Federal Court of Australia

Rehabilitation Medicine Australia Pty Ltd v N I B Health Funds Ltd (No 2) [2020] FCA 1761

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| File number: |  |
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| Judgment of: | **DERRINGTON J** |
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| Date of judgment: | 9 December 2020 |
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| Catchwords: | **STATUTORY INTERPRETATION –** construction of the *Private Health Insurance (Benefit Requirements) Rules 2011* (Cth) cl 3, Sch 5 – where subordinate legislation prescribes technical matters – where the Court is not bound by the parties’ construction |
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| Legislation: | *Acts Interpretation Act 1901* (Cth)*Legislation Act 2003* (Cth)*Private Health Insurance Act 2007* (Cth)*Private Health Insurance (Benefit Requirements) Rules 2011* (Cth)*Private Health Insurance (Health Insurance Business) Rules 2018* (Cth) |
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| Cases cited: | *Accident Towing and Advisory Committee v Combined Motor Industries Pty Ltd* [1987] VR 529*Australian Securities and Investments Commission v King* (2020) 376 ALR 1*Bell v Day* (1886) 2 QLJ 180*Bupa HI Pty Ltd v Andrew Chang Services Pty Ltd* [2018] FCA 2033*C & J Clark Ltd v Inland Revenue Commissioners* [1973] 1 WLR 905*Coleman v Power* (2004) 220 CLR 1*Collector of Customs v Agfa-Gevaert Ltd* (1996) 186 CLR 389*Department of Health v DLW Health Services Pty Ltd* (2016) 246 FCR 456*Federal Commissioner of Taxation v Consolidated Media Holdings Ltd* (2012) 250 CLR 503*Gill v Donald Humberstone & Co Ltd* [1963] 3 All ER 180*Girardi v Commissioner of State Taxation* (2013) 93 ATR 822*Harding v Coburn* [1976] 2 NZLR 577*O’Sullivan v Barton* [1947] SASR 4*Patman v Fletcher’s Fotographics Pty Ltd* (1984) 6 IR 471*Project Blue Sky Inc v Australian Broadcasting Authority* (1998) 194 CLR 355*Saif Ali v Sydney Mitchell & Co (A Firm)* [1980] AC 198*Scott v Commercial Hotel Merbein Pty Ltd* [1930] VLR 25*Sevdalis v Director of Professional Services Review* [2017] FCAFC 9*SZTAL v Minister for Immigration and Border Protection* (2017) 262 CLR 362*Wingecarribee Shire Council v De Angelis* [2016] NSWCA 189 |
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| Division: | General Division |
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| Registry: | Queensland |
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| National Practice Area: |  |
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| Date of hearing: | 3 December 2020  |
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| Counsel for the Applicant: | Mr D Campbell QC with Mr A O’Brien |
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| Solicitor for the Applicant: | ABKJ Lawyers |
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| Counsel for the Respondent: | Mr S McLeod QC |
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| Solicitor for the Respondent: | MinterEllison |
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ORDERS

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|  | QUD 47 of 2020 |
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| BETWEEN: | REHABILITATION MEDICINE AUSTRALIA PTY LTD ACN 163 741 437Applicant |
| AND: | N I B HEALTH FUNDS LTD ACN 000 124 381Respondent |

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| order made by: | DERRINGTON J |
| DATE OF ORDER: | 9 december 2020 |

THE COURT ORDERS THAT:

1. It is declared that calculating the minimum benefit payable by the respondent to the applicant for an episode of hospital treatment (being medical private room overnight accommodation) pursuant to the *Private Health insurance (Benefits Requirements) Rules 2011* (Cth) (the Benefit Rules) is to be performed by:
	1. first, identifying the relevant episode of hospital treatment using the patient classification system and payment structure in the majority of the relevant insurer’s negotiated agreements in force on 1 August of the first year with all comparable private hospitals in the State in which the second-tier eligible hospital is located;
	2. secondly, where the health insurer has fewer than five negotiated agreements with the particular category of comparable hospital in the State in which the second-tier eligible hospital is located, utilising data from the relevantly useful subset of all of the insurer’s negotiated agreements with all classes of private hospital in the State in which the second-tier eligible hospital is located (being those which provide a charge for medical private room overnight accommodation), to determine the average charge for the equivalent episode of hospital treatment; and
	3. thirdly, determining what is 85% of the average charge for the equivalent episode of hospital treatment.
2. The parties are directed to confer and to formulate a form of order disposing of paragraph 3 of the amended originating application in accordance with the declaration in paragraph 1 of this order.
3. The respondent pay the applicant’s costs of the proceeding.

Note: Entry of orders is dealt with in Rule 39.32 of the *Federal Court Rules 2011*.

