The Senate

Standing Committee on Community Affairs

Private Health Insurance Bill 2006 [Provisions] and 6 related bills [provisions]

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TABLE OF CONTENTS

MEMBERSHIP OF THE COMMITTEE .... *iii*

PRIVATE HEALTH INSURANCE BILL 2006 AND 6 RELATED BILLS 1

- THE INQUIRY 1
- THE BILLS 1
- BACKGROUND 3
- ISSUES 4
- Broader Health Cover 4
  - Definition of 'hospital treatment' 6
  - A two tier system 6
  - Chronic disease management 7
  - Care plan arrangements 9
  - Safety and quality assurance 9
  - Protection of clinical independence 11
  - Cost implications 13
- Community rating 14
- Risk equalisation 15
- Consumer protection and information 16
  - Standardised information for consumers 16
  - Informed financial consent 17
- Pre-existing conditions 18
- Overseas visitors 19
- Private Health Insurance Rules 19
- Prostheses List Fees 22
- Conclusion 23

ADDITIONAL COMMENTS BY LABOR SENATORS 25

AUSTRALIAN DEMOCRATS ADDITIONAL COMMENTS 27

APPENDIX 1 – Submissions received by the Committee 31

APPENDIX 2 – Public Hearing 33

APPENDIX 3 – Care Plans and the MBS **-** Terms of Recommendation(s) 35

PRIVATE HEALTH INSURANCE BILL 2006 AND 6 RELATED BILLS

THE INQUIRY

1.1 The Private Health Insurance Bill 2006 and six related Bills were introduced into the House of Representatives on 7 December 2006. On the same day, the Senate, on the recommendation of the Selection of Bills Committee (Report No.16 of 2006), referred the provisions of the Bills to the Community Affairs Committee (the Committee) for report. The Bills passed the House on 14 February 2007. At the conclusion of the second reading debate in the House, the Minister noted that the Bills are being considered by the Senate Community Affairs Committee and advised that:

> I will carefully consider any recommendations which the committee makes. As well, the government has already indicated that it will be moving amendments in the Senate based on further consultation with the sector.[1]

1.2 The Committee received 21 submissions relating to the Bills and these are listed at Appendix 1. The Committee considered the Bills at a public hearing in Canberra on 2 February 2007. Details of the public hearing are referred to in Appendix 2. The submissions and Hansard transcript of evidence may be accessed through the Committee's website at http://www.aph.gov.au/senate_ca

THE BILLS

1.3 The purpose of the Private Health Insurance Bill (the PHI Bill) is to establish a comprehensive regulatory regime for the private health insurance sector and to replace the current regime.

1.4 The PHI Bill contains the following elements of the new regulatory regime:

- Broader Health Cover: will allow for cover of out of hospital services that substitute for or prevent hospital care, for example dialysis and chemotherapy, allied health services and domestic nursing assistance. This will also allow health insurers to provide more flexible and innovative products which reflect modern clinical practice;
- clinical freedom: the contracts between doctors and insurers may not limit the clinical freedom of doctors to choose the most appropriate treatment for their patients;
- standard product information: insurers will be required to provide standard information statements for their products to help consumers compare policies and to understand their entitlements;

1 *House of Representatives Hansard,* 14.2.07, p.30 (The Hon Tony Abbott).

- Life Time Health Cover: people who have retained their private hospital insurance continuously for more than ten years will no longer be subject to Lifetime Health Cover penalties;
- product standards: the system of insurer registration will be replaced by product standards with which products offered by insurers must comply;
- obligations of health insurer directors and chief executive officers: obligations will be aligned with general commercial practice;
- operating rules relating to health benefit funds: the Bill sets out a framework for the establishment, operation, merger and termination of these funds in order to improve prudential oversight and protection of the public interest;
- Private Health Insurance Administration Council (PHIAC): clarifies aspects of the role of PHIAC in supervising insurers and their health benefits funds; and
- Rules: the Bill allows for subordinate legislation known as the Private Health Insurance Rules to be made by legislative instrument.

1.5 The Private Health Insurance (Transitional Provisions and Consequential Amendments) Bill 2006 provides for the transition from the current regulatory regime to the new PHI Bill. These transitional arrangements include:

- that facilities that were declared hospitals under the *National Health Act 1953* or *Health Insurance Act 1973* will be taken to be public or private hospitals under the proposed new Act until 1 July 2008 to allow hospitals to make an application to be declared a hospital under the proposed new Act;
- that outreach services declared under the National Health Act to be treated as hospital treatment under the proposed new Act until 1 July 2008; and
- a transitional registration regime for organisations registered as insurers under the National Health Act to be taken as private health insurers under the proposed new Act until 1 July 2008.

1.6 The remaining bills in the package provide for the following:

- Private Health Insurance (Prostheses Application and Listing Fees) Bill 2006: imposes listing and application fees on prostheses sponsors to recover the costs of evaluating and listing prostheses for private health insurance purposes; and
- Private Health Insurance (Collapsed Organization Levy) Amendment Bill 2006, Private Health Insurance Complaints Levy Amendment Bill 2006, Private Health Insurance (Council Administration Levy) Amendment Bill 2006, Private Health Insurance (Reinsurance Trust Fund Levy) Amendment Bill 2006: amend their respective Principal Acts to update definitions resulting from the replacement of the National Health Act by the proposed PHI Act.

1.7 The Minister commented:

> These changes will translate into greater competition and improved services for consumers. The changes will also mean much clearer and simpler regulation for health insurers and service providers.
>
> This package will create new opportunities for the private health sector, allowing greater innovation and even greater choice in private health care. When implemented, the legislation will be a win for consumers, a win for private health insurers and a win for service providers – and a win for our public hospital system too.[2]

BACKGROUND

1.8 Health insurance is regulated by the *National Health Act 1953* and the *Health Insurance Act 1973*. Health insurance may be offered only by organisations registered under the National Health Act by PHIAC.

1.9 Registered health benefits organisations (RHBOs) are subject to conditions of registration which cover matters such as categories of membership, waiting periods for benefits and the types and levels of benefits. The Minister may seek explanations from RHBOs of their activities, carry out an investigation, seek enforceable undertakings, impose directions and seek Federal Court orders to enforce compliance.[3]

1.10 The Department of Health and Ageing (DoHA) indicated that the regulatory framework for private health insurance has grown and changed over time. There has not been a comprehensive review for many years and consequently, it has become increasingly burdensome, complex and outdated. The Department identified some major issues with the current framework:

- legal complexity: complexity has arisen because of a range of factors including the reliance on two acts, the National Health Act and Health Insurance Act; the extensive use of determinations under the National Health Act; the inclusion of permissive provisions which are unnecessary; and the use of outdated language and concepts in the legislative framework;
- scope of coverage: changes in clinical practice over the last two decades have resulted in a mismatch between contemporary health care activities and the legislative framework designed to regulate them particularly with the growth in the provision of services in the community which would have in the past been provided in a hospital; and

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2 Minister for Health and Ageing, the Hon Tony Abbott, *Second Reading Speech,* as circulated with Bill, p.1.

3 *Submission* 16, p.4 (DoHA).

- regulatory focus: the use of conditions of registration as the basis of the regulatory framework has now become 'a clumsy and indirect way of setting product standards for an evolving and competitive market'.[4]

1.11 The reform package was announced by the Minister on 26 April 2006. In developing the legislation, DoHA consulted extensively with the private health sector, including insurers, hospitals, doctors and other service providers, as well as consumers. DoHA stated that it had used these comments in refining the legislation to achieve the Government's aims of 'the minimum regulation necessary to achieve the government's objectives and protect the public interest'.[5] Industry groups readily acknowledged the Department's commitment to the consultation process which allowed constructive input into the drafting process resulting in the inclusion of important amendments. The desire was expressed that such a process of engagement should become the customary practice.

ISSUES

1.12 The reforms introduced in these Bills and especially Broader Health Cover were generally supported in the submissions and evidence received by the Committee, although a number of concerns were raised and suggestions for improvement offered.

