Chapter 2

Key issues

2.1 Participants in the inquiry expressed a range of views concerning the objective of the Bill, with some supporting the draft legislation and others arguing that it should not be passed into law. Participants canvassed five specific topics:

- the role of private health funds (PHFs) in primary care;
- the potential for a two-tiered Australian health system;
- the spirit and intent of the Act and the *Health Insurance Act 1973*;
- the possible unintended consequences of the Bill; and
- the term 'private health insurance policies' within the Act.

Role of private health insurance in primary care

2.2 Senator Di Natale's second reading speech indicated that the intention of the Bill is to prevent PHFs from entering the primary care sphere.[1] Three PHFs – Medibank, Bupa Australia and the Hospitals Contribution Fund of Australia Ltd (HCF) – and the Australian Medical Association (AMA) disputed this rationale, contending that there is a role for PHFs in primary care.[2]

2.3 Medibank emphasised the importance of GPs providing primary care, in terms of individual health benefits and avoidance of the 'larger downstream healthcare costs associated with secondary and acute care'. While PHFs have traditionally not engaged with the primary care sector, Medibank argued 'only paying for the treatment of members once they reach hospital does not make sense either medically or financially'.[3]

2.4 The Australian Institute of Health and Welfare has reported:

> Expenditure on health in Australia was estimated to be $140.2 billion in 2011-12, up from $82.9 billion in 2001-02. This expenditure was 9.5% of [Gross Domestic Product] in 2011-12, up from 9.3% in 2010-11 and up from 8.4% in 2001-02. The estimated recurrent expenditure on health was $5,881 per person. Governments funded 69.7% of total health expenditure, a slight increase from 69.1% in 2010-11. The largest components of health spending were public hospital services ($42.0 billion, or 31.8% of recurrent expenditure), followed by medical services ($23.9 billion, or 18.1%) and medications ($18.8 billion, or 14.2%).[4]

---

1 *Senate Hansard*, 27 March 2014, p. 2269.

2 For example: Bupa Australia, *Submission 8*, p. 2.

3 *Submission 7*, p. 4.

4 Australian Institute of Health and Welfare 2013, 'Health expenditure Australia 2011-12', *Health and welfare expenditure series 50*, Cat. No. HWE 59, Canberra. Also see: Private Healthcare Australia, *Submission 6*, p. 2.

2.5 Medibank noted the growth in health expenditure over the last decade, and expressed concern that this trend might 'drive benefit outlays sharply higher and so lead to private health insurance [PHI] becoming unaffordable'. Ultimately:

> If this were to occur, it may lead to a re-emergence of the downward spiral of adverse selection experienced by the industry in the eighties and nineties, which saw the healthy low claimers required in a community rated system exit, leaving an ever smaller rump of less healthy, higher claiming policy holders. Such an outcome would risk forcing millions of policy holders back into the public health sector, with negative implications for the sustainability of the overall healthcare system.[5]

2.6 As a risk management strategy, Medibank argued in favour of 'addressing utilisation of the highest cost segments of the healthcare care system', by working with GPs in a community setting. To this end, Medibank instigated the GP Access program:

> The immediate goal of the GP Access program is to encourage and support Medibank members to access a GP. If this can be achieved it should improve individual health and may reduce the need for hospital admissions and associated costs, thus easing pressure on premiums and helping to maintain private health insurance affordability.[6]

2.7 In evidence, Medibank contended that the breadth of proposed new paragraph 105-5(1)(a) of the Act would prevent PHFs from working with GPs to provide such preventative health and care coordination programs.[7]

2.8 The Hon. Dr Michael Armitage, Chief Executive Officer of Private Healthcare Australia, confirmed that PHFs are 'intimately engaged in trying to improve' members' health outcomes, which is a competitive advantage. Further:

> [I]f funds are able to decrease hospital admissions for chronic disease patients…or deliver better health outcomes…or cut hospitalisations for things like heart attacks…that has an automatic flow down into the quantum of money that the funds need to request of their regulator for their increases next year…[T]here is every chance that this component of the [PHI] request for funding into future years would actually diminish health costs.[8]

2.9 Dr Armitage noted that such health outcomes would 'take pressure off the public system':

> It is also the case in the Australian system that many of the providers, because of the way the system now runs, work in both the public and the private sectors, whether they are doctors who have public and private

5 *Submission 7*, pp 4-5.