REASONS FOR JUDGMENT

DERRINGTON J:

# Introduction

1. The applicant, Rehabilitation Medicine Australia Pty Ltd (RMA), conducts the Spendelove Private Hospital in Southport, Queensland, which provides inpatient medical and rehabilitation services. The respondent, N I B Health Funds Ltd (NIB) is a registered private health insurer under the *Private Health Insurance Act 2007* (Cth) (the Act).
2. From time to time, RMA provides services to patients who hold insurance policies issued by NIB providing cover in respect of the expenses of medical treatment. The parties disagree on the amount NIB is required to pay RMA in this respect, and in particular since 1 September 2018. This amount is determined under the *Private Health Insurance (Benefit Requirements) Rules 2011* (Cth) (the Benefit Rules), issued under s 333-20 of the Act, but the parties disagree on the correct interpretation of those Benefit Rules, and more specifically the interpretation of cl 3 of Sch 5.

# The Legislative Scheme

1. Before considering the construction of the Benefit Rules, it is first necessary to briefly outline the legislative regime that governs the payment of private health insurance benefits.

## The ‘second-tier eligible hospital’ class

1. The Act creates a system whereby a hospital (being a facility declared to be a hospital by the Minister under s 121-5(6) of the Act) may apply to the Minister under s 121-8 to be included in a class of “second-tier eligible hospitals”. To be included in this class, a hospital must be a private accredited hospital, not bill patients directly for the minimum benefit payable by the patient’s insurer, make provision for informed financial consent, and submit Hospital Casemix Protocol Data to health insurers (cl 7C of the *Private Health Insurance (Health Insurance Business) Rules 2018* (Cth)).
2. If a hospital is included in the class of second-tier eligible hospitals by the Minister under s 121-8A of the Act, it will be eligible to claim second-tier default benefits from health fund insurers under the Benefit Rules, which are higher than those for hospitals that do not fall within this class. It is not in dispute that the Spendelove Private Hospital is a second-tier eligible hospital. It is also not in doubt that NIB is an insurer from whom the hospital may recover such benefits.

## The minimum benefits scheme

1. Part 3-3 of the Act specifies the type of insurance that private health insurers are allowed to make available. Under s 72-1 of the Act, an insurance policy that covers hospital treatment must meet certain “benefit requirements”, which include those set out in s 72-1(2) relating to the range of coverage and the amount of the benefit payable by the insurer. Relevantly, the amount of the benefit for hospital treatment involving rehabilitation (such as the rehabilitation services provided by the Spendelove Private Hospital) must be at least the amount worked out using the method set out in the Benefit Rules (Item 1 of the table in s 72-1(2) of the Act).
2. Under cl 4(1) of Pt 2 the Benefit Rules, the minimum benefit for rehabilitative treatment is to be determined under whichever of Schs 1, 2, 3 or 5 apply in the circumstances. Which schedule applies depends on the type of patient, the type of service, procedure, or treatment provided to a patient, and the type of hospital providing the service, procedure, or treatment. It is not in dispute that Sch 5, which provides for second-tier default benefits, applies in the circumstances of this case, as the Spendelove Private Hospital is within that category.
3. The minimum benefit payable by NIB to RMA is that provided for by cl 3 of Sch 5. As that clause is the centre of this dispute, it is appropriate to set out in full:

(1) Despite anything in Schedules 1, 2 or 3, but subject to subclause (2) of this clause, the minimum benefit for hospital treatment provided in the circumstances described in clause 2 of this Schedule is the amount worked out in accordance with this clause.

(2) Where hospital treatment is provided in the circumstances described in clause 2 of this Schedule, but:

(a) the minimum benefit worked out in accordance with this clause for the hospital treatment is below the amount determined in accordance with Schedules 1, 2 or 3 of these Rules; or

(b) an amount for the hospital treatment cannot be worked out in accordance with this clause,

the minimum benefit for that hospital treatment is the amount worked out in accordance with Schedules 1, 2 or 3 for that hospital treatment.

(3) If a hospital ceases to be a facility for the purposes of this Schedule, the minimum benefit in relation to an episode of hospital treatment for an insured person who was an admitted patient at the facility or booked for hospital treatment at the facility (as opposed to merely being on the facility’s waiting list) before the day that the hospital ceased to be a facility is the minimum benefit that would have applied if the hospital continued to be a facility at the time the treatment was provided.

(4) Subject to subclauses (2) and (8) the minimum benefit payable by an insurer for an episode of hospital treatment between 1 September of a particular year (the ***first year***) and 31 August of the next year is an amount no less than 85% of the average charge for the equivalent episode of hospital treatment, under that insurer's negotiated agreements in force on 1 August of the first year with all such comparable private hospitals in the State in which the facility is located.