Broader Health Cover

1.13 The concept of broader health cover was described by DoHA as 'the key change that will affect the delivery of private health services'. Hospital cover will expand to cover out-of-hospital services that substitute for or prevent hospitalisation, and which can safely be delivered outside of a hospital setting. It will remove the legislative barrier to health insurers paying benefits for out-of-hospital medical services, which has been a significant impediment to the development of flexible health care products that better reflect contemporary clinical practice and meet consumers' growing needs and expectations.[6]

1.14 Health insurers will be able to offer policies that cover hospital treatment; or hospital treatment and general treatment; or general treatment only (but not hospital-substitute treatment only). Treatment will be defined in relation to who provides the service, rather than where the service is provided.

1.15 Hospital treatment is defined in clause 121-5 of the Bill. This definition has changed from the current regime by allowing services that may not be provided within the walls of a hospital to be considered as hospital treatment. However, the treatment, which is intended to manage a disease, injury or condition, including the provision of goods and services, must be provided by or under the management or control of a

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4 *Submission* 16, p.6 (DoHA).

5 *Committee Hansard* 2.2.07, p.57 (DoHA).

6 *Submission* 16, p.2 (DoHA).

person who is authorised by a hospital to provide the treatment. The treatment must also be provided at a hospital or be provided, or arranged, with the direct involvement of a hospital.

1.16 General treatment is defined in clause 121-10. It is analogous to 'ancillary health benefits' as defined in the National Health Act, and is treatment intended to manage a disease, injury or condition, including the provision of goods or services, and that is not hospital treatment. Payments for professional services for which a Medicare benefit is payable continue to be prohibited for general treatment under the new legislation unless allowed by the Rules. General treatment includes, but is not limited to, hospital-substitute treatment, chronic disease management programs and ancillary services.

1.17 Broader Health Cover products will be those covered by 'hospital treatment and general treatment'.

1.18 Groups including MS Australia, MND Australia and Palliative Care Australia were particularly welcoming of the opportunities that Broader Health Cover provided:

- MS Australia welcomes the inclusion of hospital substitute services into the private health funds' suite of benefits…We see these legislative changes as an opportunity to improve and complement existing public health and community care programs for people with a chronic illness…The out-of-hospital model has the potential to improve certain elements of the system if it is well integrated into the funds' role in the public healthcare system.

  Individualised funding and reimbursement for a range of services including: non PBS medications; equipment; case management and self management programs, will provide value to the consumer. Such programs also have the potential to provide a greater value-for-money return on the government investment in the health fund sector via the health insurance rebate.[7]

- We [MND Australia] anticipate that the development and extension of health cover products will be of benefit to people living with MND and their carers. The key components of disability aids and equipment, case management to reduce hospital admission, respite care to sustain the carer and information/education programs to support individuals and families will be attractive products that will assist people living with MND to live better for longer, and significantly reduce their admission to acute care services and hospitals.[8]

- Palliative Care Australia sees potential for home based palliative care services to be provided as part of standard comprehensive private health insurance policies on the basis that appropriate home care can substitute for hospital care and prevent hospitalisation. Appropriate home care can improve patient

7 *Submission* 18, pp.1-2 (MS Australia).

8 *Submission* 9, p.3 (MND Australia).

> outcomes and actively reduce the potential for readmission to hospital for acute episodes and subsequent duration of stay. It also ensures that patients who have private health insurance have choice in their care options.[9]

Definition of 'hospital treatment'

1.19 The Australian Private Hospitals Association (APHA) and Catholic Health Australia (CHA) argued that the definition of 'hospital treatment' as treatment 'intended to manage a disease, injury or condition' is unnecessarily restrictive. They consider that the definition does not reflect the range of services currently provided in or by the private hospitals sector, including 'healthy heart' programs, diabetes education classes, mental health, drug and alcohol outreach services, that prevent hospitalisation and assist patients in managing their condition. As APHA commented:

> It is important that the BHC reforms to private health insurance do not restrict choices that patients currently enjoy, such as these and other programs to assist patients manage their condition, which are designed by their treating clinician(s) and included as part of the patient's acute treatment program.[10]

1.20 APHA and CHA both recommended that the definition of 'hospital treatment' in clause 121-5 be amended to include the provision of goods and services by hospitals that are intended to **prevent** as well as manage a disease, injury or condition so as to capture services that assist in preventing further hospitalisation.

A two tier system

1.21 Some concern was expressed that the services and benefits that could now be accessed as 'general treatment' under Broader Health Cover could create a two tier system because these services and benefits would not be available to those without private health insurance and who would remain reliant on Medicare. While there are currently services that are covered by private health insurance that are not included under Medicare, the establishment of Broader Health Cover will significantly expand the list of items covered by private health insurance but not by Medicare.

1.22 The Centre for Health Economics Research and Evaluation (CHERE) was one of the groups that noted the important difference in Medicare coverage between the new categories of treatment, believing that the intent of the Bill is for Medicare to remain the sole insurance option for services such as GP, pathology, diagnostic imaging and specialists' consultations in the ambulatory care setting. However, CHERE also considered 'that the Bill will create greater complexities in terms of the boundaries of what constitutes inpatient and outpatient care, and as a consequence between the public and private systems' thereby enabling service providers and health

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9 *Submission* 3, p.1 (Palliative Care Australia).

10 *Submission* 11, p.4 (APHA); also *Submission* 19, pp.1-2 (CHA).

insurers to respond with practices that segregate those with private insurance from those without.[11]

1.23 The Parliamentary Library commented that 'to some extent, the debate about Broader Health Cover represents a contest between the imperatives of universalism in healthcare and the need to ensure the future sustainability of the sector (by making private health insurance a more attractive product)'.[12]

Chronic disease management

1.24 Effective chronic disease management programs (CDMP) that will provide significant benefits to members with chronic diseases or those at risk of chronic diseases are supported and it is recognised that the efficient funding of such programs is an important step forward and will form a vital part of the success of Broader Health Cover.

1.25 However, the AHIA and some RHBOs consider that the proposed framework provides a restriction that will obstruct the implementation of many valuable programs. The minimum requirements for CDMPs include the provision of at least two allied health services from two or more disciplines because it ensures a multi-disciplinary approach and it also reflects the CDMP items included in the Medicare Benefits Schedule.

1.26 They contend that each CDMP will have a treatment regime and provider structure that reflects the unique requirements and risk factors associated with the particular chronic disease. Therefore, the value of a CDMP cannot be judged on the basis of how many allied providers are involved in the program. Rather, the value of a CDMP should be judged on the effectiveness of the program to achieve the objectives of reducing complications and preventing the onset of chronic disease for people with multiple risk factors.[13]

1.27 The health funds considered that a literal interpretation of the regulatory framework would result in many existing chronic disease management programs, as currently configured without the required number of providers, not being categorised as CDMPs and thus ineligible for inclusion in general treatment.

1.28 To enable the retention and expansion of such valuable programs for their members, the removal of this restriction was proposed. As ahm recommended, the regulatory framework should retain 'a broad approach by articulating principles for

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11 *Submission* 13, pp.7-9 (CHERE).

12 Parliamentary Library, *Bills Digest*, No.81, 2006-07, 8 February 2007, p.10.

13 *Submissions* 7, pp.2-4 (AHIA); 6, pp.5-8 (ahm); 8, pp.6-7 (Australian Unity); 12, pp. 3-4 (BUPA Australia).

