HEALTHCARE FINANCING AND REIMBURSEMENT: A GLOBAL REVIEW OF MAJOR TOPICS AND TRENDS

Author:
Alison Choy Flannigan, Hall & Wilcox
alison.choyflannigan@hallandwilcox.com.au

LAWS AND REGULATIONS ON HEALTHCARE FINANCING AND REIMBURSEMENT

1. Please provide a bird's eye view on the healthcare economy, indicating, in general terms, the role of the government (public healthcare) and private actors (private healthcare).

The Australian healthcare system is regulated at both the Commonwealth and state/territory level. There is a separation of powers between the Commonwealth on the one hand and the states on the other hand, in the Australian Constitution.

The Commonwealth Therapeutic Goods Administration regulates therapeutic goods under the Therapeutic Goods Act 1989 (Cth), such as medicines and medical devices.

The National Health Reform Agreement (NHRA) is an agreement between the Australian Government, and state and territory governments that provide funding for public hospitals.

Certain health practitioners, including medical practitioners and nurses, are registered with the Australian Health Practitioner Regulation Agency under the Health Practitioner Regulation National Law, which is state/territory legislation mostly uniform throughout Australia.

Private hospitals are regulated under both Commonwealth and state legislation, including under the Private Health Facilities Act 2007 (NSW).

Private health insurers are regulated under Commonwealth legislation including the Private Health Insurance Act 2007 (Cth) and the Private Health (Insurance (Prudential Supervision) Act 2015 (Cth).

2. Please provide a high-level overview of the legal framework regarding healthcare financing and reimbursement.

Australia has both a public and private healthcare system.

Public hospitals

The NHRA is an agreement between the Australian Government and states and territories that funds public hospital services.

In a public hospital, most treatment is free for anyone with a Medicare card, including costs for doctors', specialists' fees, hospital accommodation and clinical services.

Public hospitals are funded using activity-based funding, which is set by the Commonwealth Independent Health and Aged Care Pricing Authority.

Medicare

Medicare is Australia's universal health insurance scheme. It guarantees all Australians (and

some overseas visitors) access to a wide range of health and hospital services at low or no cost.

The Medicare Scheme is available to all Australian residents who hold a current Medicare card. Further information on Medicare eligibility is provided below.

Overseas visitors from countries with which Australia has a Reciprocal Health Care Agreement (RHCA) are also eligible to access the Scheme. Australia currently has RHCAs with the United Kingdom, Ireland, New Zealand, Malta, Italy, Sweden, the Netherlands, Finland, Norway, Belgium and Slovenia.

Medicare is regulated by the Health Insurance Act 1973 (Cth) and related regulations.

Medicare subsidises the costs of:

- medical services delivered in public and private hospitals;
- medical services, including primary healthcare; and
- tests, imaging and scans.

If you're a public patient in a hospital in Australia, Medicare subsidises things like:

- emergency care;
- most surgeries and procedures (there might be a wait time if it's not an emergency);
- medicines provided to you in hospital; and
- follow-up care.

Medical services that Medicare subsidises include:

- consultations with health practitioners, like general practitioners, specialists and other health practitioners, in person or via telehealth;
- mental health services, including mental health assessments, treatment plans and medicines;
- health checks; and
- some dental procedures, under the Child Dental Benefits Schedule.

Medicare, through the Medicare Benefits Schedule (MBS), covers many diagnostic imaging services, such as:

- magnetic resonance imaging (MRI);
- nuclear medicine scans like positron emission tomography (PET);
- ultrasound;
- computed tomography (CT) scans; and
- X-rays.

Medicare, through the MBS, covers pathology tests, such as blood, urine or tissue, to screen for, diagnose or monitor disease.

Pharmaceutical Benefits Scheme (PBS)

The Commonwealth subsidises medicines that are necessary to maintain the health of the community in a way that is cost effective. This is achieved by carefully assessing the therapeutic benefits and costs of medicines, including comparisons with other treatments, where appropriate. If a medicine is found to be acceptably cost-effective, then the

government negotiates its price with the supplier.

A medicine is considered cost effective by the Pharmaceutical Benefits Advisory Committee (PBAC) if, for significant medical conditions, the improvements in health outcomes justify the additional costs to the Scheme (and any harms) compared with its main alternate therapy.

The government manages the price of each medicine on the PBS.

The PBS subsidises medicines for people with a Medicare card.

