Submission to the Senate Community Affairs Committee on the

Private Health Insurance Bill 2006 (provisions) and related Bills

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Introduction

The Australian Medical Association (AMA) agrees that the funding arrangements underpinning the provision of medical and hospital care in Australia need adjustment as treatment options evolve. Existing arrangements, designed in the decades following the Second World War, support a high quality, affordable health system. These comprise three separate components: medical insurance provided through the Commonwealth's Medicare monopoly, free public hospital treatment provided by the States and funded in part by the Commonwealth and private hospital care funded largely through private insurance.

The AMA has supported the various measures introduced by the Federal Government over the last decade that have substantially boosted private health fund membership and supports these further proposals to enhance the longer term relevance and viability of the private health sector. In this context, the AMA notes the Government's comment in the Explanatory Memorandum accompanying the Bill that: " Standard and Poors consider that, under the current policy settings, there is little scope for growth in the Australian private health insurance market. Standard and Poors have forecast a slow and inevitable decline in the local market over the next five years." (Ex. Mem)

The AMA agrees that for some health conditions, such as chronic conditions which require a spectrum of practitioners working in a range of hospital and non-hospital settings, the provision of health funding through three separate systems has impeded the development of new ways of organising and delivering care. Some care currently provided in expensive hospital settings can, given technical developments, now be provided in less complex settings.

The AMA therefore agrees that existing funding arrangements should be adapted to support developments that will lead to better and more efficient health care delivery. The AMA also supports the establishment of a new regulatory regime for the private health insurance sector.

While the AMA supports the broad thrust of the Bill it does have some specific comments on the Bill. These comments are presented under the following headings:

1. The Bill in the context of the overall health system.

2. Competition and regulation issues

3. Rejection of managed care type arrangements

4. Strengthening links with general practice

5. Quality issues

6. Summary of AMA recommendations

1. The Bill in the Context of the overall health system.

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. Given the rise in expectations and the ageing of the population, it is inevitable that health expenditure will rise, not fall, as a share of GDP. Similarly, private health insurance premiums will continue to rise both as a share of GDP and as a proportion of household income.

With the ageing of the population and the rising expectations with rising incomes, Australia's national health expenditure has risen from 8.5 per cent of GDP ten years ago to around 10 per cent of GDP around the OECD average. For this expenditure, Australians receive a very large number of high quality medical, hospital and paramedical services. Australians continue to enjoy one of the best health systems in the world. The aggregate cost is very modest given what is provided.

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'. The AMA also notes a tendency for the benefits of such changes to be 'oversold' by others, reflecting current fashionable preoccupations of bureaucratic and academic health policy commentators and the aspirations of 'allied health professionals' to have their incomes buttressed by insurance subsidies. Despite recent promotion of 'team care' and the scope to provide treatment in 'new settings' such developments may in some circumstances actually raise costs.

Other factors will push up the costs of health insurance under the new regulatory regime proposed in the Bill. First, health funds have a very poor record of containing their own management costs. As they move to cover a wide range of diverse services, administration costs may rise even more quickly. Second, notwithstanding the intended limitations on what they can cover, the private health funds will be targeted for cost shifting by the public system as a result of the changes. Third, the Federal Government will find it very difficult to resist the temptation to put more financial responsibility on the private funds and therefore, ultimately, fund members.

In summary, these changes are not a panacea for financial stress facing the private health insurance industry. In fact, they may raise costs. Real sustainable change requires that insurers be able to offer fundamentally different products, for example, medical savings accounts.

2. Competition and regulation issues

The AMA welcomes the intent of these private health insurance reforms to reduce needless regulation and to provide an environment conducive to more competition in the private health insurance industry. The industry has been staid and lethargic behind a wall of regulation which has stifled innovation at the expense of contributors' interests. The

industry is dominated by a small number of large players, all averse to engaging in price competition.

The only elements of regulation that appear essential are those relating to solvency, community rating, reinsurance and standardised consumer information. Regulation should be eschewed unless a clear community benefit can be demonstrated. Regulation which only serves to allow meddling in the market for poorly conceived, extraneous policy objectives, is distorting and harmful.