6 *Submission 7*, p. 5.

7 Mr James Connors, Manager, Government and Regulatory Affairs, *Committee Hansard*, 20 August 2014, p. 2.

8 *Committee Hansard*, 20 August 2014, p. 26.

> sessions or nurses who do work for agencies…If something is working well in one sector, it will translate to the other. We see this as a real bonus for healthcare outcomes across all Australians with illness.[9]

2.10 HCF described three programs from its 'innovative range of health management programs and services', which are currently offered to members but which might not be available should the Bill be enacted.[10] This included the My Health Guardian program implemented since 2009:

> My Health Guardian, in particular, is quite a unique program. It certainly is the largest and longest-running of its type in Australia…It is not a pilot or a trial; it has, on any given day, over 25,000 people in it. They are selected and offered the opportunity to go in it. It is optional; it is an active part of what we deliver as part of our health insurance offering.[11]

2.11 The health outcomes of the My Health Guardian (MHG) program were reported in the Population Health Management journal:

> MHG proved to be an effective means to reduce the likelihood and duration of hospitalizations for individuals with diabetes and heart disease. In this study, the MHG program demonstrated a consistent effect; treatment group members had reduced admissions, readmissions, and [average length of hospital stay] relative to comparison group members, supporting the hypothesis that MHG reduces the occurrence, frequency, and severity of hospital utilization. Furthermore, the magnitude of effect increased over time demonstrating the importance of a sustained program for maximizing impact.[12]

2.12 In relation to the Bill, Mr Shaun Larkin, Managing Director of HCF, added:

> We would be concerned if any legislation passed that did not enable us to continue with the partnerships that we have sought to have [with] a general practice with the delivery of these programs.[13]

2.13 In its submission, the AMA noted that GPs provide holistic and well-coordinated care for patients but in isolation to the services offered by PHFs to their members, which might include health and well-being programs:

> This is a significant problem and fragments patient care…In this context, there is certainly scope for [PHFs] to explore the potential for greater engagement with general practice to improve the coordination of patient

---

9 *Committee Hansard*, 20 August 2014, p. 27.

10 Mr Shaun Larkin, Managing Director, Hospitals Contribution Fund of Australia Ltd. (HCF), *Committee Hansard*, 20 August 2014, p. 31.

11 Mr Shaun Larkin, *Committee Hansard*, 20 August 2014, p. 32.

12 G. Brent Hamar, Elizabeth Y. Rula, Aaron Wells, Carter Coberley, James E. Pope, and Shaun Larkin, *Population Health Management*, April 2013, 16(2): 125-131. doi:10.1089/pop.2012.0027, available at: http://online.liebertpub.com/doi/full/10.1089/pop.2012.0027 (accessed 26 August 2014).

13 *Committee Hansard*, 20 August 2014, p. 32.

> care, ensure care is provided in the most appropriate clinical settings, and avoid unnecessary hospital admissions.[14]

2.14 The Department expressed the view:

> …that any increased regulation which may discourage [PHFs] from arranging preventative or intermediary care for their members would not be a desirable outcome.[15]

Potential for a two-tiered Australian health system

2.15 Inquiry participants were divided in their support for, or opposition to,[16] the Bill, based on its objective of preventing the creation of a two-tiered Australian health system, as referred to in Senator Di Natale's second reading speech.[17]

2.16 The Australian Council of Social Services stated:

> This [health] system needs to be protected and strengthened, rather than moving towards a two tiered system that is expensive, inefficient, discriminatory and not effective in delivering better health outcomes.[18]

2.17 The Australian Nursing and Midwifery Federation (ANMF) also stated its concerns:

> The ANMF considers that permitting private insurers to enter into arrangements such as those described above will undermine the principles of universal access to health care provided by our universal insurer, Medicare, and will compromise its integrity and efficiency.
>
> Permitting private insurers to negotiate arrangements in primary health care will further disadvantage those at risk and other vulnerable groups resulting in a two tiered system that favours the insured.[19]

2.18 The PHI industry did not consider that allowing PHFs a role in primary care will create a two-tiered Australian health system. On their assessment, such a role will promote investment and innovation in new models of healthcare, with consequential benefits for insured and uninsured healthcare consumers.