Broader Health Cover and avoiding prescriptive rules on the inputs and processes for individual product categories'.[14]

1.29 The AMA recommended that in relation to chronic disease management plans, 'there need to be provisions which require the continuing involvement and agreement of the patient's usual treating medical practitioner particularly the patient's General Practitioner and, if relevant, their treating specialist or psychiatrist'.[15] DoHA responded to the AMA's proposal:

> The Private Health Insurance Bill and accompanying rules regulate private health insurance products for the purposes of the payment of private health insurance benefits. They do not, nor is it appropriate for them to, prescribe the way in which health care services are delivered. It would also be inappropriate for legislation to require the involvement of a doctor, particularly if the patient does not want that.
>
> The Bill provides the opportunity for medical practitioners to partner with health insurers to ensure that the best models of care and treatment are covered by private health insurance. The Bill does not restrict in any way patients' ability to continue seeing their usual treating practitioner.[16]

1.30 DoHA also clarified the situation regarding allied health providers, stating:

> We made some changes to the definition of 'chronic disease management program', which is rule 10 in the health insurance business rules. That requirement for two or more Allied Health professionals to be involved in a program has been taken out, but the chronic disease management program still has other elements. It has to manage, prevent or delay the onset of a chronic disease. It has to have a written plan and it has to be coordinated by a person. So there are still other requirements in the definition, but not for the two or more Allied Health professionals.[17]

CDMP Reporting

1.31 BUPA Australia noted that there is detailed PHIAC reporting for CDMPs including planning, coordination and a large range of allied health services and that this presents a significant administration burden, which may provide another hindrance to CDMP implementation. BUPA suggested that:

> The purpose, complexity and need of this reporting system requires questioning in the context of what the Industry is trying to achieve in relation to CDMPs. The perceived value of this reporting system is far

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14 *Submission* 6, p.8 (ahm).

15 *Submission* 14, p.10 and Additional Information, dated 16.2.07, pp.3-4 (AMA).

16 *Submission* 16, Additional information dated 9.2.07, p.4 (DoHA).

17 *Committee Hansard* 2.2.07, p.72 (Penny Shakespeare, DoHA).

> outweighed by the administrative burden and confusion it may cause. This reporting system must be reviewed.[18]

Care plan arrangements

1.32 Witnesses supported the need for a coordinated approach to care plans with individuals in conjunction with their medical practitioner seeking the best plan for the improvement in their health. ahm stated that:

> General Practitioners are central to the effective community management of chronic disease. GP's are well positioned to take a proactive role in managing the health care requirements of their patients through the existing Chronic Disease Management Medicare items. As such, Chronic Disease Management Programs should focus on the central role of the GP and assist in the use of the CDM MBS items where appropriate.[19]

1.33 The AMA also commented on the need for a coordinated approach to patient care:

> We are very wary of the initiatives which might unintentionally subvert the critical role of general practitioners, and indeed any other treating practitioner in the health system. It is not possible to break up and fragment patients' health by treating his or her various conditions through different and unrelated health providers. The care must be coordinated and must be adapted to reflect the particular needs of the individual. The Australian healthcare system needs more coordination and cooperation among providers not more fragmentation. Medicare has accepted that the GP is fundamental to the coordination of health care.[20]

1.34 Access to Medicare rebates for services provided under a care plan was also raised, with AHIA informing the Committee that the industry view is that funds ought to be able to pay for any doctor's service, as long as the doctors involved do not claim from Medicare also. AHIA concluded that 'this would ensure health funds can develop the best forms of Broader Health Cover…in the best interest of better health outcomes for the privately insured community'.[21] The Committee was concerned that care plan arrangements should complement and not substitute for access to Medicare and that double dipping be prevented.

Safety and quality assurance

1.35 The new minimum safety and quality requirements for privately insured health services provided by the Bill will come into operation from 1 July 2008. These requirements will ensure that all privately insured services are provided by accredited

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18 *Submission* 12, p. 5 (BUPA Australia); also *Committee Hansard* 2.2.07, p.26 (Dan Hook, ahm).

19 *Submission* 6, p.6 (ahm).

20 *Committee Hansard* 2.2.07, p.20 (AMA).

21 *Submission* 7, p.4 (AHIA).

facilities and/or suitably qualified providers. Concerns were expressed at the lack of provision as to the safety and quality regime that is to apply during the 15 month transitional period from 1 April 2007 other than ensuring that a hospital is accredited.[22]

1.36 APHA was also concerned that it appears the Bill makes an artificial distinction between the accreditation of facilities and the qualifications of service providers and that the gap created by this distinction is the lack of any requirement for accreditation of 'services'. In respect of this issue:

> APHA therefore proposes that the uniform safety and quality requirements apply to organisations, facilities, service providers (practitioners) and services. This is particularly relevant when many of the services proposed to be covered by BHC products would not necessarily be delivered within a 'facility'…APHA contends that any accreditation requirement must apply to all services funded under BHC (including for example, telephone advice lines) in both the public and private sectors.[23]

1.37 The Department responded to these comments:

> The Government will introduce safety and quality requirements for privately insured services, to take effect from 1 July 2008, which will apply to providers of services, the facilities in which services are provided and the actual services provided. This requirement will also apply to services currently being covered by private health insurance, such as physiotherapists and dental and optical services. The proposed start date of 1 July 2008 allows enough time for providers to take a considered approach to the level of accreditation required and to get accredited.
>
> In the meantime, insurers are expected to exercise a level of care on behalf of their members as they do now in choosing who will deliver services. For example, all funds currently require accreditation or certification for hospital services and for ancillary services, such as dentists. We are also aware that an existing telephone advice service offered by AHM is accredited under International Standards Organisation Quality Management Systems Requirements 9001.[24]

1.38 The Australian Medical Association (AMA) adopted a more cautious approach to accreditation, commenting that 'insisting that every program is accredited could be bureaucratically cumbersome, very expensive and only marginally improve the quality of care. Requirements that are too onerous may in fact impede development of the very types of initiative the Bill is meant to foster'. In the AMA's experience, 'formal quality assessment processes must be developed slowly and carefully'. The AMA proposed that references in the Bill and Business Rules to accreditation processes should be amended:

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22 *Submission* 11, p.2 (APHA); *Submission* 10, pp.1-2 (CHFA); *Submission* 19. p.2 (CHA).

23 *Submission* 11, pp.2-3 (APHA).

24 *Submission* 16, Additional information dated 9.2.07, p.1 (DoHA).

- to allow for measured and careful development of workable processes for accrediting new types of care delivery; and
- so that such processes be oversighted by a body reporting directly to the Federal Health Minister, that has meaningful and formal representation from the AMA, medical colleges and other relevant professional groups, as well as insurers and other interested parties.[25]

1.39 APHA supported the establishment of an industry panel comprising appropriate experts to approve services and product saying that 'having it one step removed from one segment of the industry or the sector would be preferable in order to bring a range of viewpoints, including clinical expertise and assessments of things like cost effectiveness and clinical effectiveness'.[26]

1.40 The Department responded to the suggested establishment of an industry panel responsible for the approval of proposed products in the area of general treatment:

> Private health insurers have, for many years, developed their products (within the confines of the existing legislation) to cover hospital treatment to make private health insurance attractive and responsive to new treatments as they emerge.
>
> The legislation provides health insurers with the flexibility to readily respond to, and fund, changes in clinical practice and the introduction of new technologies as they occur. The development of private health insurance products is commercially sensitive. The formal establishment of an industry panel to approve individual insurer's products would potentially stifle the development and availability of these products and is unprecedented in a commercial market.
>
> The AMA is asking to strongly influence insurers' decision making processes, whilst at the same time asking that insurers not be allowed to interfere with clinical decisions. The Department believes that the right balance has been struck in the proposed legislation between insurers and service providers to ensure that high quality, affordable care is delivered to policy holders.[27]

Protection of clinical independence

1.41 There was general agreement that decisions regarding clinical care are matters to be decided between patients and their doctors. DoHA emphasised that it is important to note that broader health cover arrangements will not limit the clinical

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25 *Submission* 14, pp.7-8 and Additional Information, dated 16.2.07, p.3 (AMA).

26 *Committee Hansard* 2.2.07, p.14 (Michael Roff, APHA).