The Scheme is available to all Australian residents who hold a current Medicare card and some overseas visitors (see above).

Pharmaceutical benefits are regulated under the National Health Act 1963 (Cth).

Australians may be required to make a co-payment towards the cost of PBS-subsidised medicine. There is a safety net threshold for all co-payments for concession card holders and family units.

Prostheses List/medical devices

The Prostheses List (PL) is a list of medical devices for which private health insurers are required to pay a benefit when a member has the relevant coverage. This requirement is set out in the Private Health Insurance Act 2007 (Cth).

The cost of devices on the PL is regulated by the Commonwealth Government and approval is required to be included on the PL.

The cost paid by public hospitals for medical devices is negotiated between the government and the medical device company.

Private health insurance

In parallel to Australia's public hospital system, Australia has a private health insurance system.

Australians are engaged to procure and maintain private health insurance because, if they don't hold private health insurance, they are required to pay additional tax, known as the Medicare Levy Surcharge. Other incentives for private health insurance are explained below.

Private hospital cover helps pay towards the cost of accommodation, theatre and specialist fees at a private hospital.

Medicare doesn't cover the cost of ambulances, glasses/contact lenses, hearing aids or most dental and elective plastic surgery. It also excludes therapy such as speech pathology, osteopathy and remedial massage. Private health insurance can fill the gaps in Medicare's coverage and may give more choice about treatment.

The benefits of private health insurance include shorter waiting times for elective surgery, choice of medical specialist and private health insurance covers some (but not all) services that Medicare doesn't.

Please refer to our comments above in relation to relevant legislation.

There are funding tiers between private health insurers and private hospitals, including those hospitals with a hospital purchaser-provider agreement with the private health insurer, second tier for government-approved second-tier private hospitals and statutory minimum benefits for the remainder of registered private hospitals.

Private health insurers are regulated by the Australian Prudential Regulation Authority and are required to comply with prudential and reporting standards.

Private sector and compensation

Healthcare can also be funded by patients (self-insured or out of pocket) or through statutory compensation schemes, including compulsory third-party motor vehicle insurance, which is compulsory with motor vehicle registration and workers compensation.

Further, other government organisations fund health services including health services for veterans.

3. What are the key regulators and supervisory bodies regarding healthcare financing and reimbursement?

Please refer to our comments in the other sections.

4. Has there been a change to healthcare financing and reimbursement as a consequence of the Covid-19 pandemic?

The main shift as a result of the Covid-19 pandemic is the availability of Medicare reimbursement for medical services provided by telemedicine.

The Australian Government provided additional funds for healthcare during Covid-19, particularly in the area of immunisation and personal protective equipment (PPE) in healthcare facilities.

5. Who has access to the healthcare system as a patient on the one side and as a medical service provider/supplier of medical goods on the other side? What are the conditions of admission?

The Medicare Scheme is available to all Australian residents who hold a current Medicare card.

To be eligible for Medicare, you must:

- be an Australian or New Zealand citizen;
- be an Australian permanent resident;
- have applied for permanent residency (some conditions apply);
- be a temporary resident covered by a ministerial order; or
- be a citizen or permanent resident of Norfolk Island, Cocos Islands, Christmas Island or Lord Howe Island.

If you're eligible, you must enrol in Medicare to access benefits. You may also be eligible if you're visiting from an RHCA country.

Overseas visitors from countries with which Australia has an RHCA are also eligible to access the Scheme. Australia currently has RHCAs with the United Kingdom, Ireland, New Zealand, Malta, Italy, Sweden, the Netherlands, Finland, Norway, Belgium and Slovenia.

HEALTH INSURANCE FINANCING AND COVERAGE

6. How are health insurance carriers financed? How are premiums determined?

Private health insurance is optional in Australia and financed by premiums payable by individuals. However, if a person eligible for private health insurance does not maintain private health insurance, this person will have to pay additional tax in the form of the Medicare Levy.

Most Australians with private health insurance currently receive a rebate from the Australian Government to help cover the cost of their premiums. The private health insurance rebate is income tested.

In addition, lifetime health cover is a loading added to the premium if an Australian doesn't have private health cover from the year they turn 31.

The setting of premiums by private health insurers is regulated by the Australian government.

Insurers must apply to the Australian Government Minister for Health for approval to increase private health insurance premiums.

7. How is the coverage of medical services by health insurance carriers regulated? Are there differences in coverage for in-person medical appointments and telemedicine appointments?