(5) The formula for calculating the ***average charge for the equivalent episode of hospital treatment*** by an insurer in each State is as follows:

 [it is not necessary to replicate the formula]

(6) In subclause (4), each ***episode of hospital treatment*** must be identified using the patient classification system and payment structure in the majority of the relevant insurer's negotiated agreements in force on 1 August of the first year with all comparable private hospitals in the State in which the facility is located.

(7) In subclause (4), for the purpose of calculating the ***average charge for the equivalent episode of hospital treatment*** in a State:

(a) the charge will include the sum of the amount payable by the insurer under that insurer’s negotiated agreement and any excess or co‑payment amounts payable by members, in accordance with the insurer's rules; and

(b) must not include any charges:

(i) referred to in the insurer’s negotiated agreements for prostheses; and

(ii) that are minimum benefits for prostheses as specified for the purpose of item 4 of the table in subsection 72-1 (2) of the Act, and

(iii) referred to in the insurer’s negotiated agreements for hospital treatment provided to nursing-home type patients.

(8) Subject to subclause (2), if an insurer has less than 5 negotiated agreements in force on 1 August of the first year with a particular category of comparable private hospitals in a State, then all of that insurer’s negotiated agreements with all classes of private hospitals in that State are to be used to calculate the minimum benefit.

1. Several terms require further explanation:
2. “Negotiated agreement”(also known as a Hospital Purchaser Provider Agreement or HPPA)is relevantly defined by cl 3 of Pt 1 of the Benefit Rules as an agreement entered into between a hospital and an insurer that includes provisions to the effect that the hospital agrees to accept payment by the insurer in satisfaction of any amount that would, apart from the agreement, be owed to the hospital in relation to an episode of hospital treatment by an insured person under a policy. Essentially, it is open to an insurer to enter into a negotiated agreement with a private hospital to set the rates payable when insured patients receive treatment at that hospital.
3. “Comparable”is defined by cl 1(3) of Sch 5 of the Benefit Rules which provides that private hospitals are comparable if they fall within the same category from the list set out in that clause. It is common ground that the Spendelove Private Hospital is a “category B” hospital, as it provides rehabilitative services for at least 50% of its episodes of hospital treatment.
4. “Patient classification system”is not defined by the Benefit Rules, however, from the evidence before the Court, it appears that there are two primary classification systems used nationally in the health care sector: Diagnosis Related Groups (DRGs) and Medicare Benefits Schedule (MBS). These classification systems provide the health care sector with a nationally consistent method of categorising all types of patients, their treatment and associated costs, which enables effective reporting and the conversion of clinical information into useable data. The parties agreed that DRGs are the primary classification system used by the Spendelove Private Hospital. Essentially, once a patient has been diagnosed they are assigned a DRG that corresponds to the treatment provided by the hospital. *Inter alia,* that DRG will indicate the applicable charge to invoice a private health insurer. For a patient admitted to the Spendelove Private Hospital, the DRG will be the “Medical Overnight Rate”.
5. “Payment structure”is also not defined by the Benefit Rules, however it appears it is usually episodic or on a *per diem* basis.
6. The minimum benefit payable is calculated in August each year, to be effective from 1 September of that year to 31 August the following year (Sch 5, cl 3(4) of the Benefit Rules). Therefore, the relevant Benefit Rules for the period in dispute are those in force at 1 September 2018 (for the year 1 September 2018 to 31 August 2019) (Compilation No. 50 dated 1 July 2018) and 1 September 2019 (for the year 1 September 2019 to 31 August 2020) (Compilation No. 59 dated 1 July 2019). There is no material difference between these two compilations for present purposes.

# BACKGROUND

1. RMA contends, and NIB denies, that NIB has misapplied the Benefit Rules since 1 September 2018.
2. For the years commencing 1 September 2016 and 1 September 2017, NIB paid RMA a benefit purportedly calculated in accordance with cl 3 of Sch 5 of the Benefit Rules. This was on the basis that at all relevant times there have been only three “comparable hospitals” in Queensland to the Spendelove Private Hospital, each of which has a negotiated agreement with NIB. As NIB had negotiated agreements with less than five comparable “category B” hospitals in Queensland, the rates equated to 85% of the average equivalent Medical Overnight Rates in NIB’s negotiated agreements with all private hospitals in Queensland. This was capable of calculation as 45 of the 84 private hospitals with whom NIB had negotiated agreements also provided for an equivalent episode of hospital treatment.
3. For the years commencing 1 September 2018 and 1 September 2019, the rates paid by NIB decreased significantly. Those rates correspond with the minimum default rates in Sch 1 of the Benefit Rules. The change was precipitated by NIB acquiring another health insurer which thereby increased NIB’s network of day hospitals. This meant that, for the purposes of cl 3(4) and (6), the majority of NIB’s negotiated agreements with private hospitals in Queensland no longer had an equivalent episode of treatment. Relevantly:
4. for the period 1 September 2018 to 31 August 2019, NIB had negotiated agreements with 101 private hospitals in Queensland, and only 48 of those provided an equivalent episode of treatment; and
5. for the period 1 September 2019 to 31 August 2020, NIB had negotiated agreements with 100 private hospitals in Queensland, and only 49 of those provided an equivalent episode of treatment.
6. NIB therefore claimed it was not possible to calculate a rate in accordance with cl 3 of Sch 5, and the default rates applied. RMA disputes this interpretation and contends that it is possible to calculate a rate under cl 3 of Sch 5.

