AHIA SUBMISSION TO THE SENATE COMMUNITY AFFAIRS COMMITTEE Private Health Insurance Bill 2006

The Australian Health Insurance Association (AHIA) thanks the Senate Community Affairs Committee for the opportunity to provide input into the Inquiry into Private Health Insurance Bill 2006.

AHIA is the peak body for 23 private health insurance funds, collectively representing the interests of more than 9.5 million Australians with private health insurance cover.

Introduction

The AHIA fully supports the intention of the Minister for Health to expand the provision of services that may be offered by health funds, namely broader health cover. It is industry's expectation that such changes will enable health insurance members to access modern care opportunities, to obtain better value for money, to receive the most appropriate care in the most appropriate setting, and to be provided with safe care with improved health outcomes.

The Bill also consists of many changes to the current regulatory framework of the operations of private health insurance companies, some of which industry does not believe are entirely appropriate, and at the time of writing this submission, we are engaged in continuing discussions about them.

AHIA and its member funds have been in constant communication with the Department of Health and Ageing (DoHA) to ensure that the legislative change best reflects the Minister's intention and, importantly, the interests of patients with private health insurance.

This communication was enhanced by the release of the Exposure Draft by the Minister which allowed for constructive industry input into the drafting processes. AHIA would recommend that this process of engagement becomes customary practice, as it provided for those in industry to work with Department representatives in the best interests of all involved. This is shown by the number of important changes that have been undertaken to the Bill since the release of the Exposure (some examples are shown below).

(i) Directors no longer subject to strict liability outside of normal industry practice
(ii) Continuation of rate protection as currently provided by industry voluntarily.
(iii) Continuation of the savings provision for partners of people accessing the 35% or 40% rebate.
(iv) Improvements to the definition of "hospital treatment".
(v) Correction to the day on which pre existing ailments apply to new members.

Areas of Potential Improvements to the Bill

As with any legislation there is always the potential for improvement in the best interests of consumers and taxpayers. Some areas are outlined below for the consideration of Committee members, and are forwarded in the context of ensuring minimal regulation is imposed to achieve the Minister's desired outcomes.

Section 169-15: Notification of CEO Change
This section requires that an insurer must notify DoHA and PHIAC of any change to the name or contact details of its CEO, before the changes take effect. This is inconsistent with the similar requirement under the ASIC regime, as set out in Section 205B of the Corporations Act, for notification of a change within 28 days. We also consider that it is not valid to argue, as have the Department's representatives at the consultation forum on 14 December, that "commonsense" would be applied in enforcing this provision, as this leaves an unreasonable discretion in the hands of the regulators. The legislation should be reasonable in the first place, rather than relying on the reasonableness of the Department in enforcing it.

Requirement for current health insurers to register under the new regime
Industry is unclear as to whether or why all existing health insurers are required to re-register under the new legislative regime. AHIA recommends that change be made such that the Bill allows for all ASIC-registered funds to be "grandfathered" into the new regime, rather than place administrative burden on health funds and numerous Department's

Further, any health insurance product approved before 1 April 2007 must be grandfathered into the new regime, rather than inappropriately wasting health fund staff and Department staff valuable time by having to reapply for all fund products that have already been approved by the Minister.

Broader Health Cover
AHIA has had the opportunity to provide input on a draft framework that would apply to Broader Health Cover that will relate directly to the Bill as outlined in circular PHI 78/06 as issued by the DoHA. AHIA considers this framework to be too prescriptive in the definitions of Chronic Disease Management Programs (CMDP). A more sensible approach would be to reflect the opportunity health funds anticipate, and to increase the opportunity to develop more appropriate chronic disease programs in the private sector, rather than be wedded to current public system models. This will ensure the best models of care can be developed for all Australians, as innovative programs are considered and developed by the private sector. Health funds should be free to determine the most appropriate service in the best interests of their members.

AHIA member funds strongly believe it is inappropriate for the proposed framework to mandate the provision of "*at least two allied health services from two or more disciplines*" for any CDMP. The stated objectives to reduce complications, or prevent or delay the onset of chronic disease should not be reliant on the number of service types a patient receives, as the actual number of the services types utilised is irrelevant to achieving the most appropriate service for a patient.