Medical services that Medicare subsidises include:

- consultations with health practitioners, like general practitioners, specialists and other health practitioners, in person or via telehealth;
- mental health services, including mental health assessments, treatment plans and medicines;
- health checks; and
- some dental procedures, under the Child Dental Benefits Schedule.

Government reimbursement of telemedicine appointments involves the '12-month rule'.

If you're working in general practice, a practitioner can only use telehealth items for patients:

- they have an existing relationship with; or
- who've visited the practice for a face-to-face service in the last 12 months.

There are exemptions to this rule if a patient is:

- in isolation or quarantine for Covid-19 due to a state or territory public health order;
- experiencing homelessness;
- under 12 months of age;
- treated at an Aboriginal Medical Services (AMS) or an Aboriginal Community Controlled Health Service (ACCHS);
- in a natural disaster area;
- needing mental health support;
- requiring urgent after hours service in unsociable hours;
- undergoing eating disorder support or pregnancy counselling;
- receiving blood borne viruses, sexual or reproductive health consultations;
- getting MyMedicare attendance service items 91900, 91903, 91906, 91910, 91913 or 91916; or

- getting an eligible service from an eligible urgent care clinic.

HOSPITAL SECTOR

8. How are services provided by hospitals in the stationary (inpatient) and ambulatory (outpatient) settings financed and reimbursed?

In a public hospital, most treatment (inpatient and outpatient) is free for anyone with a Medicare card, including costs for doctors' and specialists' fees and for hospital accommodation and clinical services.

9. How are the prices of such services determined? How is economic efficiency controlled?

The government pays for public hospital services.

If Australians choose to be admitted as private patients in public hospitals, their private health insurance may pay for some services not covered by Medicare. They may be required to pay for out-of-pocket costs, which should be disclosed up front.

HEALTHCARE PROVIDERS IN PRIVATE PRACTICE

10. How are services provided by physicians, therapists, laboratories and other service providers financed and reimbursed?

Medical services that Medicare subsidises include:

- consultations with health practitioners, like general practitioners, specialists and other health practitioners, in person or via telehealth;
- mental health services, including mental health assessments, treatment plans and medicines;
- health checks; and
- some dental procedures, under the Child Dental Benefits Schedule.

Medicare, through the MBS, covers many diagnostic imaging services, such as:

- MRI;
- nuclear medicine scans like PET;
- ultrasound;
- CT scans; and
- X-rays.

Medicare, through the MBS, covers pathology tests, such as blood, urine or tissue, to screen for, diagnose or monitor disease.

11. How are the prices of such services determined? How is economic efficiency controlled?

The government determines the reimbursement for medical services, which are reimbursed by Medicare.

Medical practitioners may charge an out-of-pocket gap.

PHARMACEUTICALS AND MEDICAL DEVICES

12. How are pharmaceuticals and medical devices financed and reimbursed?

PBS

The PBS subsidises medicines for people with a Medicare card.

The Scheme is available to all Australian residents who hold a current Medicare card and some overseas visitors (see above).

Pharmaceutical benefits are regulated under the National Health Act 1963(Cth).

Australians may be required to make a co-payment towards the cost of PBS-subsidised medicine. There is a safety net threshold for concession card holders and family units.

The Commonwealth subsidises medicines that are necessary to maintain the health of the community in a way that is cost effective.

This is achieved by carefully assessing the therapeutic benefits and costs of medicines, including comparisons with other treatments, where appropriate. If a medicine is found to be acceptably cost-effective, then the government negotiates its price with the supplier.

A medicine is considered cost effective by the PBAC if, for significant medical conditions, the improvements in health outcomes justify the additional costs to the Scheme (and any harms) compared with its main alternate therapy.

The government manages the price of each medicine on the PBS.

PL/medical devices

The PL is a list of medical devices for which private health insurers are required to pay a benefit when a member has the relevant coverage. This requirement is set out in the Private Health Insurance Act 2007 (Cth).

The cost of devices on the PL is regulated by the Commonwealth Government and approval is required to be included on the PL.

The cost paid by public hospitals for medical devices is negotiated with the government.

Products that are not covered by government reimbursement, such as the PBS and PL, need to be paid for by the patient.

Private health insurance can help to cover the cost of prescription medication that is not listed on the PBS. Whether or not a drug or medical device is covered depends on the insurance policy.