27 *Submission* 16, Additional information dated 9.2.07, pp.2-3 (DoHA).

freedom of medical practitioners. The Bill includes an explicit safeguard for this in clause 172-5.[28]

1.42 However, some groups considered that the guarantee of non-interference in clinical decision making where there is an agreement between a health fund and a medical practitioner is too limited. APHA recommended that 'the protection of clinical discretion should be a requirement of all agreements between health insurance funds and all service providers, including hospitals.[29] The AMA was also concerned that there remain risks that health funds will seek to interfere in clinical decisions such as when a patient needs to be treated in a hospital. The AMA considered that the Bill must be strengthened by the addition of requirements that refer explicitly to the new types of arrangement facilitated by the Bill and proposed revised wording for clauses 172-5 and 6 to achieve this purpose. The AMA argued that:

> A broader, more realistic guarantee of no interference in clinical management and clinical decision making extending into the location of care and into the issues around home care and chronic disease management programs is necessary. The existing guarantee is too limited.[30]

1.43 The Australian Physiotherapy Association (APA) believed that the protection of professional freedom to identify and provide appropriate treatment provided in clause 172-5 should be extended and that clause 72-5 should also provide physiotherapists parity with doctors. The APA argued that:

> It is appropriate that all health service providers should enjoy the same protections from private health insurers that are provided to doctors…The inclusion of the term 'medical practitioner' is the problem. Either the term 'medical practitioner' needs to be re-defined to include physiotherapists or else the word ‘medical’ should be substituted for ‘health’.[31]

1.44 The Department responded to the AMA and APA comments:

> The proposed clause 172-5 is based on the current paragraph 73BDAA(1)(a) of the National Health Act 1953, although it applies to private health insurers in their dealings with medical practitioners rather than hospitals dealing with medical practitioners. The Department is unaware of any complaints of insurers attempting to limit the clinical discretion of medical practitioners or other service providers.
>
> Extending the guarantee to one where there was no interference in clinical management and clinical decision making is not practicable. If this were to occur, insurers might not be able to offer policies which impose limits on benefits for treatment in particular locations, or of a particular type, or in using new experimental procedures/technologies, as they do currently.

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28 *Submission* 16, p.8 (DoHA).

29 *Submission* 11, p.5 (APHA).

30 *Submission* 14, p.9 and Additional Information, dated 16.2.07, pp.2-3 (AMA).

31 *Submission* 5, p.7 (APA).

> The Department considers that unless evidence of interference is available it would be premature to legislate as the AMA or APA is suggesting.
>
> Proposed clause 72-5 is intended to protect consumers from the impact of agreements between insurers and service providers under which the parties agree to limits on the number of services for which full benefits will be paid, and hence impose co-payments on some patients. The Department considers that patients of physiotherapists should be afforded the same protection.[32]

Cost implications

1.45 DoHA noted that the proposed broader health cover arrangements are not expected to impose additional costs on consumers or the health system. Replacing hospitalisation with care in other settings, when it is clinically appropriate and convenient for consumers, has scope to reduce hospital costs and out-of-pocket expenses for consumers.[33]

1.46 The Australian Health Management Group (ahm) spoke of managing health issues by emphasising the point that 'costs not just in private health insurance but costs to the health system generally, including consultations with doctors and the like, will be reduced if people can manage modifiable health risks. We are not talking about prescribed drugs here; we are talking about exercise, weight, nutrition, management of stress and setting goals within their own life'. However, ahm noted that 'the driver of real health care cost in Australia is new technology and an ageing population. That is not going to change because of this legislation'.[34]

1.47 A number of groups questioned the capacity of the new arrangements to constrain costs. The AMA considered that 'the changes proposed in the Bill do not alter the underlying reality that overall health care costs will continue to rise, driven by a growing and ageing population, heightened expectations as the community's wealth grows and technical developments'. The AMA argued that:

> The private health insurance funds have exaggerated their potential to contain health system costs, including the scope for reduction in acute hospital care as a consequence of the introduction of 'broader health cover'…Despite recent promotion of 'team care' and the scope to provide treatment in 'new settings' such developments may in some circumstances actually raise costs.[35]

1.48 Ian McAuley, from the University of Canberra, expressed concern at the broader cost implications.

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32 *Submission* 16, Additional information dated 9.2.07, pp.1-2, 6-7 (DoHA); also *Committee Hansard* 2.2.07, pp.68-69 (DoHA).

33 *Submission* 16, p.8 (DoHA).

34 *Committee Hansard* 2.2.07, pp.27-28 (Dan Hook, ahm).

35 *Submission* 14, p.3 (AMA).

> I have had a look at the cost-benefit analysis in the proposals. Quite frankly, I find some of it shallow. It overlooks, for example, the equity to those 57 per cent who are not insured. It ignores the inflationary effect of private health insurance. It is very hard to single out that inflationary effect, but I do notice that over the last five years the hospital and medical services component of the consumer price index has been running at about seven per cent, which is about four per cent over the general consumer price index.[36]

Community rating

1.49 The private health insurance system in Australia relies on the concept of community rating, that is funds may not discriminate on the basis of individual health risk. Insurers must also offer the same type of cover at the same price to all their customers.[37]

1.50 CHERE commented that the private health insurance funds have had an incentive to reduce the risk profile of the insured population ('cream-skimming'). Funds have undertaken marketing strategies such as offering products to attract younger, healthier cohorts. CHERE argued that the Bills, by allowing private health funds to offer separate products that cover general services and hospital services, will give the funds greater flexibility to design products targeted at specific populations and to set different prices for different products. It may be feasible for funds to set higher premiums for products targeted at high-risk individuals and lower premiums for low-risk individuals. CHERE concluded that the Bills may lead to diminished community rating and de-facto risk rating of private health insurance premiums.[38]

1.51 The Consumer Health Forum of Australia (CHF) responded to the concern about diminished community rating and stated that:

> There has been discussion in our consultations that that outcome would not be a good thing. The legislation is enabling legislation, but we would hope that it should include checks and balances to ensure that community rating was not undermined in Australia. This has been a very important part of our health system…We would be very concerned if it turned out that there were packages at different prices for people with different levels of sickness and that sort of thing.[39]

1.52 Australian Unity commented:

> Community rating is a principle that demands that all insurers look to improve the health status of their contributors rather than pursue narrow financial risk management approaches. This bill seeks to positively and

36 *Committee Hansard* 2.2.07, p.2 (Ian McAuley).

37 See *Submission* 16, pp.20-21 (DoHA) for further information.

38 *Submission* 13, pp.4-6 (CHERE).

39 *Committee Hansard* 2.2.07, p.7 (CHF).

> valuably expand the role that health insurers play in our health system. It is timely and laudable reform, in our view.[40]

1.53 Australian Health Management Group also stated, in response to Committee questions about the possible detrimental impact on consumers of not taking up health programs offered by funds, that:

> It is against community rating, and we really support community rating. These are opt-in programs that complement the current situation, which has its significant limitations. It is just not true that an exclusively patient-client health system is absolutely perfect. Our contention is that Australia will not be able to maintain the health of the nation if they depend upon that model exclusively. This gives an opportunity to complement that model, where Australians are encouraged to take responsibility for their own health, where they do not hand that responsibility to a doctor.[41]

Risk equalisation

1.54 Currently, insurers are required to contribute to a 'reinsurance pool' which is redistributed to those insurers which have a disproportionate number of over 65 year old members or extremely high users of health services. Reinsurance ensures that organisations are not disadvantaged by being required to charge the same premium to all members regardless of risk.

1.55 Following consultations with industry during 2005, the Government has decided to implement a new approach (risk equalisation) to improve pooling of risk and access to the high cost claims pool. As risk equalisation had industry support, the Government adopted this approach, rather than its preferred option of demographic risk equalisation. DoHA commented that the advantage of the proposed arrangements to the industry is that it is 'relatively familiar to them, they have the systems in place to accommodate it and report on it and make it work more readily than going to a risk based capitation model'. DoHA also noted that the smaller funds were very insistent on having the high-claims arrangements put into the new system.[42]

1.56 The Department indicated that the Government will continue to consult with industry about the potential for the adoption demographic risk equalisation.[43]

1.57 The Health Insurance Restricted Membership Association of Australia (HIRMAA), while supporting the Bill, pointed to two matters in relation to risk equalisation. First, it argued that there is not a definitive method by which the risk equalisation pool will be contained and HIRMAA considered that it should not grow at a rate much greater than the Consumer Price Index. Secondly, there was concern

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40 *Committee Hansard* 2.2.07, p.42 (Australian Unity).

