Greens' Senators Dissenting Report

1.1 The Bill was introduced into the Parliament as a private senator's bill by Senator Richard Di Natale on 27 March 2014 and referred to the Community Affairs (Legislation) Committee as the Greens wanted to amend the *Private Health Insurance Act 2007* (Act) to clarify that private health insurers may not enter into arrangements with primary care providers that provide preferential treatment to their insured members.

1.2 Australians rely on an equitable and efficient Medicare system as a central feature of the Australian health system. However there are 'some worrying signs to indicate that Medicare is under threat' if private health insurers enter the sphere of primary care by circumventing the ACT. This has the potential to create two-tiered health care system.[1]

1.3 The trial being undertaken in Queensland by Medibank Private (GP Access program) has raised concerns within the medical community as it has the potential to disrupt the relationship that individuals have with their family GP, and a situation may evolve whereby patients who are Medibank Private customers, but their GP is not a preferred provider or not part of this Medibank trial, may be forced to change their doctor in order to secure full value for their private health insurance cover.

1.4 Several submitters voiced concern about the process of private health insurers entering into the sphere of primary care and providing a service that may not be available to those without private insurance. The three contentious elements of the GP Access Program were outlined by Senator Di Natale:

> Same-day appointments – when members call one of the participating GP clinics before 10am weekdays they are guaranteed an appointment for that day. If members call later, the clinic will do their best to fit them in.
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> Fee-free consultations – members who show their Medibank card at a participating clinic or who use the after-hours GP will receive the consultation fee-free.
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> After-hours GP home-visits – members in metro areas can access an after-hours home GP visit within three hours.[2]

1.5 Submissions provided by the Private Health Funds, Medibank Private and Bupa Australia, highlighted their opposition to the Bill. The contention by Medibank Private – that the GP Access trial can reduce 'downstream' costs and work with GPs

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1 *Committee Hansard*, 27 March 2014, p. 2268.

2 Medibank Private, Submission 7, p. 5.

in a community setting[3] – was questioned in every submission not connected to a private insurance fund, as lacking the evidence base for these claims.

1.6 Dr Tim Woodruff, Vice President of the Doctors Reform Society, expanded on the inequities that are being established by the GP Access trial. It is worth summarising Dr Woodruff's explanation of the impact of the Medibank trial:

> What I would like all the Senators perhaps to do is to consider if their parents, or their brother or sister, or one of their children was not in a financial position, for reasons that could be very complicated or very simple, to afford Medibank Private insurance; whether the Senators would feel that that person is still just as deserving of access to quality health care as they themselves. What we have in this proposal, generally, from Medibank … is a proposal to improve access for those who are members and who have private health insurance. That inherently means that those family members I am talking about of yours that cannot afford it get less care, less access to care, than you might do. That seems to me inherently unfair and it is against the principles that Medicare was set up to try and adhere to.
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> If we are to go down the path of private health insurance, supporting and intruding into primary health care, what we definitely do not want, or what I believe we should not want, is for people to not be able to access as well as others that very important part of the health system. I am puzzled also by Medibank in their submission suggesting that the argument we are proposing is that it might create a two-tier health system—is misleading. It is so straightforward that a two-tiered system if this kind of trial becomes the norm.[4]

1.7 Dr Brian Owler, President of the Australian Medical Association (AMA) outlined to the Committee the AMA's concern that the private health insurers' behaviour could create a two-tier health system and noted the dangers of having a situation where privately insured patients receive preferential health care treatment in primary care. The AMA President acknowledged that there are already some areas of speciality in the health system that operate as a two-tiered health system, but this is not currently the case in primary care in general practice. However, the arrangements being initiated by private health funds represent 'a real danger' to the current system:

> There are some areas of specialty where we very much have a two-tiered health system. Currently that is not the case in primary care in general practice. What we do not want to do is have a system that encourages a two-tiered system for accessing a GP. Equity of access remains the second principle that we need to value. I also talked about universality, and that is something we cherish in the Australian system as well.

