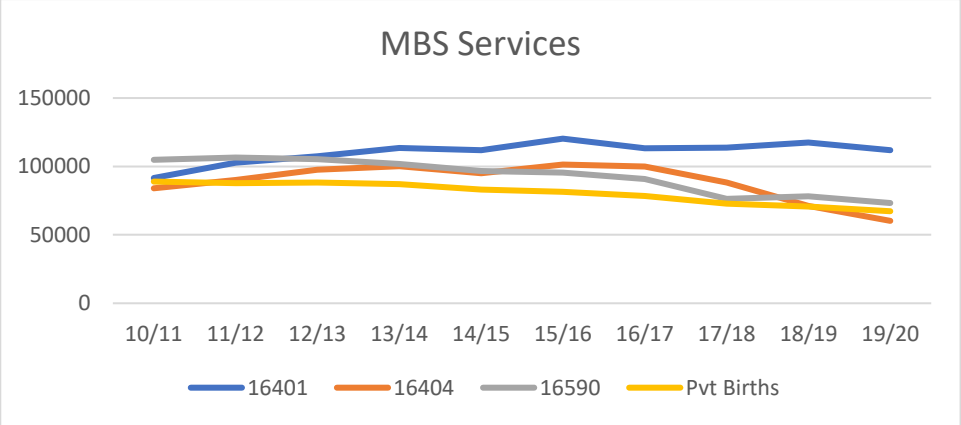
Future of Private Obstetric Services

The National Association of Specialist Obstetricians and Gynaecologists (NASOG) is committed to working with the Australian Government, private hospitals, private health insurers, other medical specialties and consumers to ensure private obstetric care in Australia is sustainable.

The interests of all groups are mutual. This is reason to work together honestly and transparently, to identify, design, implement and evaluate policy changes and/or new initiatives to address the decline in births in private hospitals.

MBS data show that over the past decade, women have continued to explore private obstetric treatment. Table 1 shows initial attendances by obstetricians increased by 22%, while subsequent attendances, pregnancy planning and management and private births decreased by 28%, 30% and 24%, respectively.

Table 1



Source: medicarestatistics.humanservices.gov.au Medicare Item Reports accessed 10 August 2020

NB: Pvt births are the total of items 16519 and 16522

This represents further reason to work together to improve the patient experience so that more women can, and do, choose private obstetric care.

Given the interrelationship of funding arrangements for private obstetrics, it will take concentrated effort from all groups to work together to avoid policy failures that inevitably come from looking at a problem through a single lens, and making decisions based on hunches.

From NASOG's perspective, the future of private obstetrics services is dependent upon developing well founded policy options with three higher order objectives:

- Make PHI cover for private births affordable.
- Limit expansion and contraction of out of pocket costs caused by arbitrary decisions about benefit levels by government and private health insurers.
- Help consumers to better understand and navigate private obstetric care, benefits and insurance arrangements.

It is important to put private obstetrics in context: it represents 3.2% of total acute separations from private hospitals in 2017-18, compared to 6.4% of public separations[i].

NASOG's responses to the Department of Health Future of Private Obstetrics Discussion Paper (July 2020) (the discussion paper) are limited because proposed policy options are not accompanied by a clear statement of intended policy outcomes or explanations of how the option will achieve that outcome. Similarly, conclusions drawn in the discussion paper do not seem to be supported by analysis or evidence.

NASOG cannot form any opinions about the merits of the Department's proposals or any way forward in the absence of clear objectives with specific rationales that are informed by detailed data.

Clearly, there is much groundwork to be done before appropriate policy options can be properly analysed and developed, and choices made about administrative changes and new initiatives.

Most of NASOG's responses to the discussion paper are about that groundwork.

What are the key drivers behind a fall in obstetric services?

The following factors have likely contributed to the decline in private obstetric births over the past decade:

- The freezing of Medicare Benefits Schedule (MBS) indexation, combined with Extended Medicare Safety Net caps, has impacted out of pocket costs for antenatal services
- The increasing cost of Private Health Insurance (PHI) premiums, combined with reductions in PHI rebates, has caused fewer women to have private obstetric cover
- Consumer expectation that PHI protects against out of pocket costs means more women choose public hospital obstetric care to avoid any out of pocket costs.

NASOG is aware that readers would add a fourth point:

- **High out of pocket costs for obstetrician services.**

This is subjective. Consequently, any measure to reduce out of pocket costs can be judged a failure. Further, such characterisation is disingenuous given out of pocket costs are a factor of decisions of Government and private health insurers about the amount of benefit they will pay for medical services.

NASOG notes that PHI benefits were not included in the estimate of patient out of pocket costs for items 16519 and 16522 in the table on page 9 of the discussion paper. There was no acknowledgement in the discussion paper that 80% of private hospital obstetrics and gynaecology is provided at no gap[ii] or that benefits that insurers pay varies by 37% ($585.70) for simple births and by 24% ($526.10) for complex births[iii].