# RELEVANT Principles of statutory interpretation

1. The Benefit Rules are a legislative instrument (*Legislation Act 2003* (Cth) s 8) and are therefore to be interpreted in accordance with the *Acts Interpretation Act 1901* (Cth) (*Legislation Act 2003* (Cth) s 13(1)) and the ordinary principles of statutory interpretation (*Collector of Customs v Agfa-Gevaert Ltd* (1996) 186 CLR 389, 398). Consideration therefore needs to be had to the text of the Benefit Rules, their context and purpose: *Australian Securities and Investments Commission v King* (2020) 376 ALR 1, 8-9 [23]; *SZTAL v Minister for Immigration and Border Protection* (2017) 262 CLR 362, 368 [14]; *Project Blue Sky Inc v Australian Broadcasting Authority* (1998) 194 CLR 355, 381-382 [69]-[70].
2. In addition, subordinate legislation that prescribes technical matters, such as the Benefit Rules, is to be interpreted in light of practical considerations to achieve the most reasonably practicable result: *Bupa HI Pty Ltd v Andrew Chang Services Pty Ltd* [2018] FCA 2033, [45]. As stated by Lord Reid in *Gill v Donald Humberstone & Co Ltd* [1963] 3 All ER 180 at 183:

[T]hey ought to be construed in light of practical considerations, rather than by a meticulous comparison of the language of their various provisions such as might be appropriate in construing sections of an Act of Parliament…if the language is capable of more than one interpretation, we ought to discard the more natural meaning if it leads to an unreasonable result, and adopt that interpretation which leads to a reasonably practicable result.

1. This approach has been adopted in the construction of other legislative instruments which provide for the payment of benefits or subsidies for the provision of medical services: see, eg, *Sevdalis v Director of Professional Services Review* [2017] FCAFC 9 at [26] where the Full Court held that the principle applied in construing the Medicare Benefits Schedule under the *Health Insurance Act 1973* (Cth)); *Secretary, Department of Health v DLW Health Services Pty Ltd* (2016) 246 FCR 456 at 471 [93] where the Full Court held that the principle applied in construing the Classification Principles under the *Aged Care Act 1997* (Cth). It does not, however, permit the Court “to embark on a wholescale rewriting of the instrument” (*Wingecarribee Shire Council v De Angelis* [2016] NSWCA 189, [20]). Regard must still be given to the text itself.

# CONSIDERATION

1. In this case, the issue of construction turns on the answer to two questions:
2. Does subclause 3(8) modify subclause 3(6) such that when the insurer has less than five negotiated agreements with comparable private hospitals in the State, the “episode of hospital treatment” should be identified by reference to its negotiated agreements with *all classes* of private hospitals in the State?
3. Should regard be had to *all* of the insurer’s negotiated agreements with private hospitals in Queensland in calculating the minimum benefit payable for an episode of hospital treatment under subclause 3(4) (or only to those negotiated agreements which contain an equivalent episode of hospital treatment)?
4. It should be noted that in considering the parties’ submissions in this respect, the Court is not bound to adopt the interpretations presented by Counsel: *Coleman v Power* (2004) 220 CLR 1, 93 [243]; *Accident Towing and Advisory Committee v Combined Motor Industries Pty Ltd* [1987] VR 529, 547; *Saif Ali v Sydney Mitchell & Co (A Firm)* [1980] AC 198, 212.