41 *Committee Hansard* 2.2.07, p.31 (ahm); see also *Committee Hansard* 2.2.07, p.48 (MBF).

42 *Committee Hansard* 2.2.06, p.64 (DoHA).

43 Explanatory Memorandum, p.13; see also *Committee Hansard* 2.2.07, p.64 (DoHA).

about components of chronic disease management programs being included in risk equalisation. HIRMAA suggested that disease management not qualify for 12 months so that PHIAC could collect relevant data and assess the appropriateness of inclusion in future risk equalisation arrangements.[44]

Consumer protection and information

Standardised information for consumers

1.58 Under Division 93 of the Bill, insurers will be required to provide standardised information statements for consumers about their private health insurance products. The purpose of this measure is to assist consumers in comparing health insurance products and to understand their entitlements under them. These changes are in response to consumer feedback and the experiences of the Private Health Insurance Ombudsman (PHIO) of reasons for consumer complaint.[45]

1.59 DoHA noted that consumers will benefit from new standard product information requirements. Health insurers will be required to maintain and publish up-to-date information about their products including premiums, waiting periods, exclusions, hospital and medical gaps and excesses. Private health insurers will also be required to respond to information requests about their products, to give advance warning of detrimental changes, and to provide information about the PHIO. Product information will also need to be provided to the PHIO for publication on a new website. The website will enable consumers to compare different products and to better understand their policy entitlements.

1.60 The legislation also requires that private health insurers give the Department and PHIAC product information so that they can monitor compliance with the legislation.[46]

1.61 Witnesses supported greater transparency and understanding for consumers in relation to private health insurance.[47] However, MBF noted that the Australian Competition and Consumer Commission had reported that in 2005-06 there had been a fall in the number of consumer complaints in relation to private health insurance information. MBF voiced concern that the imposition of the regime as proposed together with the suggested templates for information 'have in fact the potential to result in more confusion for consumers and may result in more consumers making incorrect product purchase choices'. MBF recommended that a review of the new

44 *Submission* 4, p.5 (HIRMAA); see also *Committee Hansard* 2.2.07, p.34 (HIRMAA).

45 *Submission* 16, p.25 (DoHA).

46 *Submission* 16, pp.8, 25-26 (DoHA).

47 See *Submission* 15, p.11 (MBF).

disclosure regime be conducted post implementation, including the costs of compliance.[48]

1.62 Witnesses also raised several issues in relation to the proposed PHIO website. Australian Unity Limited commented that the site would need to incorporate features so that consumers would not just purchase a product based on price rather than on their needs so as to avoid dissatisfied consumers who have made inappropriate product choices.[49] CHF supported a consumer focussed approach to designing the website and that the website include an interrogation function.[50] This was seen as particularly important as with many products available it will be a complex task for consumers to negotiate the website and find the product best suited to them. CHF also suggested that for those without internet access, an ongoing independent telephone support service was needed. CHF went on to comment:

> It would be very good to have this comparative site. It may be a hard thing to achieve, but maybe it is worth a try. But I think the fact that the site exists and includes parameters that you need to think about when you purchase private health insurance is a really positive step.[51]

1.63 HIRMAA commented that the proposed website was 'an ambitious undertaking' and stated that the website must be designed to ensure that all funds are treated equitably.[52]

1.64 With the enhancement of PHIO's role and responsibility in providing information for and protection of the interests of health consumers, APA urged that the Government should ensure that PHIO is adequately funded: for increased promotion of its services and education of health consumers and health providers; for its additional responsibilities from 1 July 2006; and commensurate with the levels of complaints requiring detailed investigation.[53]

Informed financial consent

1.65 While not dealt with in the Bills, witnesses agreed on the importance of consumers being able to access information about costs before treatment commences in all but emergency cases. The Australian Health Insurance Association (AHIA) noted that almost 20 per cent of privately insured hospital episodes faced unexpected bills and this was a major cause of discontent with private health insurance. CHF commented that:

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48 *Submission* 15, p.12 (MBF).

49 *Submission* 8, p.9 (Australian Unity Ltd).

50 *Submission* 10, p.2 (CHF); see also *Committee Hansard* 2.2.07, pp.8, 10 (CHF).

51 *Committee Hansard* 2.2.07, p.10 (CHF).

52 *Submission* 4, p.4 (HIRMAA).

53 *Submission* 5, p.10 (APA).

> So many people who have struggled to hang onto their private health insurance find that, when they come to use it, there are unexpected costs that they had not really known they would have to bear, often coming from a number of different sources.[54]

1.66 Health funds considered that, in the interests of privately insured patients, the lead clinician involved in a medical procedure should be legislatively required to inform each patient of all the approximate and estimated costs they will face during a procedure. The AHIA noted that the AMA has been conducting an information campaign to encourage doctors to obtain informed financial consent but considered that the lead clinician should provide all fees from all practitioners, rather than just giving the patient the relevant contact details for the additional practitioners involved in their treatment.[55]

1.67 In the AHIA's view obtaining informed financial consent should be required by legislation rather than relying on self-regulation, because of the importance of the issue and the need to ensure that it is resolved permanently.

1.68 The Committee notes that Minister has indicated that if the AMA's campaign fails and 'if doctors don't, as a matter of course, obtain informed financial consent from patients, the Government will make it mandatory'.[56]

1.69 CHF also supported a detailed information strategy for consumers and suggested that this strategy should build on the promotion of the PHIO's website and the private health insurance reforms.[57]

Pre-existing conditions

1.70 HIRMAA raised concern about the proposal to allow only a two month waiting period for psychiatric, rehabilitation and palliative care rather than the existing 12 months waiting period for a pre-existing ailment. HIRMAA commented that:

> It is our contention that the proposed two months waiting period only applies in the absence of the PEA conditions. Any variation to this condition would expose all funds to widespread exploitation and seriously weaken the integrity of the PEA provisions. Equally it may potentially generate significant increases in contribution rates. At best, funds would be required to provide a buffer within their pricing structure to accommodate members' costs which would inevitably be incurred if the PEA provisions

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54 *Committee Hansard* 2.2.07, p.5 (CHF).

55 *Submission* 7, p.5 (AHIA); see also *Submission* 8, p.5 (Australian Unity); *Committee Hansard* 2.2.07, p.39 (AHIA).

56 Minister for Health and Ageing, The Hon Tony Abbott, Speech, Surgeons Conference, Sydney Convention Centre, Darling Harbour, 16 May 2006.

57 *Submission* 10, p.2 (CHF).

> were waived. At worst, it may well result in a dramatically increased claims experience that would in turn create a sharp spike in pricing.[58]

1.71 Palliative Care Australia expressed 'alarm' at HIRMAA's suggestion that palliative care be classed as a pre existing ailment and subject to a greater waiting period than two months, stating that 'a terminal illness cannot be predicted and is not a pre-existing ailment. It is appropriate that palliative care continues to be classified for a two month waiting period with rehabilitation and psychiatric care'.[59]

1.72 DoHA responded to HIRMAA's contention:

> The provisions in the Bill reflect the requirements of the current Act. While it appears that some insurers may have not been complying with the current Act, the Department does not accept that non-compliance with a regulatory requirement is a substantive argument for changing the requirement.[60]

Overseas visitors

1.73 An issue raised by IMAN International and Australian Health Management Group (ahm) was the sale of health insurance to overseas visitors, including overseas students. It was noted that currently overseas students studying in Australia must obtain private health insurance from an RHBO. Health cover for other overseas visitors may be offered by RHBOs, general insurers and offshore operators. ahm commented that, although it had not fully examined the recently released Rules, it believed that the proposed definition of 'health related business' will result in the provision of health cover to overseas students no longer being restricted to RHBOs. ahm argued that there are 'good public policy and consumer protection reasons' for maintaining the current requirements, including that those insured with RHBOs will enjoy the protections of the new regulatory regime and that community rating only applies to that group.[61]

1.74 DoHA responded to these concerns by stating that there is no change to the current arrangements: 'the status quo is maintained through the rules rather than the legislation'.[62]

Private Health Insurance Rules

1.75 The legislation will rely on Rules 'to fill in the detail of the regulatory framework'.[63] DoHA released 13 draft Private Health Insurance Rules on 1 February 2007, seeking comments from interested parties by 26 February 2007.