The new legislation approaches the ideal of light regulation in essential areas only. A key issue will be whether the business rules pursuant to the legislation bring in, via the back door, needless elements of regulation that the reforms seek to remove. The AMA will monitor developments after the legislation is introduced. If the reforms do not result in new players entering the market, the AMA will seek changes to facilitate this outcome. Another key barometer will be whether the reforms stand in the way of desirable, more fundamental, innovations in health financing such as medical savings accounts.

The AMA has doubts about the retention of the power to regulate private health fund premiums. Direct price regulation is ultimately distorting. When the powers have been exercised (such as the 2001 decision to deny all premium increases in the lead-up to a Federal election) they have been used vicariously. The funds have to remain financially viable to carry out their role. The only price control that will prove effective in the long term is that which comes from having a private health insurance industry that is open to healthy and vigorous competition.

In summary, the AMA considers that, in relation to regulation and competition issues, the proposed reforms are moving in the right direction and should improve competition and improve the long-term sustainability of private health insurance. Developments will be monitored closely to see whether the potential benefits are realised.

3. Rejection of managed care type arrangements

The AMA notes the Minister's comments in introducing this legislation:

"*Day procedures, outpatient services, hospital in the home, wellness and prevention are all part of the healthcare equation in a way that simply was not envisaged when the current regulatory regime was devised over half a century ago.*

Hospital cover will expand to cover out-of-hospital services that substitute for or prevent hospital care. This is a groundbreaking change.

Broader health cover will also allow health insurers to work with a wide range of service providers to develop more flexible and innovative products that reflect modern clinical practice and consumer expectations. Health insurers will be able to better assist consumers to manage and prevent acute and chronic conditions. Many people can benefit from tailored programs that support and sustain healthy lifestyles, services such as

personalised health checks, dietary guidance, exercise supervision, and support to quit smoking."

The AMA supports those aspects of the Bill which will enable private insurers to follow improvements in health care provision made possible by innovations developed by specialist doctors and other health providers. A key point the AMA wishes to stress in this submission is that any changes in the way specialised and general practice medical care is delivered under the new arrangements should be introduced to enhance the quality of care. The changes must not be seen as an opportunity to manage costs downwards.

The trends noted by the Minister are driven by improvements in medical training and research, improved medical management of various chronic conditions, by greater knowledge and understanding of health interventions, by improved technology and greater capacity and resources in the non-hospital sector. These technical developments have been developed slowly, carefully and incrementally. The benefits of new treatment arrangements for any specific condition need to be carefully assessed. All factors, including any potential for reduced standards and lower quality care must be considered before new treatment paradigms are supported by funding arrangements.

Nobody involved in determining health policy would be unaware of the backlash against 'managed care' in the 1990s. This was a major public issue in the USA and similar issues emerged in Australia in the 1990s in association with the contracting arrangements between health insurers and specialist doctors and between insurers and private hospitals that were introduced in 1995 by the previous government. It became apparent in both countries that individuals, the ultimate purchasers of health insurance, rejected heavy handed, third party interference in decisions regarding their clinical care and where that care was best provided.

To make the point bluntly, the potentially exciting and beneficial changes promoted by this Bill should not be seen by health insurance companies as an opportunity to provide complex specialist care 'on the cheap'. Nor should they be seen as a means of shifting costs onto others, such as the families of the sick, by cost-cutting measures hiding behind fancy euphemisms such as 'hospital in the home'. Such an attitude would lessen not enhance the attractiveness of private insurance.

The AMA is not suggesting that it is the intent of the present legislation to facilitate third party interference in clinical decision making. However:

- The Bill allows a good deal of discretion to the health funds under the General Treatment heading.
- There are no default benefits for 'general treatment' so there is no certainty to providers of even minimum health insurer support without explicit health fund approval of arrangements.
- The health funds will have increased capacity to support one provider over another based on criteria other than quality of care and outcomes.

- There is no clear separation of the financers of health care from the providers of health care.
- Health funds could finance and provide services either directly of through intermediaries.

Decisions regarding clinical care are matters to be decided between patients and their doctors. The AMA is pleased to note that the government has responded to its concerns about this clinical independence by including clause 172-5 in the Miscellaneous Section of the Bill.