## Construction contended for by RMA

### RMA’s preferred interpretation

1. RMA contended that the first step in determining the minimum benefit payable under cl 3 of Sch 5 is to identify the relevant episode of hospital treatment. Subclause 3(6) provides that the episode of treatment must be identified by using the patient classification system and payment structure in the majority of the insurer’s negotiated agreements with all *comparable* hospitals in the State. RMA submitted that subclause 3(8) does not modify the operation of this clause, citing the fact that subclause 3(6) is not, by its terms, stated to be subject to subclause 3(8) or otherwise affected by it. Moreover, RMA contended that subclause 3(8) is directed to calculating the minimum benefit payable, rather than identifying the relevant episode of hospital treatment. Taking this construction, RMA submitted that all of the three comparable hospitals with which NIB had negotiated agreements provide a “medical private room” rate calculated on a *per diem* basis, which is equivalent to the Medical Overnight Rate provided by the Spendelove Private Hospital. RMA submitted that the relevant episode of hospital treatment could be readily identified on this basis.
2. RMA submitted that the next step was to determine the average charge for the equivalent episode of hospital treatment under subclauses 3(4) and 3(5). It submitted that those clauses should be read such that if there are five or more comparable hospitals in the State with whom the insurer has a negotiated agreement, then the average charge is calculated using only those agreements. If there are less than five such agreements, as in this case, subclause 3(8) operates so as to “pick up” the negotiated agreements with all classes of private hospital that provide a rate for the relevant episode of hospital treatment (i.e. which provide a Medical Overnight Rate, or equivalent). On this reading, a minimum benefit can be determined.
3. Essentially, RMA’s preferred construction is an answer of “no” to both questions. It submitted that this interpretation should be preferred as it is open on the language of Sch 3 and achieves the practical purpose of the legislative regime by providing a higher level of remuneration to “second-tier hospitals” such as the Spendelove Private Hospital. It also claimed that this interpretation avoided the “commercially nonsensical position” whereby NIB would only be required to pay RMA the default rates under Sch 1, which are less than the cost to the Spendelove Private Hospital to provide its services.

### RMA’s alternative construction

1. RMA alternatively submitted that if subclause 3(6) is read with and affected by subclause 3(8), then the former should be read so that only those negotiated agreements that provide a rate for the equivalent episode of hospital treatment are used in calculating the minimum benefit payable. RMA argued that this construction would give effect to the word “equivalent” in subclause 3(4), which would otherwise have no work to do.
2. Essentially, this argument would see an answer of “yes” to the first question, and “no” to the second. It was submitted that an interpretation which answered “yes” to the second question would be difficult to accept as it would allow an insurer to avoid the operation of Sch 5 by relying on the fact that the majority of its negotiated agreements were with day hospitals that do not, by their nature, provide an overnight rate.

## Construction contended for by NIB

1. NIB contended that, properly construed, subclause 3(8) modifies subclause 3(6) so as to require each episode of hospital treatment to be identified using the majority of the insurer’s negotiated agreements with *all classes* of private hospital in the State. It submitted that this construction should be preferred for several reasons, relevantly:
2. Subclause 3(8) requires an insurer’s agreements with all classes of private hospital in the State to be used “to calculate” the minimum benefit, which properly construed refers to the entire exercise mandated by subclause 3(4), including the identification of each episode of hospital treatment in accordance with subclause 3(6);
3. While subclause 3(6) is not expressly subject to subclause 3(8), it provides for the identification of episodes of hospital treatment in subclause 3(4), which is expressly subject to subclause 3(8); and
4. There is no rational reason for limiting the process of identifying the episode of hospital treatment to comparable, rather than all, private hospitals. Rather, increasing the number of negotiated agreements used in the calculation of the minimum benefit was more likely to produce representative or fair results.
5. NIB further submitted that RMA’s alternative construction should also be rejected. It asserted that RMA’s alternative contention in fact appears to be that subclause 3(6) should be read so that only those negotiated agreements that provide a rate for the equivalent episode of hospital treatment should be used to identify each episode of hospital treatment. RMA contended that this construction (as characterised by NIB) was contrary to the terms of subclause 3(6), which expressly requires regard be had to the insurer’s negotiated agreements with either *all* comparable private hospitals in the State (if unmodified by subclause 3(8)) or *all classes* of private hospitals in the State (if modified by subclause 3(8)). Further, it submitted the alternative construction required the parties to first make some assumption about the equivalent episode of hospital treatment, and then identify the negotiated agreements that provide for that episode of hospital treatment, thereby inverting the process required by subclause 3(6).
6. Essentially, it submitted that the answer to question 1 should be “yes”, thereby obviating the need to answer question 2. It said that, on its construction, it was not possible to calculate the minimum benefit payable under subclause 3(4), because the majority of NIB’s negotiated agreements with all private hospitals in Queensland did not provide for a Medical Overnight Rate or equivalent.

