance of subsequent decisions to recommend particular treatments for particular patients.

Second, interventions targeted at hospitals usually have a broader impact than those targeted at medical practitioners, which, in turn, have a broader impact than those targeted at particular types of services or sub-populations of patients. A possible exception to this general rule is the broad pre-approval process used by New Zealand health insurers for all patients to rule out pre-existing conditions. This pre-admission process is quite onerous in putting the onus of responsibility on individual patients for providing information to health insurers. While Australian health insurers encourage their members to check their coverage with them prior to surgery (for the purposes of understanding excesses and any policy exclusions), there is no firm requirement to do so. Instead, the onus is on medical practitioners to provide informed financial consent so that patients are aware of any gap payments they may face.

Both these observations have real implications for reviewing and debating the merits of 'clinical autonomy' where the focus has historically been on decision-making by individual medical practitioners. A broader systems approach that captures the government's regulatory framework and the current practice of hospital contracting by private health insurers is likely to be equally valuable in understanding how the scope of clinical practice may change in the future.

Table 4.1 Existing tools used by private health insurers that may impact on clinical autonomy, Aus and NZ

Type of intervention	Main target of intervention	Timing of intervention	Description of existing examples
Incorporating quality and clinical governance requirements in contracts between private health insurers and private hospitals	All contracted hospitals	Impacts prior to care being recommended	Medibank requires contracted hospitals to participate in national data registries and external benchmarking. Contracted hospitals must have a governance framework relating to safety and quality improvement programs with systems to monitor continuous improvement and regular reporting to and review by the hospital's governing body.
Selected contracting of hospitals	Hospitals (affects the number of hospitals for which benefits are payable)	Impacts prior to care being recommended	nib (in Australia) has agreements with only 80% of private hospitals. Non-contracted hospitals are paid at default benefits.
Approval of specialised programs at hospitals	Hospitals (affects the number of hospitals that offer programs for which health insurers will pay benefits)	Impacts prior to care being recommended	Since 1996, Australian private health insurers have approved psychiatric and rehabilitation programs at individual private hospitals. The Private Mental Health Alliance issues written guidelines that private health insurers can use in determining health insurance benefits.
Approval of providers	Providers (may influence the number of providers who can provide reimbursable care, or may influence the volume of care delivered by these providers)	Impacts prior to care being recommended	Southern Cross enters into contracts with a selection of providers through its Affiliated Provider program. Some services may only be provided by Affiliated Providers.
			HCF provides dental services through its own seven clinics in metropolitan Sydney. It also contracts with a network of participating providers in other locations
Pre-approval requirements for all or most services	Patients	Impacts prior to care being provided	New Zealand health insurers typically require patients to seek approval for all surgical procedures that are likely to exceed \$1000. In addition, pre-approval is used to check patient eligibility for payment of benefits linked to pre-existing conditions. The Accuro pre-approval form requires information to be provided on the surgeon (date of first specialist consultation and whether other treatment was offered); the history of symptoms; and a detailed quote for the cost of the procedure.

Impact of the changing role of private health insurers on clinical autonomy

Type of intervention	Main target of intervention	Timing of intervention	Description of existing examples
Pre-approval requirements for selected services	Providers	Impacts prior to care being provided	Until recently Medibank had a pre-approval process for plastic surgery through which it determined prospectively whether the proposed surgery was for medical or cosmetic reasons
			The HBF Limited Surgical Items List includes MBS item numbers which 'have been found to include a high cosmetic component' and they are excluded from medical gap benefit payments. HBF requires that if a service includes any such MBS item numbers, medical practitioners 'must contact HBF prior to providing the service to ascertain if any MBS benefits are payable'.
Setting clinical criteria that determine eligibility for nominated procedures	Providers (must provide information that patients meet the eligibility criteria)	Impacts prior to care being provided	Southern Cross issues a series of 'Eligibility Criteria' that limit the services for which it will pay benefits to patients with specific clinical indications. The criteria include both clinical indications which must be present before benefits will be payable, as well as other clinical indications for which benefits will not be payable.
			Bupa announced in 2014 that it would introduce eligibility criteria for specific procedures to determine medical necessity (no longer in effect).
Self-assessed certification by specialists to provide nominated care	Providers (relates to specific services)	Impacts prior to care being provided	The Medibank and Bupa pre-approvals for plastic surgery were replaced with a self-assessed certification by specialists that care was clinically necessary for appropriate treatment of the patient.
Requirements for clinical certification or documentation for benefit assessment	Providers (usually relates to selected services)	Impacts after care has been provided	Health insurers that are members of the Australian Health Service Alliance require specialists to complete ICU and CCU certificates for individual patients and provide clinical details on reasons for admission, pre-existing co-morbidities, patho-physiology and complicating factors.
			nib (in Australia) requires supporting documentation on use of surgically implanted prostheses, human tissue items, medical devices. It also requires information that a cancelled procedure, patient transfer or re-admission occurred.