NASOG wants to work with the Australian Government and private health insurers to undertake a detailed review and analysis of fees charged by obstetricians and other medical specialties involved in obstetric care. This is critical to objectively identifying an appropriate policy outcome and to truly understanding where efforts need to be focussed.

NASOG is also interested in establishing a mechanism for benchmarking fees and MBS rebates and PHI benefits and appropriate indexation to maintain a consistent financial experience for consumers.

The discussion paper outlines the frequency of government policy changes to MBS funding for obstetric services, none of which started with a clear policy objective or a planned, contemporaneous evaluation to determine if the policy objectives were being met.

The MBS policy pendulum swings and under/over-corrections of the past must be avoided if private obstetric practice is to have a strong and sustainable future.

The impact on public obstetric services is a critical consideration. If the private sector is rendered unviable by the downward spiral in PHI participation, the public sector cannot absorb the demand for obstetric services without seriously compromising accepted clinical practice. Given this scenario, it is a real possibility in the future that there will be limited career positions, or appeal for junior doctors to pursue obstetrics as a speciality.

Significant additional capital and recurrent funding would be required from the Australian and state governments to increase the capacity of public hospitals to meet the increased demand and provide an appropriate standard of care. Even if governments committed to increasing public hospital capacity, the implementation tail is long, with public hospitals unable to cope in the meantime.

These are important reasons for making PHI obstetrics cover more affordable, to offer consumers choice and ease demand for public hospital services.

The level of Government support for private obstetrics, through MBS and PHI rebates or new arrangements, must factor in offsets for the public sector and provide incentives for young obstetricians to choose private practice.

Any changes to the current arrangements and new initiatives must be designed to address very clearly stated policy objectives and measurable outcomes, with planned and agreed evaluation that is undertaken with the medical profession. This will engage the obstetric profession and engender ownership of the policy objectives and their outcomes.

Emerging models of private obstetrics

Based on the discourse in the discussion paper, this option appears to be favoured by the Department of Health.

Proliferation of 'emerging models of private obstetrics' is not supported. They have not been subject to any scrutiny of their policy objective, their design and implementation, nor evaluation. These models:

- Are manifested in deals between private health insurers and private hospitals which lock private medical practitioners out of negotiations but into billing arrangements.
- Are offered to practitioners in circumstances that are coercive – two days to agree, with vague caveats for clinical practice and program compliance and no opportunity to seek advice due to confidentiality clauses.
- Tie a doctor to a 'no gap' fee/benefit arrangement that includes a requirement to satisfy the insurer of anything the insurer decides to 'require'.

Under these circumstances, it cannot be interpreted that because obstetricians have signed participation agreements, the individuals or the profession as a whole support them.

Further, these models are not an optimal solution. **Not all patients with obstetric cover are eligible for these programs** – women with complicating health factors or who are carrying more than one baby are excluded. Proliferation of such 'deals' will only make it harder and more complex for consumers to choose a private doctor, a private hospital and PHI product. It is not proven that insurers are profiting from this activity through increased participation in PHI, or that private hospitals are profiting from increased obstetric admissions.

These deals already contain aspects of managed care[1]. Some of these models make bulk billing antenatal services a condition of participation, which the Department appears to find an attractive vehicle for paying bundled MBS rebates. If insurers also purchase hospitals, such as Medibank Private's recent purchase of a 49% share in East Sydney Private Hospital, there is potential for insurers to put profit ahead of quality patient care. The Department must surely be interested in ensuring the Government's contribution to private obstetrics through MBS and PHI rebates is directed to patient care and not dividends to shareholders.

There is no guarantee that savings will eventuate. In the United States, where such purchaser/provider agreements are a key feature of health financing, health spending is now at 17% of GDP compared to Australia at 9.3%[iv]. The US no longer reports obstetrics health care utilisation data to the OECD to allow service comparison.

These 'models' need proper evaluation of their effectiveness and impact on patient experience, both in terms of clinical outcomes and out of pocket costs. Bupa is offering its Hatch program in Brisbane only until 30 November 2020[v]. The reasons for Bupa's limited pursuit of its program will be material to further consideration of these models of care. It is too early to assume they are good for private obstetric care. There is certainly no evidence on which to assume they are material to 'the obstetrics profession achieving reduced high out of pocket costs for patients under the current MBS funding model' (asserted on page 7 of the discussion paper).

Further evaluation of these models should include representatives from all of the groups identified at the beginning of this document.

MBS Bundling options

There is no evidence that appropriate obstetric clinical care is contested – which is usually the first reason to introduce bundled payments – either from the recent MBS Taskforce Review (2016) or from the data presented in the discussion paper.