13. How are the prices of pharmaceuticals and medical devices determined? How is economic efficiency controlled?

In order to attract government financing for pharmaceuticals, the product usually needs to be registered or listed with the Therapeutic Goods Administration under the Therapeutic Goods Act 1989 (Cth) and approved under the PBS, which is a separate application. The price is negotiated between the pharmaceutical company and the government.

The listing process begins with a positive PBAC recommendation. A sponsor can include in

its PBAC submission an offer to enter into a deed of agreement. This approach has become more common as industry has become aware of risk sharing arrangements and the advantages of beginning these discussions as early as possible.

The PL is a schedule of medical devices and benefits that defines the minimum amount private health insurers are required to pay hospitals that utilise these devices in the provision of care to privately insured individuals. The PL forms part of the Private Health Insurance (Prostheses) Rules, which is a legislative instrument made under the Private Health Insurance Act 2007. The price is negotiated between the pharmaceutical company and the government.

LITIGATION INVOLVING HEALTHCARE FINANCING AND REIMBURSEMENT

14. Please provide a high-level overview of major litigation topics and landmark cases regarding healthcare financing and reimbursement.

Due to Australia's universal healthcare system, there are few landmark cases regarding healthcare financing and reimbursement, other than cases for Medicare fraud.

There have been cases involving private health insurers engaging in misleading and deceptive conduct:

Medical Benefits Fund of Australia Ltd v Cassidy; John Bevins Pty Ltd v Cassidy (2003) 135 FCR ; (2004) 13 ANZ Ins Cas 61-59; (2003) ATPR 41-97; [2003] FCAFC 289

Medical Benefits Fund of Australia Ltd ('MBF') commissioned the second respondent (Bevins) to conceive and prepare a series of television, print and railway billboard advertisements in connection with MBF's private health insurance products. One of the television advertisements in the series depicted the story of a couple who were expecting a baby and contained a representation that MBF would waive waiting periods in respect of its private health insurance product. The print and billboard advertisements similarly represented that waiting periods would be waived. However, the waiting period in respect of MBF's private health insurance for pregnancy and obstetric services was not waived.

The judge at first instance found that MBF had engaged in misleading and deceptive conduct in respect of the television advertisement and billboards, but not the newspaper advertisements. The judge at first instance, in respect of the second respondent, who was alleged to have been knowingly concerned with MBF's contravention, found that Bevins (and its employees) did not subjectively appreciate that the MBF advertisements were misleading and did not intend to mislead or deceive the public, but that, nevertheless, Bevins, as the creator of the advertisements, knew the matters that made the representations misleading, that is, that waiting periods applied in the case of pregnancy. The judge at first instance found that Bevins had knowledge of the essential facts that constituted the contraventions, even although they were not consciously aware that those facts would give rise to a contravention and that therefore the necessary criterion for liability under section 75B(1)(c) of the Trade Practices Act 1974 (Cth) (TPA) (or section 12GD(1)(e) of the Australian Securities and Investments Commission Act (ASIC Act)) was established. Both MBF and Bevins appealed.

The appeal by MBF was dismissed and the appeal by Bevins was allowed:

Per Stone J, with Moore and Mansfield JJ agreeing: '(i) It is the entire effect of the advertisement in question, particularly the first impression, which made the advertisement misleading. The disproportion between the dominant representation and the qualification by

asterisk was insufficient to draw attention to the waiver.'

However, there have been many government inquiries. For example, the New South Wales Government has commissioned a Special Inquiry into Heathcare Funding, the report of which is due in April 2025: **https://healthcarefunding.specialcommission.nsw.gov.au/documents/#terms-of-referencel**.

RECENT DEVELOPMENTS AND TRENDS

15. What are the recent developments and trends for the next few years? Please outline any unresolved issues, proposed changes or trends for healthcare financing and reimbursement, and briefly indicate how these may foreseeably affect the medical sector in the near future.

Because Australia has a universal healthcare system, the cost of the government funding healthcare remains an issue.

In 2021, the Australian Government Department of Health and Aged Care (the 'Department') commenced four years of reform activity to improve the PL and its arrangements. These reforms include changes aimed at improving the alignment of the PL scheduled benefits with prices paid in the public hospital system, streamlining the administration of the list, and better defining the purpose and scope of the PL. Revisions to the purpose and scope of the PL aim to provide greater clarity and certainty about which items are eligible for inclusion on the PL.

Further, there are continuing government reforms in products such as medicinal cannabis and vaping.