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3 Medibank Private, *Submission 7.*

4 Dr Tim Woodruff, *Committee Hansard,* p. 8.

> The issues that we face—and I am encouraged by the evidence given by the ADA for outlining the potential—are that we do not want to see a system where those with private health insurance get access to a GP, while those who do not private health insurance cannot.
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> We know that the arrangement between IPN and Medibank Private may work in a small setting, where you have one insurer and one group of practices, particularly where those practices are under-subscribed. But, if you have a very busy practice with more patients than you can deal with or you have multiple insurers and engaging in the same arrangement, what you will end up with is a situation where you have to have private health insurance to get that appointment. The only way that those practices are going to be able to guarantee and fill their requirements to the insurer is to see those patients more quickly and patients without private health insurance cannot get access at all. I think that is a real danger of the current arrangement.[5]

1.8 Dr Woodruff also supported the position that the involvement of private health funds in primary care could herald the advent of a two-tier health system. Dr Woodruff questioned the fairness of the Medibank GP Access program and noted that an individual who is a member of Medibank Private will get a different and better service than someone who is not:

> Those members who have Medibank Private cover will get fee-free consultations, same day appointments and after-hours GP home visits. That is not what other people get. That is two-tiered.[6]

1.9 The Australian Dental Association (ADA) submitted that dental service delivery is being permanently and adversely affected by the private health insurance (PHI) industry because they are already dictating both the provider and the type of care:

> The PHI industry, through the terms of their policies and discriminatory rebate practices, seeks to dictate the provider and the nature of treatment received by Australian dental patients. The dentist is best placed to advise Australians on their oral health care, yet this is a role which the PHI industry is increasingly assuming and this is adversely impacting on the quality of care being delivered.[7]

1.10 In testimony before the Committee, the ADA expanded on how patient care is already being undermined by private insurance funds and gave examples of how this is happening. The ADA noted that this situation is contrary to the Act. The general

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5 Associate Professor Brian Owler, AMA, *Committee Hansard*, 20 August2014, p. 21.

6 Dr Tim Woodruff, Doctors Reform Society, Hansard, p 9.

7 *Submission 5*, p. 3.

overview of the situation confronting some dental patients is summarised in this evidence:

> The ADA has examples where patients referred to specialists, for instance, for treatment are being advised by private health insurers' staff to see a different dentist because there will be a less out-of-pocket expense, and they are being asked to see people who are not specialists but, in fact, their provider's preferred general practitioners. The Private Health Insurance Act, in section 172.5, where it refers to agreements with medical practitioners, states:
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> *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.*
>
> We see what is happening as being contrary to that. Individuals paying for private health insurance and requiring health care have a right to choose where it is provided and by whom. They should not be penalised for their choice. The private health insurer arrangements with dentists are providing cheaper treatment to their members but it is resulting in a two-tiered system, even for those very same people that hold private health cover.[8]

1.11 Mr Boyd-Boland and Mrs Erving from the ADA expressed concerns that private health funds entering into preferred provider arrangements could undermine continuity of care and penalise individual for their choice of health practitioner. The ADA further noted their concerns about directing private health insurers directing their members to particular providers.[9]

1.12 The ADA further added that some dentists who may apply to be part of a preferred provider scheme are being denied access because there are already sufficient practitioners in that region.

> Mrs Irving: If I could just add to that, one of the things that we are seeing happening in dentistry is that, even if you are a dentist in that region and you apply to become part of the scheme, you are getting knocked back, because they have already got enough providers in the area. So you do not even have the option to become part of the group if you want to become part of the group. So they are also controlling who can get in. It then becomes a real problem if you are in an area where you do not have access to any other provider. If your provider is not allowed in, you are going to

8 Mr Robert Boyd-Boland, Chief Executive Officer, ADA *Committee Hansard*, 20 August 2014, p. 15.

9 Australian Dental Association, *Committee Hansard*, 20 August 2014, p. 17.

> pay those higher rebates, even though you have paid the same premium for that policy.[10]

1.13 Mr Rod Wellington, Chief Executive Officer, Services for Australian Rural and Remote Allied Health (SARRAH), agreed that this Bill is needed to ensure access and equity in Australia's health care system and that the equitable Medicare system would be diminished if private health insurers are involved in primary care:

> SARRAH strongly supports the bill. The key recommendations we wish to emphasise to this committee for inclusion into your report are that the government acknowledge that access to health care is a fundamental human right for every Australian, irrespective of where they live; acknowledge that private insurers involvement in the provision of primary health care may diminish the universal Medicare system and adversely impact on equitable access by disadvantaged groups to primary health care services; and respond to the need for greater integrated health services to ensure the consumers are able to benefit from the health system at an early stage, potentially avoiding the need for more expensive tertiary-level care.[11]

1.14 Both ACOSS and SARRAH outlined to the Committee their research showing that a Medicare system, with a single pricing mechanism, acts as controller of health costs. A change that benefits only privately insured customers could actually see GP costs increase for many people, especially those on lower incomes. ACOSS pointed out that people on low incomes have a disproportionate burden of poor health and that they are dropping out of private cover as costs rise.[12] Ms Vassarotti explained the consequences of allowing a new system what gave some people better access to after-hours care and guaranteed bulk-billing:

> Ms Vassarotti**:** As referenced in my opening statement, primary health care is the gateway to health services in Australia. This is where we can ensure that we get the best health outcomes. It is our belief that the Australian community has entered into a compact around ensuring that everybody has access to appropriate health care when they need it, independently of their ability to pay. In the end it will cost the economy and the community less if we give access to that service to the whole community and to people who need that kind of service, rather than to those who are privileged enough to pay for it.[13]

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10 Mrs Irving, Australian Dental Association, *Committee Hansard*, 20 August 2014, p. 17.