However 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 setting. The legislation needs to be rock solid in preventing this.

The AMA believes that Clause 172-5 must be strengthened by the addition of requirements that refer explicitly to the new types of arrangement facilitated by the Bill. The AMA will be putting proposals to the government in this regard.

Although the Explanatory Memorandum and other documents makes it clear that General Treatment does not include services for which a Medicare benefit is payable, Clause 121-10(3) states that services which attract a "Medicare benefit" are not covered under general treatment "unless the Private Health Insurance (Health Insurance Business) Rules provide otherwise."

There is no guidance as to the circumstance in which the Business Rule would or could provide otherwise and our clear preference would be for there to be no power for Rules to provide otherwise.

The AMA will be seeking clarification of the intent of this Clause and in the absence of a satisfactory explanation, will be seeking its deletion.

4. Strengthening links with general practice

The general practice sector is an essential component of the Australian health care system. The vast majority of Australians look to their general practitioner for guidance when facing a health issue. Australians trust their GP guidance in looking after their health.

In terms of the broad health financing system the gatekeeper role of the general practitioner, manifested in Australia through the referral system, is critical to the maintenance of an affordable, coordinated health system.

The AMA notes the wide range of programs the Federal government funds that aim to support general practice and that seek to enhance the quality of general practice. The AMA has quibbles over aspects of some of these programs but, in broad terms, the AMA endorses this extensive support for general practice.

The AMA is therefore wary of initiatives which might unintentionally subvert this critical role of general practice in the health system. It is not possible to manage a patient's health by treating his or her various conditions through different, unrelated health providers with 'one size fits all' recipes. Care must be coordinated and must be adapted to reflect the particular needs of the individual. The Australian health system needs more coordination and cooperation among providers, not more fragmentation.

More broadly the challenge for the health insurers will be to develop health insurance products which complement, not subvert, both general practice and specialist care.

The AMA will seek discussions with the Government to propose amendments to the Bill that will require programs developed by health funds under these new provisions to enhance rather than undermine the central role of the general practitioner in the health system.

Access to any chronic or preventive health program must be on the basis of a clinical decision initiated by the patient's usual general practitioner. Under the current proposal access can be arranged by the patient's treating medical practitioner or other health care provider.

The Government has proposed a definition of other health care provider in the Draft Business Rules as "allied health professionals and coordinators of disease management programs." This will allow employees of health funds or health care programs to make a clinical decision regarding patient care. This is not only a clear conflict of interest but these providers are not trained to diagnose and make decisions on the treatment or prevention of chronic disease. Only the patients "usual" medical practitioner can undertake this task.

The AMA is calling for access to any program to only be on referral from the patient's treating medical practitioner. Without this caveat patient health may be put at risk.

Equally concerning to the AMA is the possibility patients will be coerced to participate in programs that a medical practitioner does not assess as being necessary to their health care. The potential exists for the patient to be forced to take part in a program that has no clear medical benefit and be penalised if they refuse or the program fails to impact on their health.

Patients must continue to have access to the high quality care they deserve. Therefore, the AMA believes that the list of health care service providers eligible to deliver preventive and chronic disease management programs must be determined in consultation with the medical profession.

The AMA has developed a Position Statement on Private Health Insurance and Primary Care Services. This is attached for information.

5. Quality issues

The Bill provides that an insurance product will not be an approved product unless it meets the requirements of the Private Health Insurance (Accreditation) Rules. These Rules are not developed at this point. In effect this means that by 2008, no health fund shall pay a benefit to an unaccredited provider.

The AMA understands there may be some nervousness about the quality of care under these new arrangements given that private health insurers will be moving into unknown territory under the concept of General Treatment.