Type of intervention	Main target of intervention	Timing of intervention	Description of existing examples
Establishing powers for health insurers to determine whether services are medically necessary	Providers (all services)	Impacts after care has been provided	Bupa's Fund Rules indicate that benefits are not payable for 'any services which the company reasonably believes are excessive and not reasonably necessary for the adequate care of the policy holder or their dependent children'.
Non-payment for hospital-acquired complications, adverse events or never events	Hospitals (through contracts with health insurers)	Impacts after care has been provided	Bupa entered into an agreement with Healthscope where Healthscope agreed to forgo payment if any of 14 'never events' occurred in one of their hospitals.
			Medibank has contracted with many private hospitals under terms which include the non-payment for a list of 165 hospital acquired complications that fall within three broad groups – falls in hospital, bed sores and surgical complications.
Requirements to allow insurers to undertake audits of health practitioners' records (including patient records and billing documentation)	Providers (covers all services)	Impacts after care has been provided	<p>Most Australian health insurers specify in their medical gap arrangements a condition that allows them to audit provider records. For example:</p> <ul style="list-style-type: none"> ➤ HCF has the right to audit any benefits paid and any related records to verify the calculation of the benefits. ➤ nib (in Australia) requires medical practitioners to provide access to clinical data and invoices for particular services. It may also conduct inspection visits to practitioners' offices to examine records.
Allowing targeted audits to assess the appropriateness of care	Selected providers (and selected services)	Impacts after care has been provided	The Australian Society of Plastic Surgeons reached agreement with Medibank and Bupa to a system of annual audits that review a sample of cases among a sample of providers.

4.4 Outcomes and impact of interventions

The final component of the systems framework outlined in Figure 4.1 is the nature of the impact of different interventions by private health insurers. By definition, all the interventions examined in Chapter 3 or included in Table 4.1 have a potential impact on clinical autonomy. However, the way in which this impact is experienced varies across the interventions and may include some or all of these negative impacts:

- Denial of access to some hospitals for patients;
- Denial of access to some treatments for patients;
- Delays in access to treatment for patients;
- Non-payment or reduced benefits to hospitals for some services;
- Non-payment or reduced benefits to medical practitioners for some services;
- Non-payment or reduced benefits to patients for some services;
- Non-payment or reduced benefits to patients for services provided by some providers; and
- Provision of information back to medical practitioners.

Most of these negative impacts will directly affect patients. This is obviously true for any intervention that erodes access to care, as well as most of the interventions that affect the payment of benefits. Some of the P4P interventions are intended to limit benefits payable only to hospitals, with additional costs not passed on to patients. This is the case with the Healthscope and Bupa agreement in relation to non-payment for any of 14 'never events'. However, it is unknown whether the hospital contracts entered into by Medibank for non-payment of adverse events require the hospitals to absorb these costs or whether patients may experience increased co-payments. The only impact that does not directly impact on patients is when private health insurers provide information back to medical practitioners as a result of audits (although there may be consequences for future patients if benefits are cut back for services provided by relevant doctors).

In addition to these initial impacts, there may be downstream negative impacts (not always directly measurable or attributable) including:

- Diminished continuity of care for patients;
- Reductions in health insurance membership (if health insurance is not seen as representing 'value for money');
- Shifting of care for some high-risk patients to public hospitals; and
- Worsening of health outcomes for patients due to denied or delayed access to treatment.

This listing of potential negative impacts is balanced by the potential benefits that link back to the reasons for intervention by private health insurers. These potential benefits include:

- Patients receive psychiatric and rehabilitation services that meet program guidelines;
- Patients receive medical and surgical services that meet clinical guidelines;
- Patients do not receive medically unnecessary services;
- Patients receive hospital services with lower or no co-payments; and
- Patients receive medical services with lower or no co-payments.

The potential downstream benefits (again not always directly measurable or attributable) resulting from intervention by private health insurers include:

- Reductions in health insurance premiums;
- Increase or stability in health insurance membership (if health insurance is seen as representing good value for money); and
- Reduction in variation in clinical practice.

In conclusion, stakeholders are likely to place different values on the relative costs and benefits of intervention by private health insurers.

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