The discussion paper does not explain how bundled payments will address out of pocket expenses. In relation to bundled payments, the OECD found that tariff setting is more complex and brings an added administrative burden[vi].

[1] Managed care emerged in the American health system in the 1980s as a way to manage suppliers' induced demand and to contain insurers' costs, whereby insurers own health care facilities, employ medical personnel or contract selectively with independent providers.

MBS Bundling options can only be properly considered in the context of a clearly stated policy objective.

> Does the Department want to reduce MBS rebates?
>
> Or is it intended to 'cap' out of pocket costs by applying a single, higher MBS benefit for antenatal services to specific fee amounts?

A detailed analysis of fees charged and benefits paid, by all medical specialities involved in obstetric care, is needed to understand where and when out of pocket costs are occurring, how they influence women to choose public obstetric care, and how a single, bundled MBS benefit might change that choice.

Bundled payments will create higher administrative costs, which would have to be justified by the policy objective.

EMSN changes and bundling

If other policy setting and implementation is done well, the EMSN could be redundant.

Private health insurance

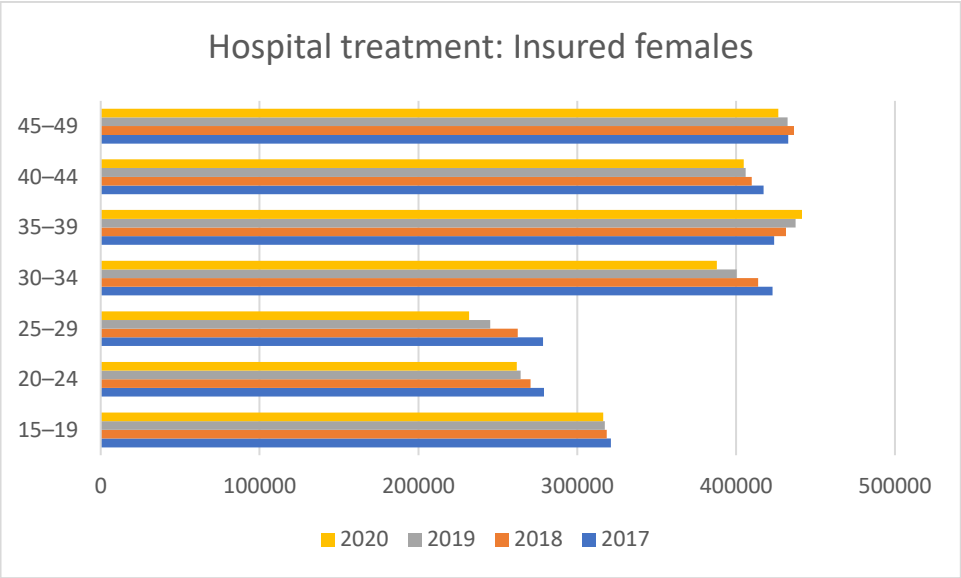
The number of childbirths in private hospitals decreased on average by 3.8% in each of the five years to 2017-18, and by 6.6% from 2016-17[vii]. The proportion of births in the private setting was 22.5% in 2017-18, which is 5% lower than in 2010-11[viii].

The Australian healthcare system relies on a steady balance of public and private services. The recent and rapid shift to the public sector is undesirable:

- Significant capital investment in private hospitals, and which has contributed to economic growth, will lay idle.
- Public hospitals do not have the capacity to meet increased demand.

Fewer women are covered by private health insurance (PHI). Table 2 shows the age groups of women who were covered by hospital treatment tables in the March quarter of the past four years.

Table 2



Source: Australian Prudential Regulation Authority Private health insurance membership and coverage March 2020. Table 5 Coverage of Hospital Treatment Tables offered by Health Benefits Funds, Insured Persons by Gender and Age Cohort XLSX. Accessed 4 August 2020

The decline in PHI held by the age groups 20-24, 25-29 and 30-34 are likely to be having some impact on the decline in births in private hospitals.

However, there is no publicly available data to show how many women hold, or held, cover for obstetric services, that allows analysis of cause and effect.

Such data would inform policy changes, such as including obstetric cover in all PHI policies, to provide incentives for women to hold PHI for obstetric services.

Proposals for private health insurance policy change

Combine MBS benefits and PHI benefits in a single payment to be administered by private health insurers

This is an administrative implementation option IF the notion of bundled payments proceeds. Consequently, it is too early in this process to consider a single possible administrative arrangement.

This proposed administrative option represents a significant change to the current arrangements – most fundamentally the payment of government benefits for out of hospital services via a private company which has shareholder interests to consider.

It is hard to see why passing MBS benefits to private health insurers to make payments on behalf of the Government for antenatal care is needed.

