APA Submission to the Inquiry into Private Health Insurance Bill 2006 [provisions] and related Bills

Presented to the Community Affairs Committee of the Department of the Senate

Prepared by the

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Authorised by

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INTRODUCTION

This submission provides comment on the Private Health Insurance Bill 2006 [provisions] and related Bills. The APA submission to the Exposure draft of the Private Health Insurance Bill recommended that the Federal Government should permit a comprehensive Senate inquiry process to ensure that the provisions of the Bill did not have unintended consequences. The APA is pleased that this has occurred.

The APA reiterates the call made in its earlier submission to the Department of Health and Ageing (DoHA) that the Federal government should reinstate legislative reference to physiotherapy including for 'hospital treatment' and 'hospital-substitute treatment'.

In this submission the APA identifies a number of issues, including:

- The full impact of the legislation cannot be gauged. Depending on the Rules the legislative impact could be positive or problematic for health consumers and physiotherapists. An exposure draft of the Private Health Insurance Rules should be released for consideration by this Senate inquiry.
- Current provisions in the PHI Bill, regarding agreements with a private health insurer should be amended to explicitly ensure that such agreements do not limit the professional freedom of physiotherapists to identify and provide appropriate treatments to patients.
- Sections of the PHI Bill provide less protection to physiotherapists than to doctors in regard to the actions of private health insurers.
- The Federal Government should ensure that an objective of the Private Health Insurance Administration Council (PHIAC) remains to minimise the level of health insurance premiums.

The Bill may facilitate greater control over health service provision by private health insurance funds. For example, officials of the Department of Health and Ageing (DoHA) 'definitely' acknowledge 'further potential for health care funds to have…contracting arrangements' with health service providers (Senate Community Affairs Committee 2006).

The APA will not support interference by private health funds in the clinical decision making of a physiotherapist or manipulation of contracting arrangements to undermine the quality of patient care.

The opportunity, provided by this Bill, to develop clinically appropriate alternatives to hospitalisation is welcomed by the APA. Physiotherapists and allied health professionals deliver many interventions that promote hospital avoidance - recognition of this fact in the Bill would be welcomed by the APA.

The APA would be pleased to provide additional information on any aspect of this submission and meet with the Senate Committee to explain its perspective in detail.

RECOMMENDATIONS

The Federal Government should:

- release an exposure draft of the Private Health Insurance Rules to the Senate inquiry;
- amend the Bill to reinstate explicit reference to physiotherapy, including for 'hospital treatment' and 'hospital-substitute treatment';
- amend Section 172-5 of the Private Health Insurance Bill 2006 to explicitly ensure that the protection of professional freedom to identify and provide appropriate treatment is extended to include physiotherapists. Similarly, the Federal Government should amend Section 72-5 of the Private Health Insurance Bill 2006 to provide physiotherapists parity with doctors;
- amend Section 247-5 of the Private Health Insurance Bill 2006 to allow physiotherapists to appoint a representative on their behalf to participate in mediation, if required;
- enhance the powers and increase the resources of the Australian Competition and Consumer Commission to protect smaller health care providers from private health insurance funds using their increased market power inappropriately;
- ensure that the Office of the Private Health Insurance Ombudsman 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; and
- ensure that an objective of the Private Health Insurance Administration Council (PHIAC) remains to minimise the level of health insurance premiums.

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PROVIDING KEY INFORMATION

Australian citizens and smaller health care providers are entitled to have full, transparent, and complete information on the significant legislative changes proposed by these Bills.

The APA welcomes the fact that a Senate inquiry into the legislation has been permitted. Nonetheless much of the legislative detail is contained in the Rules and these Rules are yet to be released.

Recommendation

The Federal Government are urged to release an exposure draft of the Private Health Insurance Rules and provide adequate time for relevant organisations, including under-resourced consumer groups and small health providers, to scrutinise the full implications of the draft Rules and to provide feedback.

REINSTATING PHYSIOTHERAPY IN RELEVANT DEFINITIONS

Out of respect for the physiotherapy profession and in the interests of equitable access to physiotherapy, optimal health care and cost-effective expenditure, legislative references to physiotherapy should be reinstated.

The APA notes that unlike the current legislation, key sections of the proposed legislation omit explicit reference to physiotherapy.