Medical innovation, and current and future practice, means that it may be appropriate that a patient's chronic disease can be managed by one service. Mandating more than one service by more than one discipline may:

(i) add unnecessary costs via inefficient practices to meet the definition unnecessarily.
(ii) discriminate against rural, regional or remote areas where more than one allied health service or allied health service provider may not be available.
(iii) Stifle innovation and/or not allow for future/current practice

The examples below support the need to enable health funds to determine the most appropriate services required by their members.

Example One: Pre-Diabetes
Pre-diabetic members are at serious risk of their disease progressing to diabetes, yet experience shows that an appropriate program can be run by a single Nurse Diabetes Educator. Although clinically appropriate, as they are provided by a single practitioner, who is not allied health qualified, these programs will not be permitted. As such, a greater number of pre-diabetics than would otherwise be the case will progress to develop diabetes, which will undoubtedly result in increased costs to the health fund.

Example Two: Voluntary Psychiatric Programs
Program for members that have recently undergone hospital admissions for psychiatric illness. This program includes:
- Initial assessment by a mental health provider;
- Development of a relapse prevention plan;
- Ongoing intervention calls, frequency of which is based on the initial risk assessment;
- 24 hour access to a support line which includes triage and crisis support;
- A review after 12 months.

Example Three : NHMRC Programs
Any program that has an evidence base with a level of evidence of between I and IV as outlined by the National Health and Medical Research Council (NHMRC) should be allowed.

Example Four: Cardiac Programs
A cardiac program for members of health funds that have recently undergone cardiac surgery. This program includes a diet and exercise program and periodic calls by a cardiac nurse.

Example Five: Chronic Disease Self Management Program
Kate Lorig and her colleagues at Stanford University have developed a generic self management course for consumers called the Chronic Disease Self Management Program (CDSMP). The program was developed from a literature review of existing patient education programs and focus groups. It is a consumer course that can be delivered by trained laypersons or health professionals. The impact of the program has been evaluated in a randomised controlled trial and it has been shown to deliver significant reductions in hospitalisations and improvement in health. Under the proposed criteria requiring two allied health professionals this program would not be approved despite its efficacy.

Example Six: MCKESSON Congestive Heart Failure and Coronary Artery Disease Management Programs.
These programs are telephone-based, proactive support programs for patients with chronic heart conditions delivered by registered nurses who provide patient education and self management to people who have been assessed against a set of clinical indicators relating to congestive heart failure and coronary artery disease. The Programs are based on current published evidence based research and national health guidelines. One registered nurse works with an assigned number of patients to deliver the program through a series of outbound calls linked to a GP developed care plan or an action plan. The Program nurse provides regular communication to program participants' GPs and has access to a Medical Director who provides clinical oversight of the program.

Example Seven: Single GP Involvement
Chronic Disease and Risk Programs delivered by Divisions of GP or other health providers such as multi GP Practices (examples include the recent National Primary Care Collaborative or the Co-ordinated Care Trial conducted by GP Partners in Brisbane North). These are structured face to face programs that provide care co-ordination, case management (where appropriate), patient education focused on self management skills including improved compliance with medication and goals around lifestyle changes. These programs are usually delivered either by practice nurses or service co-ordinators who assume responsibility for a group of patients

It is extremely important that the proposed Broader Health Cover system remains non-mandatory to ensure the most efficient use of private health insurance members and taxpayers funds. A non-mandatory system enables health funds to form agreements with health service providers in the interests of members, rather than having a system where benefit payments are prescribed – as in the current default benefit system for hospitals - which may not provide any benefit to patients. Rather than providers being presented with an income without demonstrating evidence that supports better patient outcomes, the non-mandatory framework for BHC services brings competition and innovation to the market.

Restrictions on Payments for Out of Hospital GP and Specialists Consultations
The framework quite clearly articulates that the existing restrictions on insurers paying benefits for out of hospital GP and specialist consultations that attract a Medicare rebate will remain.

Industry view is that funds ought to be able to pay for ANY doctor's service, as long as the doctor's involved do not claim from Medicare also. This would ensure health funds can develop the best forms of Broader Health Cover (the most appropriate care that reflects contemporary clinical practice) in the interests of better health outcomes for the privately insured community. Including such barriers within the BHC framework only adds further confusion to the health care financing system for consumers.

