16 February 2007

Mr Elton Humphery
Committee Secretary
Community Affairs Committee
Department of the Senate
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Mr Humphery

Private Health Insurance Bill 2006 - Supplementary submission to Senate Community Affairs Committee

You asked the AMA to consider some of the issues discussed at the public hearings and to provide further written submissions as appropriate. The AMA appreciated the opportunity to appear before the Committee and we felt the hearings were very useful in exposing some of the issues which have been fairly opaque to us to this point.

1) HCF Helping Hand Program

The Committee was interested in further comments on this program. The Australian Private Hospitals Association initially raised the matter with the Committee. The AMA has had a number of complaints from Psychiatrists in private practice about the HCF Program and a similar program beginning to be offered by Medibank Private. In broad terms the concerns are as follows:

a) This represents US style managed care –the interference in clinical control and clinical decision making of the treating doctor.

b) Patients are enrolled into the program on the basis of health insurance claims data. While it is probable there is a general member authority at the time of joining a health fund for the health fund to use member data to pay claims, it is not as probable that this authority can be used to pass data to other parties for other purposes. In the case of the Helping Hand Program, members are identified for the program from claims data (acute psychiatric admissions data), their details are passed on to McKesson and they are assumed to be in the Program unless they opt out. **AMA believes that there should be no sharing of data with third parties.**

c) The patient is currently enrolled into the program unless they make a decision to opt out. If there is no decision, the first thing that happens is a contact from a "qualified mental health

professional" working for McKesson. There is no prior reference to the treating Psychiatrist and McKesson has no knowledge or awareness of the treatment being provided by the treating Psychiatrist. Providing "programs" which have a clinical focus and not just a psycho-educational focus does seem to be encroaching into the therapeutic relationship between the patient and the Psychiatrist without any prior consent or knowledge of the treating doctor. **The program should be an opt in program and there should be consultation with and support from the treating Psychiatrist before entry to the program.**

d) Patients should be made very aware of the voluntary nature of the programs and it should also be clear that there will be no detriment in private health insurance cover or benefits paid under that cover from non participation. Pressure can be a subtle concept particularly for persons with a mental illness. **Health fund documentation needs to be cleared by relevant medical representative groups and the Private Health Insurance Ombudsman and there needs to be explicit guarantees of no detriment from non participation.**

e) **Finally, the question of medical indemnity insurance responsibility needs to be clarified.** If the programs go beyond psycho-educational services and creep into the realm of the clinical, questions arise as to professional indemnity insurance responsibility.

2) Delayed commencement of the Bill

We can see no great imperative for the Bill to come into effect on 1 April 2007. AMA is not aware of any catastrophic consequences from a delay in commencement of even consequences of a moderate degree. The Minister and the Department have approached this exercise on the basis that they will not make it a strongly divisive political piece of legislation and I think if a case could be made that benefits would flow from a delay of three months, it should be taken up.

From our perspective, such a delay would be advantageous and would enable us to have a more relaxed discussion with the Government around the small number of recommendations we have put forward.

3) Guarantee of clinical freedom

We made the point in our original submission that decisions regarding clinical care are matters to be decided between patients and their doctors and that it was pleasing to note that the government had partly responded to our concerns about 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 for example. We also gave an example in our verbal evidence on 2 February of a health fund seeking to interfere in care by not providing benefits for anaesthesia services in some situations even where the body of clinical opinion supported the involvement of anaesthetists. 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. We have given further thought to this and suggest an amendment to clause 172-5 along the following lines:

172-5 Agreements with medical practitioners
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:

a) *limit the medical practitioner's professional freedom to identify and provide appropriate treatments within the scope of accepted clinical practice;*
b) *purport to give the insurer any entitlement to dictate that the medical practitioner undertake particular types of clinical service or use particular products;*
c) *provide that different levels of benefit will apply to treatments not approved by the insurer, where these treatments have not already been named and specifically excluded by the insurer from the scope of the agreement;*
d) *in any other way, directly or indirectly, restrict or limit the clinical freedom of the medical practitioner, for any reason not related to the health of the person insured, including through reducing or placing excesses upon benefits which would otherwise be payable to the person insured.*

And in relation to the Helping Hand type programs:

Interference with medical treatment

172-6 *(1) Where a person insured, or their medical practitioner or any other health professional, provides a private health insurer with information about the treatment of the person insured for the purpose of supporting a claim, the insurer may not use that information for any purpose other than processing the claim.*

(2) A private health insurer may not suggest or recommend to an insured person that they seek a certain type or course of treatment, nor facilitate an approach to the insured person by a third party not already providing treatment to the insured person.

4) An industry panel

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 (see HCF Helping Hand), the AMA recommends establishment of an industry panel responsible for approval of proposed products in the area of general treatment. The panel should comprise strong medical representation, including the AMA and be formally established under the PHI Bill and the Business Rules.

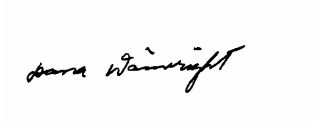
We believe the idea of an industry panel received strong support from some of the other organisations presenting to the meeting and it would be wise to have such a panel providing direct advice to the Minister for the first 5 years of operation of the new Bill. An amendment to the Bill to provide for an advisory panel with strong medical representation should be relatively easy to develop.

5) The need to involve the patient's usual treating practitioner

This issue arise mostly in relation to Chronic Disease Management Programs and would usually affect the General Practitioner. The AMA believes there could be serious consequences from a failure to involve the patient's usual treating practitioner right from the start including the advisability of a patient entering a program. There is also a need for regular review with the usual treating practitioner.

This matter could be addressed by a more broadly worded clause covering clinical interference as previously mentioned or through a properly constituted industry panel giving advice to the Minister with strong medical representation. We believe that a mere reading of health fund submissions would show there is not a strong appreciation of the need to involve the medical practitioner at all stages.

The AMA would be happy to provide any further advice to the Committee as necessary.



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