However, 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 considering quality issues associated with these new arrangements the AMA wishes to raise several issues.

i) In any episode of health or medical treatment the main guarantee of quality has always been and will remain the professionalism and commitment of doctors and others to provide treatment that is in the best interest of the individual patient. This is turn depends on the maintenance and support of high quality medical and health education and training and the ethical commitment of doctors and other professionals to serve patient interests, not personal interests or the interests of some third party such as a government or insurer funding care.

ii) Quality is more likely to be assured under these new arrangements by measures which address the concerns raised in Sections 3 and 4 of this submission, that is, by ensuring that health insurance funds are not able to inappropriately dictate where, how and by whom care is provided so that things are done more cheaply and by measures which ensure care is not fragmented among numerous providers.

iii) The government may have greater faith than the AMA has in the ability of centralised bureaucratic accreditation processes to ensure high quality care is provided. The AMA, reflecting the attitudes of the front line practitioners who actually provide care, is irritated by the propensity of some bureaucratic organisations to 'appropriate' the word quality and to then boldly promote themselves as arbiters of all things to do with quality. The reality is that the main factors determining quality are outside of their control.

How and whether such formal accreditation processes 'add value' is difficult to assess. The AMA is not in any way discrediting the efforts of organisations such as the Australian Council of Healthcare Standards (ACHS). (In the 1970s the AMA was the main sponsor of the ACHS). However, in the AMA's experience, formal quality assessment processes must be developed slowly and carefully.

New accreditation processes for the new means of providing care envisioned by this Bill must be allowed to evolve slowly. It is fanciful to suggest that some centralised bureaucratic structure can foresee the sorts of issues that will and features of new programs that will need on-going assessment by an accreditation process. The requirement that all programs be accredited by some useful, credible process by July 2008, is simply unachievable.

The AMA will be proposing to the government that the current references in the Bill, or in the Business Rules under the Bill, to accreditation processes, be significantly amended.

The AMA will be proposing changes that:

- allow for measured and careful development of workable processes for accrediting new types of care delivery, and,

- 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.

Such a body would be more appropriate than the recently formed Australian Commission on Safety and Quality in Health Care which is actually a committee established by public health administrators and which is more representative of public sector health bodies and which does not have expertise in private sector matters. It lacks formal representation from professional groups and, as far as the matter is able to be ascertained, reports to a committee dominated by State health bureaucrats.

6. Summary of AMA recommendations

a) The AMA believes 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. 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.

b) The AMA has established policies requiring a clear separation between the financing of private health services through private health insurance and the provision of that care. These policies reflect the best interests of the patient and the quality of health care. There are fairly obvious conflicts of interest in having private health funds involved in the provision of care. The AMA recommends that the Bill contain provisions which more clearly establish this separation. It is not sufficient to do this via business rules or other subsidiary legislation.

c) Given the groundbreaking aspects of the Bill and the need to ensure new products do not disrupt existing patterns of specialist and general practice care, the AMA recommends establishment of an industry panel responsible for approval of proposed products in the area of general treatment. The panel to comprise strong medical representation, including the AMA and be formally established under the PHI Bill and the Business Rules.

d) The AMA has serious concerns that the mandatory nature of the quality provisions in the Bill will encourage overly bureaucratic and costly arrangements which are only marginally related to actual quality services. The AMA recommends greater consideration of the quality provisions of the Bill given that the potential for over regulation and increased costs that are inimical to the broader purpose of the Bill. In particular we recommend the creation of a body reporting directly to the Federal Health Minister with strong professional representation and a focus on the quality aspects of new General Treatment initiatives.

e) The AMA further recommends the consideration of provisions to allow the development of default benefit arrangements in the general treatment area in the event that it may prove necessary to have them.

f) The AMA also recommends an amendment to Clause 121-10(3) to make it clear that services which attract a "Medicare benefit" are not covered under general treatment and the business rules cannot provide otherwise.

g) The AMA is concerned that in the absence of mechanisms to the contrary, Health Funds will de facto determine the nature of the health services provided in the private health sector by offering no default participating products which will involve traps for providers and consumers alike. The AMA recommends the Government consider provisions to allow the health insurers and the medical profession to engage in discussions, other than at the individual level, to ensure that there are providers willing to offer services consistent with health insurance products to be sold in the market place.

h) In relation to Chronic Disease Management Plans, there need to be provisions which require the continuing involvement and agreement of the patients usual treating medical practitioner particularly the patient's General Practitioner and, if relevant, their treating specialist or psychiatrist.