11 Mr Rod Wellington, Services for Australian Rural and Remote Allied Health, *Committee Hansard*, 20 August 2104, p. 12.

12 Ms Rebecca Vassarotti, Australian Council of Social Service, *Committee Hansard*, 20 August 2014, p. 11.

13 Ms Rebecca Vassarotti, Australian Council of Social Service, *Committee Hansard*, 20 August 2014, p. 11.

Threat to Medicare

1.15 The CHF submission noted that the Medibank trial does not uphold the intention of the *Private Health Insurance Act 2007* and expressed concerns about the legal basis of its trial. CHF expressed their broad concern about the involvement of private health insurers in the provision of primary health care as this has the 'potential to diminish the universality of Medicare and undermine equitable access to primary care'. CHF submitted:

> CHF has significant concerns with the Medibank trial and its potential to undermine the principles of universality enshrined in Medicare, by increasing barriers to primary care for those who are uninsured. Accordingly, we support the Bill.[14]

1.16 The Doctors Reform Society also supported the Bill and highlighted their concerns that the Medicare system is under 'direct threat' from the intrusion of private health funds in primary care. They submitted that further premium rises would result and coverage decrease:

> … such changes are likely also to be detrimental to those who can afford private health insurance now. If such insurance covers primary health care, premiums must rise, making coverage less accessible to middle and low income earners and less appealing to low users of medical services. They will drop their cover, which in turn will lead to further premium rises.
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> We already have health insurance for primary health care. It is called Medicare. It can and should be improved but adding an extra layer of private health insurance will be more expensive and lead to greater inequity.[15]

1.17 The Australian Council of Social Service (ACOSS) concurred that the Medibank trail would undermine Medicare and would establish a preferential system for some individuals:

> The key concern that ACOSS has with this trial is that it begins to create in primary healthcare a system where there is preferential service to Medibank Private members over patients trying to access the services of participating GPs. This fundamentally undermines a principle of Medicare—that everyone should have access to high-quality healthcare independent of their ability to pay or their ability to afford private health insurance.[16]

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14 Consumer Health Forum, *Submission* 2.

15 Doctors Reform Society, *Submission* 4, p. 2.

16 Ms Rebecca Vassarotti, Australian Council of Social Service, *Committee Hansard*, 20 August 2014, p. 11.

PHI rationale questionable

1.18 Medibank Private conceded that Healthcare costs as a proportion of GDP have been relatively stable over 10 years and that Commonwealth expenditure has decreased; while health insurance premiums have risen up two to three times above the Consumer Price Index.[17]

1.19 The AMA President, Professor Owler, expressed the Associations concerns about the 'backdoor approach' being pursued by the private health insurers and that it will lead to the 'slippery slope' of managed care, which the AMA cautioned against:

> If we have these backdoor approaches circumventing legislation and coming up with these one-off arrangements we will go down the slippery slope of managed care. Anyone who thinks that managed care is not the endgame of some of the private health insurers needs to open their eyes, because that is clearly the endgame. You can call it whatever you want—you can call it a 'payer-centred healthcare system'—but at the end of the day that is what managed care is.[18]

1.20 The view expressed by the Australian Dental Association is that the rationale behind the trails of private health insurers is to maximise their profit and manage the care of customers by limiting the amounts they pay out for services. Mrs Irving began be outlining how private health funds already refuse to pay for some services and then Mr Boyd-Boland expanded on the interference in clinical practice:

> Mrs Irving: They are also refusing to pay rebates now on some treatments. They are now trying to say, 'That service should be provided only by a specialist so we are not going to pay the rebate on that.' In dentistry all dentists can perform all types of treatment; there are no restrictions, as there are in medicine. They are actually restricting patients' rebates on the basis of their own views rather than what is actually good clinical practice.
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> Mr Boyd-Boland: Behind these arrangements there are business rules and it is very difficult to delve into those business rules. When we talked to the Private Health Insurance Ombudsman we had the explanation that those business rules are not widely published because they are too hard to follow. If you are going to enter into a contract of insurance, you ought to know the ins and outs of the whole arrangement that you are entering into. The fact that these business rules are not readily available or are not readily understood when you read them, I think is a flaw in the system.
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> Senator DI NATALE: Let me see if I understand what you are suggesting. Medicare at the moment is basically a government insurer. It is very rare for government, for Medicare, to involve themselves in the day-to-day practice of a GP. A GP will see someone and will charge against an item number.