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58 *Submission* 4, p.6 (HIRMAA); see also *Committee Hansard* 2.2.07, p.39 (HIRMAA).

59 *Submission* 3, Additional Information dated 6.2.07, p.2 (Palliative Care Australia).

60 *Submission* 16, Additional Information dated 9.2.07, p.6 (DoHA).

61 *Submission* 1, pp.2-5, (IMAN International) and *Submission* 6, p.13 (ahm); see also *Committee Hansard* 2.2.07, pp.26-27 (ahm).

62 *Committee Hansard* 2.2.07, p.71 (DoHA).

1.76 Witnesses noted that the reforms rely heavily on the Rules but until a full examination of them is made, the impact of the Bills cannot be fully assessed. BUPA Australia commented:

> It is important that these Rules do not provide any constraint to the achievement of the Government's objectives, namely to add value to private health insurance products and to support the long term sustainability of the private health industry.
>
> It is vital that industry has input into the content of these Rules and that an appropriate consultation process is put in place prior to the finalisation of this component of the legislation.[64]

1.77 DoHA stated that the Government will consider comments made about the draft Rules and take up suggestions that it considers appropriate. The Department noted that some amendments had already been incorporated following feedback received during the consultation on the draft discussion paper on the development of the Rules. In addition, DoHA has plans to continue consulting after the legislation has been put in place. Industry consultation forums on the Rules are planned for late February and also following the 1 April commencement date. Monitoring the implementation of the legislation will take place and this will involve consulting with industry.[65] The Committee welcomes the extensive consultation that has taken place and DoHA's undertaking to continue consultation with industry in relation to the legislation and Rules.

1.78 However, the Medical Benefits Fund (MBF) expressed concern 'about the number of provisions under the Bill which can be modified substantially in whole or in part through the making of Rules by the Minister or PHIAC (as the case may be)'. Whilst noting that the Rules are reviewable by Parliament, MBF submitted 'that the Bill should be amended to provide some requirements regarding any changes made to the provisions of the Bill through the Rules, in accordance with the recommendations of the Taskforce on Reducing Regulatory Burden,' and 'the only situations where these requirements should be excused are for matters which require urgent action especially in relation to any prudential or other risks to the industry or consumers'.[66]

1.79 With the draft Rules having been publicly released the day before the hearing, the Committee invited witnesses to make supplementary submissions once they had reviewed the draft Rules. The Committee received a number of comments including the following:

- Palliative Care Australia noted that dedicated rules for Broader Health Cover are absent although they have been included briefly in the Health Insurance

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63 *Committee Hansard* 2.2.07, p.57 (DoHA).

64 *Submission* 12, p.2 (BUPA).

65 *Committee Hansard* 2.2.07, p.72 (DoHA).

66 *Submission* 15, p.17 (MBF).

Business Rules and Risk Equalisation Policy Rules. PCA is concerned that with the absence of dedicated rules, programs and services of most benefit to palliative patients will be of lower priority;[67]

- MS Australia and MND Australia both raised concerns that the clarity of definitions in Rule 10 of the Health Insurance Business Rules could be improved. They proposed that neurological diseases and conditions be included in the list of chronic diseases and that the person coordinating CDMPs be defined to ensure that the person has the requisite skill and capacity to perform the role properly with knowledge of, experience and expertise in the individual disease;[68]
- The Australian Physiotherapy Association was pleased to note that the current level of direct public access to safe and effective treatment by physiotherapists is maintained in the draft Business Rules and stressed that 'they should not be altered in any way that undermines this level of access';[69]
- Australian Unity considered that the concerns raised in its submission that requirements for chronic disease management programs may unnecessarily rule out some worthwhile programs appear to have been resolved in the draft Health Insurance Business Rules and 'we are now generally happy that the conditions proposed in the draft Rules provide a practicable framework for such programs';[70]
- APHA raised concerns about rules 7 and 8 of the Health Insurance Business Rules that provide matters to which the Minister is to have regard in declaring or revoking that a facility is a hospital. APHA contends that the requirements are 'totally unnecessary as specific prescriptive requirements for the establishment of emergency departments are contained in State licensing requirements for private hospitals' and that the terms such as 'reasonable' and 'appropriate' are highly subjective. APHA commented that 'a primary purpose of legislation is to provide prescriptive guidance rather than be open to subjective interpretation' and recommended that rules 7(f) and 8(d) be deleted from the draft Business Rules.

  If this was not possible, it recommended that the Rules 'provide for a transparent administrative process that would include a mechanism to advise a facility that the Minister is considering revoking a declaration and also enable the provision of input and advice by the facility prior to the Minister's decision';[71]

67 *Submission* 3, Additional information, dated 6.2.07, p.2 (Palliative Care).

68 *Submission* 9, Additional Information, dated 7.2.07 (MND Australia) and *Submission* 18, Supplementary Submission, dated 9.2.07 (MS Australia)

69 *Submission* 5, Supplementary Submission, dated 12.2.07, p.3 (APA).

70 *Submission* 8, Supplementary Submission, dated 9.2.07, p.1 (Australian Unity).

71 *Submission* 11, Supplementary Submission, dated 9.2.07, pp.1-2 (APHA).

- NSW Health also raised concerns with Rule 7(b) of the Business Rules. NSW Health considered that the Rule is not worded in a way that appears to be consistent with NSW's obligations under the Australian Health Care Agreement (AHCA) arguing that the requirement for individual public hospitals to ensure 'reasonable access' to a 'reasonable range of services' for the purpose of declaration as a 'hospital' under the Bill has the effect of imposing a new substantive obligation on public hospitals in NSW which is separate from and additional to the obligations on the State of NSW under the AHCA. It is inappropriate for such an obligation to be imposed on NSW public hospitals outside the AHCA framework in this way.[72]

1.80 The Committee supports the comments made by MBF regarding the use of Rules. The Committee considers that the over reliance on extensive subordinate legislation to implement important reform packages does not allow for sufficient scrutiny of the objectives of the legislation. In particular, as the draft Rules only became available the day before the Committee's hearing, witnesses were unable to raise particular points of concern with the Committee during the hearing. The Committee considers that, in order to properly examine legislation and its impact on users, subordinate legislation should be made available at the same time, or as near as possible, as the primary legislation.

1.81 The Committee also notes that the Senate Scrutiny of Bills Report in its report on the Private Health Insurance Bill commented on provisions which may be considered to delegate legislative powers inappropriately.[73]

Prostheses List Fees

1.82 The Medical Industry Association of Australia (MIAA) expressed concerns that there had been steep rises in application fees for the current Prostheses List. The MIAA fears that fees recoverable under the Private Health Insurance (Prostheses Application and Listing Fees) Bill 2006 might be of such an order as to represent 'a significant additional impost on device suppliers'. It recommends that this Bill should be amended to include the requirement to recover no more than the total costs incurred in administering the Prostheses List program.[74]

1.83 The Committee notes that the Government has undertaken to review the Prostheses List program following recent reforms to Medicare rebate arrangements for prostheses.

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72 *Submission* 21, Attachment B (NSW Health).

73 Senate Scrutiny of Bills Committee, *Alert Digest No 1 of 2007,* 7 February 2007, pp.29-31.

74 *Submission* 20, p.2 (MIAA).