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Appendix A

AMA Position Statement

Private Health Insurance and Primary Care Services

2006

Preamble

The limited expansion of services by private health insurance providers into primary care services may, where the patient is privately insured, positively impact on the access of care services for such patients, provide general practitioners with more options for patient care, particularly preventative care, improve the continuity of care and serve to better medicalise insurers products.

The AMA has concerns, however, that given the benefits to be derived from coverage of additional services in terms of patient outcomes these should be in the first instance insured by Medicare. Limiting certain services to those who can afford private health insurance, particularly those related to preventative health measures represents the establishment of a two tiered system.

The AMA notes that there are inherent risks in supporting an expansion of health insurance fund services into primary care medical services and any arrangements or program design that create such risks will be rejected by the medical profession. In particular, these risks are associated with:

- A focus on cost reduction rather than quality and continuity of care;
- Imprecise patient-selection techniques;
- The development of fund holding models that lead to rationed care by insurers;
- Access to appropriate and quality information and education for patients related to their health needs;
- Absence of quality monitoring of outcomes on health status and reductions in hospitalisation or readmissions, particularly elderly patients;
- Overall cost effectiveness
- The establishment of a two-tiered system of access in primary care.

The AMA believes there are, however, reasons to consider support for the limited expansion of private health insurance to provide or pay for primary medical care and other health services that are acceptable to the profession on the basis that they meet a range of specific criteria. The types of services/coverage that may be acceptable include:

- Preventative health programs;
- Provision of health information to members
- General practitioners attendance on their patients in public hospitals;
- Development of a medical model for private health insurance list of extras, and;
- Programs that improve equity of access to rural and disadvantaged patients (eg rural patient travel to medical care).

The provision of private health insurance coverage for primary medical care services has the potential to compromise the quality of care and must be considered against a range of criteria that focus on maintenance of the quality of care, particularly associated with independent clinical decision making of the doctor.

Policy Resolution

The AMA supports the limited expansion of private health insurance to provide or pay for medical and other health services in primary care that are not currently covered by Medicare. Such programs or services must meet the following essential criteria in that they:

- *provide access by the patient on the basis of a clinical decision initiated by the patient's usual general practitioner;*
- *maintain the quality and standards accepted by the profession;*
- *are developed in consultation with the AMA and other relevant GP organisations*
- *allow patient choice*
- *ensure that access for patients is fair and equitable;*
- *support good patient care;*
- *encourage continuity of care through the patient's usual general practitioner;*
- *incorporate processes that contribute to continuity of care;*
- *recognise the general practitioner as central to the patient care team.*

There are inherent risks in supporting the expansion of health insurance fund services into primary care medical services including, in particular:

- *A focus on cost reduction rather than quality and continuity of care;*
- *The development of fund holding models that lead to rationed care by insurers;*

and in that context a program or service that private health insurance funds cover in the primary medical care sector will be deemed unacceptable to the profession if it incorporates one or more of the following criteria:

- *it incorporates or is likely to leave the general practitioner open to any influence or pressure that compromises independent clinical decision making or the manner of practice;*
- *it allocates decision making on patient care to a medical practitioner "employed" by the fund rather than an "independent" or the patients usual general practitioner;*
- *it incorporates any means or strategies by which the private health insurer might control or manage the care of the patient;*
- *it incorporates or is likely to incorporate any "rating" of general practitioners either within the fund or publicly;*
- *it compromises or threatens to compromise the quality and standard of patient care;*
- *it places any limits on the level of patient MBS rebates;*
- *it undermines the universality and equity of the MBS;*

- *it forms the basis of any future decision on the patients' access to insurance coverage with that insurer (the patient who participates in a diabetes management program for example must not be subsequently discriminated against by that insurer because they have diabetes);*
- *it involves fund holding or funds pooling that is inconsistent with AMA policy, limited or otherwise, by any entity;*
- *it limits or provides access to services on the basis of capitation*;*
- *it limits the right of doctors to set their own fees.*

**Capitation - a fixed per capita payment made periodically to a medical service provider by a managed care group in return for medical care provided to enrolled individuals (Merriam-Webster's Dictionary of Law)*