17 Medibank Private, *Committee Hansard*, 20 August 2014, p. 3.

18 Associate Professor Brian Owler, AMA, *Committee Hansard*, 20 August 2014, p 20.

> Provided that Medicare are comfortable that it is within the range of acceptable practice, it will be funded. The only people who are investigated are people who look like they might be fraudulently misusing the system. Are you saying that once you move away from that model and you have private insurers in this space, they will have a much greater involvement in the clinical practice—the clinical relationship between a health practitioner and their patient? Are you saying that they will be making decisions ahead of the clinical practitioner?
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> Mr Boyd-Boland: I believe it is their statutory obligation to maximise the return to shareholders—and that one way to achieve the maximising of return to shareholders is designing the treatment that will be provided and providing an incentive to go down a particular treatment plan path that favours the insurer rather than the health outcome of the patient.
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> Senator DI NATALE: That is a pretty big allegation to make.
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> Mr Boyd-Boland: Yes.
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> Senator DI NATALE: You also suggest that—
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> Mr Boyd-Boland: We regularly make that allegation.[19]

1.21 The evidence from submitters not involved in private health insurance supported the proposition that individuals who are not Medibank Private customers would not get the same level of service as Medibank Private customers. This represents a fundamental shift in primary care. Currently under Medicare, patients are treated equally, even with the acknowledgement that there are problems in regional and rural areas in terms of access.

1.22 It was significant that the Australian Medical Association (AMA) raised concerns that what is being trialled could fundamentally change the relationship between doctors and their patients, and this momentous shift away from Medicare has not been undertaken with the level of consultation and consideration needed for such a radical alteration to primary care in Australia:

> Prof. Owler: I think people need to understand that they do want to payer-centred system and we need to make sure that we do not go down the slippery slope of managed care. If we are going to have changes in general practice they need to be considered, they need to be with consultation, they need to have safeguards for the independence of the doctor-patient relationship and they need to protect equity of access in our healthcare system.
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> CHAIR: Thank you. I might just get you to clarify what your position is on the bill? Are you supportive of the bill or are you opposing the bill?
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> Prof. Owler: We support the intent of the bill.[20]

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19 Australian Dental Association, *Committee Hansard*, 20 August 2014, p. 18.

20 Associate Professor Brian Owler, AMA, *Committee Hansard*, 20 August 2014, p 22.

Unintended Consequences

1.23 The Greens agree with the recommendations in the Chair's report that the Bill may have some potential unintended consequences for the wider operation of health initiatives. The wording in the Bill should be clarified as outlined in the Chair's report [2.30] and addressed by the Department of Health; that the Bill:

> …may unnecessarily duplicate the current restrictions within Commonwealth legislation while potentially affecting access to broader health cover initiatives such as 'hospital-substitute treatment' [for example, chemotherapy and macular degeneration].
>
> …
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> Given this risk, the introduction of this Bill may necessitate a significant review of existing Commonwealth legislation to ensure that there are no inconsistencies or unintended consequences for [PHF] funding of clinically appropriate alternatives to hospital treatment, for example, unintentional restrictions placed on hospital-substitute treatment and/or programs which aim to manage or prevent chronic disease.[21]

Term 'private health insurance policies' within the Act

1.24 The Greens agree that the term 'private health insurance policies' be changed to 'complying health insurance policies' to ensure that non-residents are not impacted. This is outlined in the Chair's report [2.34]:

Proposed new Part 3-7—GP Services of the Bill refers to *private health insurance policies. Medibank queried whether this term should read 'complying health insurance policies'.[38] At the public hearing, a representative explained:

> It is a small wording impact, but it means that the Bill can be interpreted as affecting products and services offered to non-residents…To us, that includes overseas students and overseas visitors who are covered [byMedibank]. We have about 200,000 or so policy holders with overseas student cover—students who come to Australia to study and, as a visa requirement, they have to take out a policy that covers the duration of their visa in Australia…It is the same with overseas visitors…This Bill would potentially restrict the types of services that Medibank can offer to those customers[.][22]

21 Submission 10, p.1.

22 Mr James Connors, *Committee Hansard*, 20 August 2014, p. 2.

Recommendation 1

1.25 The Australian Greens recommend that the Senate passes the Bill with the suggested amendments

Senator Rachel Siewert **Senator Richard Di Natale**