Conclusion

1.84 The Committee supports the measures being introduced in the Private Health Insurance Bill and related Bills. However, the Committee considers that there are a few areas that could be improved or refined and has recommended accordingly. The Committee also notes and is strongly supportive of the undertaking from the Department of Health and Ageing to maintain consultations with the sector after the commencement of the legislation.

Recommendations

1.85 The Committee recommends:

1. That the definition of 'hospital treatment' in clause 121-5 of the PHI Bill be amended to include the term 'prevent' to ensure that 'hospital treatment is treatment that is intended to manage or prevent a disease, injury or condition...' (paragraphs 1.19-1.20).

2. That care plan arrangements under Broader Health Cover:

(a) Should complement and not substitute for access to Medicare, and not prevent a patient accessing Medicare;

(b) May involve medical services. However, a plan must not "double dip" Medicare by claiming a payment for a medical service from both the health fund and a Medicare rebate;

(c) Should respect the clinical judgment of medical practitioners and other health professionals involved in formulating and implementing the plan, including the patient's own general practitioner and treating specialists wherever appropriate; and

(d) Should follow the principles set out in Appendix 3 as a Care Plan Charter.

That the new Act or Rules incorporate the principles in the Care Plan Charter set out in Appendix 3 (paragraphs 1.32-1.34).

3. That to demonstrate a commitment to quality improvement and to guarantee patient safety, existing quality assurance, professional standards and accreditation regimes should continue to apply to broader health cover services provided until alternative accreditation or equivalent arrangements have been put in place under this legislation (paragraph 1.35).

4. That the administrative requirements underpinning chronic disease management programs be reviewed with the intention of reducing the administrative burden (paragraph 1.31).

5. That the operation of the provisions protecting clinical independence provided in clause 172-5 be independently reviewed after 4 years from the commencement of the Act to ensure that the implementation of broader health cover has not resulted in any reduced clinical oversight of patient care nor had any negative impact on the quality of and delivery of health services to patients (paragraphs 1.41-1.44).

6. That the issue of the extent to which fees under the Private Health Insurance (Prostheses Application and Listing Fees) Bill 2006 might exceed the administrative costs associated with operating the Prostheses List program should be considered during the Government review of that program (paragraphs 1.82-1.83).

7. That the Government give due consideration during the consultative process to the comments made by submitters that raised possible shortcomings in the draft Rules (paragraph 1.79).

8. That subject to the above recommendations, the Committee recommends that the Senate pass the Bills.

Senator Gary Humphries
Chairman

February 2007

ADDITIONAL COMMENTS BY LABOR SENATORS

Doctors' clinical autonomy

Labor believes the protections on doctors' clinical autonomy in the Bill are not strong enough as they currently stand.

The protection on doctors' clinical autonomy in the existing section in the Bill (172-5) is limited to medical purchaser provider agreements – that is, agreements between health insurers and medical practitioners.

Both the AMA and the Australian Private Hospitals Association argue that the legislation needs to include protections of doctors' clinical freedom in other circumstances and contexts, such as hospital purchaser provider agreements.

The National Health Act currently includes a section on doctors' clinical autonomy in hospital purchaser provider agreements – it is not clear why this protection is not also included in the Private Health Insurance Bill.

Accordingly, Labor believes the Bill should be amended to include protection of doctors' clinical autonomy in hospital purchaser provider agreements, as well as other purchaser provider agreements which may arise from the Broader Health Cover provisions in the Bill.

Recommendation:

That the provisions in the legislation regarding doctors' clinical independence be strengthened so that they include hospital purchaser provider agreements and other purchaser provider agreements which may arise from the Broader Health Cover provisions included in the package.

Private health insurance premiums

Section 82BA (2)(c) of the National Health Act 1953 which sets out the objectives of PHIAC, includes 'minimising the level of health insurance premiums' as one of PHIAC's objectives.

This clause has not been included in the Private Health Insurance Bill, thus reducing the number of PHIAC’s objectives from four to three.

Labor believes that the specific objective of minimising private health insurance premium levels should be retained in the legislation, either in PHIAC's objectives, or, as an explicit responsibility of the Minister (who has direct responsibility for approving premium increases).

Labor believes this objective should be included in the legislation, in addition to the more general clause in PHIAC's objectives about 'protecting the interests of consumers'.

Recommendation:

Labor Senators recommend that the Private Health Insurance Bill be amended to include 'minimising the level of health insurance premiums' as one of PHIAC's objectives. Alternatively, the Labor Senators recommend that 'minimising the level of health insurance premiums' be included in the Minister's responsibilities as set out in the legislation.

Senator Claire Moore
ALP, Queensland

Senator Carol Brown
ALP, Tasmania

Senator Helen Polley
ALP, Tasmania

Senator Jan McLucas
ALP, Queensland

Australian Democrats Additional Comments

Inquiry into Private Health Insurance Bill 2006 [provisions] and related Bills

The Private Health Insurance Bill 2006 (provisions) and related Bills represent significant changes to private health insurance arrangements – changes that have implications not only for the privately insured population but also for the 56% of the population who are dependent on the public system.

The Democrats start from the position that an individual's health care, and indeed their health status, should not be determined by virtue of their financial status or ability to buy and maintain health insurance. The Democrats are not opposed to private health care and indeed see some value in a viable private health care sector that complements the public health system. That notwithstanding, we disagree with the extent of public funding for the private sector and the escalating commitment by Government to subsidising private health insurance.

Over the last decade the Federal Government has introduced measures such as the 30% premium rebate, coerced individuals into taking out private health insurance through measures such as lifetime rating and provided tax-penalties for higher income earners – the latter meaning that many people are actually paid for taking up the product.

Ian McAuley, from the University of Canberra, commented that 'What we have had in private health insurance when we count measures such as the rebate, the one per cent tax penalty and the Lifetime Health Cover etcetera are five rounds of increasing industry assistance now costing about $4 billion a year. That is $3 billion in direct outlays and at least $1 billion in forgone revenue because of the one per cent incentive'[1].

The Democrats have commented on numerous occasions about the inefficiency of the 30% private health insurance rebate and the inappropriateness of spending billions of dollars of the health budget in a manner which undermines the health system as a whole. There is ample evidence that private health insurance is not only inflationary causing overall spending on health care to rise, but is inefficient, misallocates resources and undermines equitable access to health care.

Rather than taking the challenge of considering the most appropriate forms of health financing to meet the health needs of a wealthy developed country such as Australia in the 21st century, the Government has chosen to provide what is little more than industry protection for an inefficient intermediary in health care. McAuley states that 'there are more efficient ways of providing consumer choice and supporting private service providers than churning funds through a financial intermediary such as private insurance'[2].

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1 *Committee Hansard* 2.2.07, p.7 (Ian McAuley).

2 *Submission* 2, p.1 (Ian McAuley).

Substantial evidence suggests that a single national public health insurer is the most efficient and equitable way to fund health care. This is not the same as saying that all health care should be free or delivered by public organisations but simply that a single national insurer has the ability to contain costs and unnecessary usage.

The Government needs to delink the private health sector from the private insurance industry. It is entirely feasible to provide support for private health care and consumer choice by mechanisms other than supporting the private health insurance industry. The Government subsidy to private health insurance would be better spent through direct funding to private hospitals and service providers.

As McAuley notes such an approach "relieves the government of the need to regulate the insurance industry which….is very complex and difficult. It bypasses the billion dollars in administration costs. It gives the government some control over costs and usage, and it gives the government far more control over equity in the system. It particularly would provide equity for that 57 per cent of the population who do not have private health insurance but who meet these or similar expenses from their own pockets. We would have more consumer choice, more self-reliance and a reduction of the moral hazard which occurs, particularly given that insurers and the government are pushing strongly for 100 per cent cover and zero deductible policies"[3].

It is also noteworthy that these changes have been justified in part on the basis that they will reduce costs and therefore reduce pressure on health insurance premiums. It is difficult however to accept this premise. Providing services to patients in the community is not necessarily less expensive, and administration costs for managing these new processes may be substantial. MBF itself noted that 'any potential for health cost control through more innovative models of care are unlikely to be reflected in premiums overs the short term" and indeed suggested that the costs of covering [preventive programs] will be upfront resulting in a potential upward pressure on prices in the short to medium term'[4].