The *National Health Act 1953* (Cth) is currently the main legislation governing private health insurance in Australia. Division IV of the Act, on health insurance businesses, defines 'hospital treatment' to include 'relevant health services'. These in turn are defined to mean 'medical, surgical, diagnostic, nursing, dental, chiropody, chiropractic, eye therapy, occupational therapy, physiotherapy, speech therapy or similar services or treatment' (emphasis added).

In contrast to the above, the PHI Bill defines 'hospital treatment' to include 'therapeutic' services or goods intended to manage a disease, injury or condition.' The APA is concerned that the term 'therapeutic' is not defined in the PHI Bill. In other words, unlike the *National Health Act 1953*, the Bill does not explicitly include physiotherapy as part of 'hospital treatment'.

The APA has a similar concern with the definition of 'hospital-substitute treatment' in Schedule 1, which also omits reference to physiotherapy.

Recommendation

The Federal government should amend the Bill to reinstate explicit reference to physiotherapy, including for 'hospital treatment' and 'hospital-substitute treatment'.

THE VITAL ROLE OF PHYSIOTHERAPY IN REDUCING HOSPITALISATION COSTS

Physiotherapy interventions are an efficient and effective means of containing hospital expenditure.

The DoHA fact sheet (2006) states: 'From April 2007, health funds will be able to offer products that pay benefits for services that are part of, prevent, or substitute for hospital services.'

Notwithstanding the significant body of evidence that private health insurance funds have largely been responsible for increasing hospitalisation rates in Australia (OECD 2003) to a very high level by international standards (Deeble 2003), thus increasing the Commonwealth's share of the health care budget (Segal 2004), the APA provides in-principle support for the reduction of hospitalisation rates through this legislation, subject to further detail.

The APA has consistently emphasised that physiotherapists are experts at preventive health and rehabilitation and have a vital role to play in reducing hospitalisation rates and facilitating early hospital discharge. The following example of physiotherapy treatment for incontinence is illustrative.

> A substantial body of evidence indicates the efficacy of physiotherapy in continence management. A study published in the *Australia and New Zealand Journal of Obstetrics and Gynaecology* found that 82 per cent of women were cured of stress urinary incontinence after one episode of physiotherapy care (Neumann 2005a). A further outcome of the study, published in the *Australia and New Zealand Journal of Public Health*, found that physiotherapy management of female stress urinary incontinence costs on average $302.40 while surgical management costs between $4668 and $6124 (Neumann 2005b).
>
> In addition to being less cost effective, surgical management also requires a substantially greater workforce contribution by more highly trained staff. For example, the surgeon would be a sub-specialist urogynaecologist with a minimum of 15 years training and a specialist anaesthetist would have a minimum of 12 years training. Alternatively, the continence physiotherapist would have four years undergraduate training with two or more additional years of training or experience.

In order to facilitate hospital avoidance it will also be important that private health funds recognise there will be need for different schedules of fees for physiotherapists treating different conditions. Incontinence treatment is one

such example, where a long consultation (60-90 minutes) is required and should attract a higher rebate.

PROTECTING THE PROFESSIONAL FREEDOMS OF PHYSIOTHERAPISTS

The APA will not support interference by private health funds in the clinical decision making of a physiotherapist or manipulation of contracting arrangements to undermine the quality of patient care.

In his second reading speech to the PHI Bill, Minister Abbott stated:

> The bill also ensures that the contracts that doctors have with insurers may not limit the clinical freedom of doctors to choose the most appropriate treatment for their patients.

The APA argues that it is appropriate that *all* health service providers should enjoy the same protections from private health insurers that are provided to doctors. Section 172-5 of the PHI Bill currently states:

> If a private health insurer enters into an agreement with a *medical practitioner for the provision of treatment to persons insured by the insurer, the agreement must not limit the medical practitioner's professional freedom, within the scope of accepted clinical practice, to identify and provide appropriate treatments.

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'.