## The correct construction

1. The task of statutory construction begins and ends with a consideration of the text: *Federal Commissioner of Taxation v Consolidated Media Holdings Ltd* (2012) 250 CLR 503, 519 [39]. In general, a legislative instrument should be read “in the ordinary way in which a document is read, that is, from the beginning onwards”: *Patman v Fletcher’s Fotographics Pty Ltd* (1984) 6 IR 471, 474 *per* Priestley JA, followed in *Girardi v Commissioner of State Taxation* (2013) 93 ATR 822, 825 [8]. That is not to say that each clause should be read as divorced from its surrounding statutory context, however for present purposes a “step by step” approach is appropriate given the instrument in question purports to be a methodological guide for the purposes of calculating a price, rate, or other like outcome.

### Step 1 - determine which schedule prima facie applies in working out the minimum benefit payable - subclauses 3(1), 3(2) and 3(3)

1. The starting point in determining the minimum benefit payable is subclause 3(1), which provides that the amount of the minimum benefit is to be worked out in accordance with cl 3 of Sch 5, unless subclause 3(2) applies.
2. Subclause 3(2) provides for an exception to that general rule, whereby the amount is to be worked out in accordance with Schs 1, 2, or 3 if either of the conditions in subclause 3(2) are satisfied. Two things might be said about those conditions. The first is that subclause 3(2)(a) is intended to prevent the minimum benefit falling below the level which might be calculated if it were assessed by reference to one of the other schedules. That is indicative of an intention to protect the revenue of hospitals whose income is dependent upon payments under the schedule. The second is that it is not irrelevant that subclause 3(2)(b) expressly contemplates that it may not be possible to calculate a minimum benefit under cl 3.
3. Subclause 3(3) is not relevant to the issues presently under consideration.

### Step 2 - determine whether the minimum benefit payable is capable of calculation under clause 3 - subclause 3(4)

1. Subclause 3(4) is of central importance as it sets out the manner in which the minimum benefit payable is to ordinarily be determined. It is worth repeating:

Subject to subclauses (2) and (8) the minimum benefit payable by an insurer for an episode of hospital treatment between 1 September of a particular year (the ***first year***) and 31 August of the next year is an amount no less than 85% of the average charge for the equivalent episode of hospital treatment, under that insurer's negotiated agreements in force on 1 August of the first year with all such comparable private hospitals in the State in which the facility is located.

1. By way of general observation it is apparent that the principal purpose of subclause 3(4) is to benchmark the amount payable to the recipient hospital against the average amount charged for the equivalent episode of hospital treatment provided at comparable hospitals with which the insurer has negotiated agreements. Although the rate is to be 85% of that average, it is apparent that the clause seeks to ascertain a commercial, or near commercial, rate for the service provided. This is achieved by relying upon the prices paid under commercially negotiated agreements as a reliable indication of the actual commercial cost of providing such services.
2. Importantly, subclause 3(4) is expressed as being “subject to subclauses (2) and (8)”. The expression “subject to” should not be treated as indicating that there is in fact a conflict between subclauses 3(4), 3(2) and 3(8). Although this phrase has been described as “a standard way of making clear which provision is to govern in the event of conflict” (*Harding v Coburn* [1976] 2 NZLR 577, 582), in the event that there is no conflict, the phrase has no effect. As explained by Megarry J in *C & J Clark Ltd v Inland Revenue Commissioners* [1973] 1 WLR 905 at 911:

[T]he phrase “subject to” is a simple provision which merely subjects the provisions of the subject subsections to the provisions of the master subsections. Where there is no clash, the phrase does nothing: if there is collision, the phrase shows what is to prevail. The phrase provides no warranty of universal collision.

On this approach, subclause 3(4) should first be construed, if possible, without regard to subclauses (2) and (8).