The Democrats have long been advocates for a greater orientation towards prevention and early intervention within Australia's health system and are strongly supportive of the principles that underlie moves in that direction. Similarly the Democrats support broader access to non-hospital based care.

Health care should be provided in the most appropriate and safe setting possible and funding mechanisms should be designed to support this. Equally it is desirable that processes should be in place to assist people to participate in preventative programs that better assist them in managing chronic conditions. The burgeoning rates of chronic diseases such as diabetes and their accompanying long-term health consequences and financial costs make it imperative that we look at earlier and more effective management of these conditions.

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3 *Committee Hansard* 2.2.07, p.8 (Ian McAuley).

4 *Submission* 15, p.10-11 (MBF).

However the Democrats are also concerned that the changes contained within this legislation may contribute to the dismantling of the public health insurance system. While it is not easy to predict the effect of changes to health insurance, it is true to say that if public health insurance were to play a lessor role in health care then the role of private health insurance would need to expand to fill in any gap created by the withdrawal of Medicare. This legislation appears to represent moves in that direction, albeit presented as offering benefits to the quality of health care for the privately insured.

As noted in the Chair's report while there are currently services covered by private health insurance that are not included in Medicare, Broader Health Cover will significantly expand the list of items covered by private health insurance but not Medicare. This undermines the universal nature of the health care system in Australia by providing access to services to those who have private health insurance that are not available to those who do not have private health insurance.

Given the increasing amount of public funding directed to private health insurance, it is timely that we re-evaluate its nature, role and degree of government support. However this re-evaluation must take place in the context of the broader health system and any changes to private health insurance must not be to the detriment of the system as a whole.

Indeed it is time that we revisited the whole health system, including the system of health financing. In designing a health care system that is equitable and efficient and best adapted to meet 21st century health care needs, the sanctity of private health insurance should not be above examination.

Senator Lyn Allison
AD, Victoria

APPENDIX 1

Submissions received by the Committee

1 IMAN International Pty Limited (NSW)

2 McAuley, Mr Ian (ACT)

3 Palliative Care Australia (ACT)
- Additional information concerning broader health cover, dated 6.2.07

4 Health Insurance Restricted Membership Association of Australia (HIRMAA) (VIC)

5 Australian Physiotherapy Association (APA) (VIC)
- Supplementary submission received 12.2.07

6 Australian Health Management Group Limited (ahm) (NSW)
- Supplementary submission received 7.2.07

7 Australian Health Insurance Association (AHIA) (ACT)

8 Australian Unity Limited (VIC)
- Supplementary submission dated 9.2.07

9 MND Australia (NSW)
- Additional information concerning draft rules dated 7.2.07

10 Consumers' Health Forum of Australia (ACT)

11 Australian Private Hospitals Association (APHA) (ACT)
- Supplementary submission dated 9.2.07
- Additional information dated 20.2.07

12 BUPA Australia (VIC)

13 Centre for Health Economics Research and Evaluation (CHERE) NSW

14 Australian Medical Association (AMA) (ACT)
- Supplementary submission dated 16.2.06

15 Medical Benefits Fund of Australia Limited (MBF) (NSW)

16 Department of Health and Ageing (ACT)
- Response to questions on notice dated 9.2.07 and published research articles relating to patient utilisation of services

17 Doctors Reform Society (NSW)

18 MS Australia (ACT)
- Supplementary submission dated 9.2.07

19 Catholic Health Australia (ACT)

20 Medical Industry Association of Australia (NSW)

21 NSW Health (NSW)

APPENDIX 2

Public Hearing

Friday, 2 February 2007
Parliament House, Canberra

Committee Members in attendance

Senator Gary Humphries (Chair)
Senator Claire Moore (Deputy Chair)
Senator Lyn Allison
Senator Jan McLucas
Senator the Hon Kay Patterson

Witnesses

Mr Ian McAuley, Lecturer, University of Canberra

Consumers' Health Forum of Australia

Ms Helen Hopkins, Executive Director

Australian Private Hospitals Association (APHA)

Mr Michael Roff, Executive Director

Mr Paul Mackey, Director, Policy and Research

Australian Medical Association (AMA)

Dr Dana Wainwright, Chair of Council

Mr John O'Dea, Director, Medical Practice

Australian Health Management Group Limited (ahm)

Mr Dan Hook, Chief Executive Officer

Mr Greg Rheinberger, Deputy Chief Executive Officer

Australian Health Insurance Association (AHIA)

The Hon Dr Michael Armitage, Chief Executive Officer

Health Insurance Restricted Membership Association of Australia (HIRMAA)

Mr John Rashleigh, President

Mr Ron Wilson, Executive Director

Medical Benefits Fund of Australia Limited (MBF)

Dr Christine Bennett, Group Executive, Health and Financial Solutions and Chief Medical Officer

Mr Ian Burningham, Group Executive, Corporate and Capital Management

Australian Unity Limited

Mr Rohan Mead, Group Managing Director

Mr David Bradley, Manager, Strategic Initiatives

MND Australia

Ms Carol Birks, National Executive Director

MS Australia

Ms Sharon Eacott, Advocate

Australian Physiotherapy Association (APA)

Mr Damian Mitsch, National Manager

Ms Jenny Kerr, Director

Palliative Care Australia

Ms Donna Daniell, Chief Executive Officer

Department of Health and Ageing

Mr David Kalisch, Deputy Secretary

Mr Charles Maskell-Knight, Principal Adviser, Acute Care Division

Ms Penny Shakespeare, Assistant Secretary, Private Health Insurance Branch, Acute Care Division

Ms Belinda Highmore, Director, Broader Health Cover Section, Private Health Insurance Branch, Acute Care Division

Ms Veronica Hancock, Director, Consumer Strategies Section, Private Health Insurance Branch, Acute Care Division

APPENDIX 3

CARE PLANS AND THE MBS: TERMS OF RECOMMENDATION(S)

The Committee recommends that:

(1) Medicare must remain at the centre of Australians' access to out-of-hospital medical care.

(2) A care plan arrangement between a patient, his or her medical practitioner and his or her health fund must complement access to Medicare, not substitute for it.

(3) A care plan arrangement can be constructed around services subsidised by Medicare and the Pharmaceutical Benefits Scheme.

(4) No care plan arrangement should prohibit the patient from accessing Medicare-funded services, or include gap insurance for Medicare-funded services.

(5) An out-of-hospital medical service related to a care plan arrangement can be covered by Medicare or private health insurance, but not both.

(6) No individual medical service can be claimed by a provider on both MBS and PHI cover.

(7) If a service can be performed under a care management plan or Medicare item, the patient has the right of choice on covering the cost either through Medicare or their health fund.

(8) Subject to those constraints, private health funds may coordinate and pay for care plan arrangements that may incidentally involve medical and allied health services (eg checking blood pressure, air flow tests, routine physical examinations) that can also be provided under a Medicare consultation item.

(9) No service funded under a care plan arrangement should also attract a Medicare benefit. Similarly, nothing should preclude the payment by a health fund for a care plan arrangement including medical services not covered by Medicare (eg a long check-up consultation by a GP for a person with given risk factors).

(10) Care plan arrangements generally should be agreed by a supervising clinician (in consultation with the patient's usual general practitioner as clinically necessary or as requested by the patient) and the participant, and should lead to improved health outcomes for the participant.

(11) The health fund should ensure that the patient's usual general practitioner and specialists are advised that the patient is participating in a care plan arrangement.

(12) While a health fund may contract health professionals to participate in the provision of care plan arrangements, those health professionals must have the clinical freedom to recommend what is best for the participant's health outcomes.

(13) In considering or participating in a care plan arrangement, nothing should prevent a patient from consulting his or her treating general practitioner or specialists about his or her treatment choices.

(14) No patient should be penalised by a health fund for declining the offer of a care plan arrangement.