FURTHER ENHANCEMENTS TO THE PHI REGULATORY SYSTEM

Consumer Information
Consumers should have access to information about the performance or success rates of hospitals and doctors so that they can make informed decisions about their own health. Such information should recognise the different types of patients and conditions involved, so that clinicians undertaking more complex or risky treatments are not penalised. We note that this approach has been recommended by the recent House of Representatives Standing Committee Report into Health Funding.

If disclosure was mandated by law, it is our understanding that no change would be required to the Privacy Act as this information could be published under the exemption for uses permitted by law (as the Privacy legislation itself expressly provides that it is subordinate to other laws in this respect). Currently the Privacy Act and the threat of defamation prohibit health funds from aggregating such information in the interests of consumers.

Informed Financial Consent
Consumers should also be able to access information from health insurers about the billing practices of medical specialists so that they can be fully informed before they make decisions about their treatment. All patients should be aware of, and agree to, the full cost of medical treatment before it occurs. Whilst this issue is currently not dealt with in the Bill, we

consider it to be an important aspect of the overall reforms, which should be addressed in the Bill. This issue has also featured prominently in the Minister's statements on the reforms.

Health funds strongly support all patients being given information prior to medical treatment in order for them to give Informed Financial Consent (IFC), in all but emergency cases. Unexpected out of pocket costs, caused by lack of informed financial consent – an area outside the control of health funds - is currently one of the major causes of discontentment with private health insurance.

In almost 20 percent of privately insured hospital episodes patients faced unexpected bills, according to the most recent figures released by the Federal Department of Health and Ageing.

Health Funds believe it is in the interests of our members for the lead clinician involved in a medical procedure to be legislatively required to inform each patient of all the approximate and estimated costs they will face during the procedure. Hence the lead clinician or proceduralist would be expected to provide information about not only his/her costs but also those of (for example) the anaesthetist, pathologist, and any other practitioners involved in a procedure.

Industry notes that the Australian Medical Association has been conducting an information campaign to encourage doctors to obtain IFC, and that the AMA's policy is that the admitting practitioner provide patients with information about their own fees and estimated fees of other medical providers where possible, but as a minimum to provide their names and contact details. The Federal Government has stated that if there is not substantial improvement in the level of IFC by early 2007, it will legislate to require doctors to obtain IFC or face penalties.

In our view obtaining IFC 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, not just for the period of an education campaign.

In addition, as above we consider that the lead clinician should be responsible for advising the patient of all fees from all practitioners, rather than merely giving the patient relevant contact details. We believe this is essential so that patients, who are often in a vulnerable situation, can obtain a full assessment of the costs they are likely to incur, without the extra time and effort required to contact a number of individual practitioners.

Our recommended approach is in line with the recommendations of the House of Representatives Standing Committee on Health and Ageing Report on Inquiry into Health Funding, November 2006, which recommended that the Private Health Insurance legislation should be amended to specify the obligations of the lead clinician for IFC.

Once consumers have been provided with information by the lead clinician, health funds have a role to play by providing information on any gaps which may apply, as well as by providing "no gap" or "known gap" products. There are approximately 1200 Health Fund specific Staff available to provide this information in Call Centres, etc., in addition to the funds' regular Retail Staff, so this information would be readily available once the approximate costs are known.

Information Disclosure by Hospital
There is information asymmetry when it comes to negotiating hospital contracts. Health Insurers financial and performance data is revealed in detail via PHIAC's annual report, Operations of the Registered Health Benefit Organisations, but health funds have only limited information in respect to hospitals and in many cases have only their own claims data available to them. An example of this can be seen in one Facility's 2005/6 Annual Report which provides only group level financial data, and even then only of a very limited nature.

This Bill is an opportunity to ensure that both hospitals and health funds have similar access to financial and performance data. This will assist in establishing a "level playing field" to the benefit of all patients.

I would be more than happy to elaborate on any of the above issues in person at the request of the Committee.

Yours sincerely

HON DR MICHAEL ARMITAGE
CHIEF EXECUTIVE OFFICER

25 January 2007