#### Identify the “episode of hospital treatment” - subclause 3(6)

1. The next step is to identify the relevant “episode of hospital treatment”. It is important to keep in mind that the import of this step is to identify a specific medical service in respect of which the minimum benefit is payable. This process is a qualitative one and, as subclause 3(6) reveals, involves consideration of the patient classification system and payment structure in the majority of the insurer’s negotiated agreements with *all comparable* hospitals in the State. It would also seem apparent that the intention is to identify a comparable form of treatment which is provided by comparable hospitals so as to give content to the particular service provided. This, no doubt, is necessary for the following steps which seek to ascertain the amounts which are paid by other hospitals for that service. As Mr Campbell QC for RMA put it in oral submissions – it is a necessary step to ensure the calculation being made involves “a comparison of apples with apples”.
2. The nub of the case then arises – is clause 3(6) required to be read with subclause 3(8), as contended for by NIB, such that the “episode of hospital treatment” is to be identified by reference to *all classes* of private hospitals as opposed to *all comparable* private hospitals? In short, the answer is “no”. That is so for the following reasons.
3. First, subclause 3(6) is not expressed as being subject to, or affected by, subclause 3(8), and it should therefore not be construed as being so. Indeed, no ambiguity arises on the plain ordinary meaning of the subclause, and it should be applied as it is expressed.
4. Second, subclause 3(6) and subclause 3(8) focus on two different processes: while subclause 3(8) is concerned with the *calculation* of the minimum benefit, subclause 3(6) is concerned with the *identification* of a relevant “episode of hospital treatment”. Contrary to NIB’s submissions, the reference to “calculate” should not be taken as a broad term encompassing the act of “identifying” the episode of hospital treatment in subclause 3(6). While “identify” means “to ascertain or assert what a thing… is; to determine the identity of; to recognise as belonging to a particular category or kind”, “calculate” means “to estimate or determine by arithmetical or mathematical reckoning”: *Oxford English Dictionary* (2nd edition, 1989). Both words bear distinct meanings and the legislative decision to use two different words, where the same word could have been used, indicates the performance of two separate processes: see, eg, *O’Sullivan v Barton* [1947] SASR 4, 8; *Bell v Day* (1886) 2 QLJ 180, 181-182. As stated by Irvine CJ in *Scott v Commercial Hotel Merbein Pty Ltd* [1930] VLR 25 at 30, “though it is not to be conclusive, the employment of different language in the same Act may show that the Legislature had in view different objects”. It follows that, even where the insurer has less than five negotiated agreements with a particular category of comparable private hospital, the relevant “episode of hospital treatment” can and is to be identified by reference to those agreements which do exist.
5. Third, and contrary to NIB’s submissions, there is no practical reason – at this stage of the exercise of calculating the minimum benefit – to increase the number of negotiated agreements to produce more representative or fair results. Clause 3(6) is solely concerned with identifying the relevant “episode of hospital treatment”. Unlike the quantitative act of calculating the minimum benefit, which understandably requires a dataset larger than five to reduce the width of the confidence interval in calculating the mean, the qualitative act of identifying the relevant “episode of hospital treatment” can be accurately performed using a small dataset.
6. On this construction, the “episode of hospital treatment” is, therefore, to be determined by reference to the three hospitals, comparable to the Spendelove Private Hospital, with which NIB has negotiated agreements. The patient classification system used by all three is the DRG system, and the payment structure is on a *per diem* basis. On this basis, the equivalentepisode of hospital treatment is capable of being *identified* (but not yet *calculated*) as the “medical private room” rate provided by each of these comparable private hospitals.

### Step 3 - calculate the minimum benefit – subclauses 3(4) and 3(5)

1. Once the relevant “episode of hospital treatment” is identified, subclause 3(4), read with subclause 3(5), then directs that the average charge for the equivalent episode of hospital treatment is to be calculated by reference to the insurer’s negotiated agreements with “all such comparable private hospitals in the State”. The formula for the making of the calculation is found in subclause 3(5) which provides for calculating the mean of several numbers: it essentially provides that the average charge for an overnight medical room is to be calculated by dividing the sum total of the equivalent rate in the insurer’s negotiated agreements by the total number of those agreements. Whether the formula includes only negotiated agreements with comparable private hospitals, or all negotiated agreements with all classes of private hospitals is determined by subclause 3(8).

#### Determine whether the calculation is performed using some or all of the negotiated agreements - subclause 3(8)

1. It is at this stage that subclause 3(8) possibly has operative effect, directing that if an insurer has less than five negotiated agreements with a particular category of comparable hospitals in a State, then *all* of that insurer’s negotiated agreements with *all classes* of private hospitals in that State are to be used to calculate the minimum benefit (emphasis added).
2. It is significant that subclause 3(8) expressly provides that the average charge for the equivalent episode of hospital treatment is to be calculated using “*all*” of the insurer’s negotiated agreements, not merely those which provide for an equivalent episode of hospital treatment. This would suggest, *prima facie,* that when – as here – there is no equivalent rate provided for in each of those agreements, it is not possible to calculate the average charge for the equivalent episode of hospital treatment under subclauses 3(4) and 3(5). Neither party contended that this construction should be accepted by the Court, and indeed, this cannot have been the construction adopted by the parties in determining the benefit payable by NIB in 2016 and 2017 as both agreed that it was possible to calculate the minimum benefit under cl 3 during these years. The reason is clear – if subclauses 3(4) and 3(5) were read in this way, the process of calculating the minimum benefit would break down if just one of the private hospitals with which NIB had a negotiated agreement did not provide an equivalent episode of hospital treatment to that under consideration. This would give clause 3 a very rigid operation and render the entire calculation process virtually redundant. In short, it would be an absurd outcome, completely incongruous with the clear intention and purpose of this schedule.
3. The evident purpose of subclause 3(8) is to increase the pool of negotiated agreements to use in the calculation of the average charge under subclauses 3(4) and 3(5) in circumstances where an insurer has less than five negotiated agreements with comparable private hospitals in the State. As mentioned above, increasing the size of the dataset in this manner has a clear practical advantage in reducing the margin of error involved in the calculation.
4. Moreover, the structure of the scheme, as well as the secondary material associated with the Benefit Rules, indicates an intention that the amount paid to “second-tier” hospitals (such as the Spendelove Private Hospital) should be higher, wherever possible and on account of the additional accreditation they require, than the amount that would otherwise be paid. As the explanatory statement to the Benefit Rules provides:

The purpose of second-tier default benefits is to protect quality private facilities and to provide an incentive for private facilities to become accredited and meet other administrative criteria, hence increasing the level of quality hospital care available to customers.

1. In light of these practical considerations, it is pellucid that subclause 3(8) does not in fact mandate that data from allof the insurer’s negotiated agreements are to be input into the formula, regardless of their usefulness in arriving at an average charge. How then should this subclause be construed?
2. NIB did not offer a construction, as its argument did not contemplate a process of calculating the minimum benefit whereby subclause 3(6) was not modified by subclause 3(8).
3. On either of RMA’s constructions, words would likely need to be read into subclause 3(8) or subclause 3(4), such that the phrase “all of that insurer’s negotiated agreements with all classes of private hospitals” should be taken as “all of that insurer’s negotiated agreements with all classes of private hospitals *that provide for an equivalent episode of hospital treatment*”.
4. A simpler construction is open on the text of subclause 3(8), namely that the choice of the word “use” indicates that only that subset of the whole which will serve a practical or effective purpose in calculating the average charge should be ultimately input into the formula. This construction is consistent with the definition of “use” as, “to put to practical or effective use; to make use of, employ” or “to make use or take advantage of… as a means of accomplishing or achieving something”: *Oxford English Dictionary* (3rd ed, 2011). In other words, when subclause 3(8) applies, all the negotiated agreements with all classes of private hospital are *available* (but not required) to be used in calculating the average charge for the equivalent episode of hospital treatment. This construction achieves the most reasonably practicable result and is consistent with the evident legislative intention that the amount paid to “second-tier eligible” hospitals for a service should – wherever possible – be higher than would otherwise be the case.
5. Ultimately, subclause 3(8) requires that in instances where there are less than five negotiated agreements with comparable hospitals, the calculation in subclauses 3(4) and 3(5) is to be undertaken by using all the agreements with all classes of private hospitals that provide for an equivalent episode of hospital treatment. Here, the calculation under subclauses 3(4) and 3(5) is therefore to be performed by reference only to those negotiated agreements that contain an equivalent overnight rate.

# Conclusion

1. This construction, in effect (although not in form) matches that contended for by RMA.
2. It is therefore declared that calculating the minimum benefit payable by NIB to RMA for an episode of hospital treatment (being medical private room overnight accommodation) pursuant to the Benefit Rules is to be performed by:
3. first, identifying the relevant episode of hospital treatment using the patient classification system and payment structure in the majority of the relevant insurer's negotiated agreements in force on 1 August of the first year with all comparable private hospitals in the State in which the second-tier eligible hospital is located;
4. secondly, where the health insurer has fewer than five negotiated agreements with the particular category of comparable hospital in the State in which the second-tier eligible hospital is located, utilising data from the relevantly useful subset of all of the insurer's negotiated agreements with all classes of private hospital in the State in which the second-tier eligible hospital is located (being those which provide a charge for medical private room overnight accommodation), to determine the average charge for the equivalent episode of hospital treatment; and
5. thirdly, determining what is 85% of the average charge for the equivalent episode of hospital treatment.

# QUANTUM

1. When the matter came on for hearing, RMA indicated that it no longer pressed the submissions made in its written outline in respect of quantum, having conceded that NIB was not obliged to pay any allegedly outstanding amount until various administrative steps were undertaken. Given the parties’ agreement on this matter it is not necessary to make any finding in respect of quantum at this stage. The parties proposed they be directed to confer and formulate a form of order in relation to quantum in accordance with the declaration as expressed above. That proposal was appropriate and an order has been made accordingly.

# Costs

1. Neither party suggested that the ordinary rule that costs follow the event should not apply. Therefore the respondent is to pay the applicant’s costs of this proceeding.

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| I certify that the preceding fifty-four (54) numbered paragraphs are a true copy of the Reasons for Judgment of the Honourable Justice Derrington. |

Associate:

Dated: 9 December 2020