The APA is also concerned about Section 72-5 of the PHI Bill which appears to favour medical practitioners and work against the interests of physiotherapists and their patients. This Section states:

> 72-5 Rules requirement in relation to provision of benefits
> (1) For the purposes of paragraph 72-1(1)(d), the *rules of the private health insurer that issues the policy meet the rules requirement in this section if the rules have the effect required by subsection (2).
>
> (2) The effect required is that if, under an agreement or arrangement with a private health insurer, a particular *health care provider (other than a *medical practitioner) provides particular *hospital treatment or *hospital-substitute treatment to people insured under the same *complying health insurance product of the insurer, any charge for the treatment:
> (a) that is payable by an insured person; and
> (b) which is not recoverable by a benefit under the product;
> must be the same for all of the people insured under the product, *irrespective of:*

(c) the frequency with which that provider provides that particular treatment to people insured under that product; or
(d) any other matter.

(3) The Private Health Insurance (Complying Product) Rules may modify the effect required by subsection (2) in relation to all or particular kinds of *complying health insurance products, benefits, treatments or **health care providers*. To the extent the Rules do so, the rules requirement is taken to be met if the conditions in the Rules are met (italics added).

Once again this clause appears to treat physiotherapists and other health professionals less favourably than doctors.

The APA contends that 'clinical independence must not be corrupted' by legislative pressure favouring the financial interests of private health insurers and that payment for physiotherapy services should reflect the true cost, *variety* and *complexity* of these services (APA 2004).

In the event that the Private Health Insurance Ombudsman directs mediation between a private health insurer and a doctor, the PHI Bill permits the doctor to appoint an individual to participate in the mediation on their behalf. However, the same option is not provided to physiotherapists. Thus section 247-10 (1) of the PHI Bill states:

If the Private Health Insurance Ombudsman directs a *medical practitioner under subsection 247-5(1) to participate in mediation, the medical practitioner may appoint an individual to participate in the mediation on the practitioner's behalf.

It appears to be unfair that other health professionals should not have the right to appoint a representative to participate in mediation on their behalf, particularly when they are facing private health insurers with extensive human resources and legal expertise.

The inclusion of the term 'medical practitioner' is the problem. Either the term 'medical practitioner' needs to be re-defined to include physiotherapist or else the word 'medical' should be omitted'.

Recommendations

The Federal Government should amend Section 172-5 of the Private Health Insurance Bill 2006 to explicitly ensure that the protection of professional freedom to identify and provide appropriate treatment is extended to include physiotherapists.

The Federal Government should amend Section 72-5 of the Private Health Insurance Bill 2006 to provide physiotherapists parity with doctors.

The Federal Government should amend Section 247-5 of the Private Health Insurance Bill 2006 to allow physiotherapists to appoint a representative on their behalf to participate in mediation, if required.

PROTECTING THE VULNERABLE FROM THE ABUSE OF MARKET POWER

To safeguard the interests of consumers and small business providers of physiotherapy services the Australian Competition and Consumer Commission (ACCC) should be empowered and adequately resourced to prevent large private health insurers from abusing their market power.

The APA holds concerns that this legislation, together with sale of Medibank Private, will facilitate opportunity for larger private health insurance funds to use their market power in an inappropriate way when dealing with smaller health care providers. This could disadvantage both smaller health care providers and their patients.

Currently some health funds use preferred provider schemes as a mechanism to try, inappropriately, to influence clinical decision-making. For example, the APA has received reports from members that funds have threatened to take away their preferred provider status if they do not reduce the number of treatments per patient. Under this new legislative regime there is a significant risk that pressure could be applied to small health care businesses to comply with contract terms aimed at limiting or reducing access to clinically-indicated treatment. Clearly such limitations would be detrimental to the health of consumers.

APA members already express concerns to the APA about inappropriate pressure tactics from certain health funds. While these complaints could often form a sound basis for an unconscionable conduct claim to the ACCC, smaller health care providers are generally loathe to pursue their legal entitlements for fear of negative impact on the future of their business.

Recommendation

The Federal government should enhance the powers and increase the resources of the Australian Competition and Consumer Commission to protect smaller health care providers from private health insurance funds using their increased market power inappropriately.

JUSTICE FOR HEALTH CARE CONSUMERS

Justice in the provision of health care requires information and adequately resourced, fair, effective and impartial processes for expressing concerns and obtaining redress.

The APA is concerned that the interests of health consumers will be inadequately protected if funding for the Private Health Insurance Ombudsman (PHIO) is not significantly increased.

The PHIO is a government funded, independent service, whose main role is to protect the interests of people who are covered by private health insurance, although it will also accept complaints from others including a health fund or a health service provider.