> Does the Government believe private health insurers will do a better job at controlling MBS expenditure, by limiting the number of services a privately insured patient receives?
>
> Does the Government want private health insurers to do its bidding by making bulk billing of MBS antenatal items a condition of participating in their gap cover schemes?
>
> Will private health insurers be able to compete for policy holders on the basis of promised obstetric benefits?
>
> By how much will insurers "clip the ticket" to cover administrative costs?

A transparent and robust regulatory mechanism would need to be overseen by a third party, which will come at additional cost. Lessons learned from the Royal Commission into the financial services sector would need to be applied.

Instead NASOG believes this particular discussion should focus on policies designed to increase the number of women holding policies that cover private obstetric care. NASOG offers the following policy options, recognising the need for them to be informed by data about the extent to which PHI policies have covered women for private obstetric care, and which have been dropped.

Mandatory age based premium discounts apply to policies that cover women for obstetrics.

Since 1 April 2019, insurers are able, but not required, to provide premium discounts on hospital cover of two per cent for each year that a person is aged under 30 when they first purchase hospital insurance, to a maximum of 10 per cent for 18 to 25 year olds. Once a policy holder has an age-based discount, they will retain that discount rate until they turn 41 if they remain on the same policy. These discounts will then be gradually phased out after a policy holder turns 41.[ix]

These policy parameters could be applied to a mandatory aged based premium discount for gold policies (the only policies that cover obstetrics). It would encourage families to take out the highest PHI cover earlier and to retain that cover beyond the birth of their children. This solution has flow on benefits for all medical specialties.

> It alleviates the long-standing problem of people not realising they have policies with reduced cover until they seek private treatment.
>
> It is beneficial for all insurers that younger people hold high premium policies to offset benefits paid for older policy holders.
>
> There would likely be an impact for the Government on PHI rebates.

Upgrade to a gold policy without a waiting period on one occasion in a policy holder's lifetime

Since 1 April 2018, PHI policy holders with limited cover for psychiatric care are able to upgrade their cover to access higher benefits for in-hospital treatment without serving a waiting period. Policy holders are only able to use this exemption from the existing two month waiting period once.

This approach could apply when a person upgrades to a gold policy for obstetric purposes. This could be proven by pregnancy confirmation. The policy would need to be upgraded within 11 weeks of pregnancy confirmation to allow for appropriate pregnancy planning and management.

Combined with the previous measure, families would be encouraged to retain the highest level of private insurance.

NASOG acknowledges that this, and the previous proposal, will need to be modelled to determine the impact on PHI rebates, but suggests the investment would be less than its contribution to increasing public hospital capacity.

Include obstetric cover in all policy tiers

This option should be explored in more detail.

NASOG would need to better understand how the proposal to include obstetric cover in all PHI policies would work in practice.

> Would insurers apply different benefit levels for obstetric cover added to silver and bronze policies?
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> Would cover be tied to the arrangements described in 'emerging models'?
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> Would the range of services covered be different in silver and bronze policies?
>
> Or would the additional premium equate to gold policy arrangements?

Selling the private option to patients

There is no doubt that women and their partners find it difficult to navigate private health insurance when planning a family. On face value, the proposals in the discussion paper, will only make it more complex.

A specific communication package for patients should be developed that provides a guide to the current funding arrangements for private obstetrics and the reasons for choosing private care, how to make choices about doctors, hospitals and insurers, and what to expect along the way. This is the starting point.

A strong communication package would counteract the 'urban myths' associated with private obstetric care. It would help women to understand the benefits of holding private health insurance for private obstetric care.

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[i] Australian Institute of Health and Welfare. *Admitted Patient Care 2017-18*. Table 5.3: Acute separations by Major Diagnostic Category version 8.0 and medical/surgical/other partition, public and private hospitals, 2017-18

[ii] Australian Prudential Regulation Agency. Quarterly private health insurance statistics. *Private health insurance medical services statistics March 2020*. In Hospital Medical Services paid for by Private Health Insurers: Australia. Accessed 6 August 2020

[iii] Australian Medical Association. *Private Health Insurance Report Card 2018.* 26 March 2018

[iv] OECD. OECD.Stat. *Health expenditure and financing.* Accessed 14 August 2020

[v] https://www.bupa.com.au/campaigns/health-insurance/hatch

[vi] Organisation for Economic Co-operation and Development (2016) *Better Ways to Pay for Health Care*. OECD Health Policy Studies, OECD Publishing, Paris

[vii] Australian Institute of Health and Welfare. *Admitted Patient Care 2017-18* and *Admitted Patient Care 2014-15*. Tables 5.1: Separations by broad category of service, public and private hospitals, 2013-14 to 2017-18 (and 2010-11 to 2014-15).

[viii] Calculated from the above tables.

[ix] Department of Health. Fact Sheet. *Private Health Insurance Reforms. Discounts for 18 to 29 years olds.* 17 February 2019