On 1 July 2006 amendments to the *National Health Act 1953* (Cth) expanded the powers of the PHIO in dealing with complaints and conducting investigations. It is important that health consumers and health care providers are informed about these new powers and their right to lodge complaints. Lack of information about complaint options may be contributing to the decline in total complaints received by the PHIO.

Significantly, the number and proportion of complaints requiring more detailed investigation has increased over the last three years. Nonetheless the Federal Government appropriation to the PHIO declined between 2005 and 2006 (PHIO Annual Report 2006).

Recommendation

The Federal Government should ensure that the Office of the Private Health Insurance Ombudsman 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.

FINANCIAL PROTECTION FOR HEALTH CARE CONSUMERS

The interests of health care consumers using private health insurance need to be safeguarded through the minimisation of the level of health insurance premiums.

The Private Health Insurance Administration Council (PHIAC) is the independent prudential regulator that oversees the operations of private health insurance funds.

The PHIAC was established in 1989 under section 82B of the *National Health Act 1953* (Cth). Its functions are explained in detail in Section 82G. The PHIAC is required to achieve a balance between four broad objectives:

- fostering an efficient and competitive health insurance industry;
- ensuring the prudential safety of individual registered organisations;
- minimising the level of health insurance premiums; and
- protecting the interests of consumers.

Section 82BA (2)(c) of the *National Health Act 1953* requires 'minimising the level of health insurance premiums'. This clause has been removed from the current legislative proposal to the less explicit requirement to 'protect the interests of consumers' (see Section 264-5(b)).

The objective to minimise the level of health insurance premiums remains vitally important. Private health insurance premiums have increased 40% over the past five years at a rate double CPI [and] higher than wages growth…Premiums in 2005 increased by an average 7.6%' (CPSU 2006).

Recommendation

The Federal Government should ensure that an objective of the Private Health Insurance Administration Council (PHIAC) remains to minimise the level of health insurance premiums.

ABOUT THE APA

The Australian Physiotherapy Association (APA) is the voice of the physiotherapy profession in Australia and leads the profession internationally. Physiotherapists must be fully qualified and eligible for registration with the Physiotherapists' Registration Board in their respective state or territory to be eligible for full APA membership. Australia has approximately 11 300 registered practising physiotherapists. The APA has more than 11 000 non-student members. The APA national office is located in Melbourne, with branch offices in every state and territory. Further information on the APA is available at <www.physiotherapy.asn.au>.

APA VISION

All Australians will have access to quality physiotherapy, when and where required, to optimise health and wellbeing.

APA POLICY CONTEXT

The following extracts from key APA policies may assist in contextualising the views of the APA on private health insurance.

The APA Platform supports a universal, publicly funded Medicare system, equitable access to publicly funded health services, and contends that:

- The APA opposes private or government monopoly of healthcare or health purchasing.
- The APA contends that clinical independence must not be corrupted by pressure being applied by large health purchasers or providers.
- Payments to insured patients should be a rebate to the patient and that patients should have the choice to choose treatment of greater value from a private provider through gap fees.
- Affordable ancillary cover is vital to the continued viability of physiotherapy in the private health sector.
- Payment for physiotherapy services should reflect the true cost, variety and complexity of these services.
- Market price is the most appropriate indicator of the relative value of physiotherapy services in the private sector (APA 2004).

The APA Strategic Plan includes to:

- Safeguard interests of consumers and providers of physiotherapy services.
- Advocate for equitable access to physiotherapy and optimal health care for all Australians.

- Lobby key stakeholders to overcome identified barriers to consumer access to physiotherapy.
- Improve access to physiotherapy services to meet the needs of consumers (APA 2005).

The APA Code of Conduct includes that:

- APA members shall advance the common good.
- Physiotherapists shall work towards achieving justice in the provision of health care for all people (APA 2001).

The APA Position Statement on Health Funding Provider Agreements includes:

- Price caps that interfere with the clinical decision making of a physiotherapist or limit the quality of patient care are unacceptable.
- Physiotherapy is a core health service and health funds should offer fund members reasonable rebates for standard as well as special or complex physiotherapy services such as two-area treatment, neurological treatment, lymphoedema and continence management (APA 2000).

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