2.19 Private Healthcare Australia submitted that PHI is 'not merely the domain of the rich', with more than 54% of consumers holding some level of cover.[20] Further:

---

14 *Submission 1*, p. 2. The Australian Medical Association (AMA) outlined potential areas in which private health funds might play a part, including wellness programs, maintenance of shared electronic health care records, hospital in the home, palliative care, minor procedures, and GP directed hospital avoidance programs. Also see: Associate Professor Brian Owler, President, AMA, *Committee Hansard*, 20 August 2014, pp 22-23.

15 *Submission 10*, p. 2. Also see: Mr Shaun Larkin, HCF, *Committee Hansard*, 20 August 2014, p. 31.

16 For example: AMA, *Submission 1*, p. 1; Doctors Reform Society, *Submission 4*, p. 2.

17 *Senate Hansard*, 27 March 2014, p. 2269.

18 *Submission 3*, p. 2.

19 *Submission 9*, p. 1.

> While health funds will provide healthcare benefits only to their members, all Australians would benefit from the outcomes of greater private sector investment facilitating new models of integrated care. If new or improved treatment models trialled by health funds are able to help to reduce hospitalisation rates for certain conditions, the government would spend less money on hospital care and find itself with the capacity to utilise these savings to offer improved or expanded services to all Australians, whether through Medicare or other programs.[21]

2.20 Medibank highlighted the potential for PHF programs to assist members in rural and remote areas to access healthcare services:

> We have another program called Anywhere Healthcare which is a telehealth video conferencing based medical service that we are also involved in which is really about getting access to rural and remote areas and providing a level of access to care and to specialist treatments...We are fully aware of the lack of access that those in regional and remote areas have with respect to health care, and we have got ways to offset that or address it.[22]

2.21 A representative from Medibank also described plans for the GP Access program to provide additional support to GPs, particularly for people with chronic conditions:

> Some of the assistance we are looking to provide are things such as an administration resource to ensure that people are attending their health visits, also things such as disease specific education, healthy living information or whatever we can do to assist the GPs to look after these chronically ill patients.[23]

Spirit and intent of the Act and the Health Insurance Act 1973

2.22 At present, the Act and the *Health Insurance Act 1973* prohibit PHI coverage for out-of-hospital services where there is a Medicare benefit payable (including 'GP services' provided in a community setting).[24]

2.23 Medibank advised that it contributes funding toward the management and administrative costs of the GP Access program.[25] Accordingly, the Department concluded:

---

20 See: Mr James Connors, Medibank, *Committee Hansard*, 20 August 2014, p. 6, who noted that the GP Access program further benefits these members as low income policy holders.

21 *Submission 6*, pp 3-4.

22 Mr Dan O'Brien, General Manager, Corporate Affairs, Medibank, *Committee Hansard*, 20 August 2014, p. 5.

23 Ms Natalie Kelly, Head of Strategy and Corporate Development, Medibank, *Committee Hansard*, 20 August 2014, p. 5. Mr James Connors noted that Phase 2 of the GP Access program accords with the AMA's preferred model of PHF involvement in primary care: see *Committee Hansard*, 20 August 2014, p. 5.

24 Section 121-10 of the *Private Health Insurance Act 2007*; section 126 of the *Health Insurance Act 1973*. Both provisions allow for limited exceptions, for example, subsection 126(5A) of the *Health Insurance Act 1973* excepts 'hospital treatment' or 'hospital-substitute treatment'.

> [T]he arrangement between Medibank and its [external provider, Independent Practitioner Network (IPN)] is not health insurance business, but a management expense. This arrangement does not appear to contravene Commonwealth legislation and is beyond the scope of the Act and any amendment that the Bill attempts to effect.[26]

2.24 The Consumers Health Forum accepted the Department's view that the GP Access program appears to be technically compliant with the Act,[27] and a representative from Medibank confirmed receipt of legal advice, indicating that the GP Access program is not in breach of the Act.[28] The Department gave evidence that it too has obtained legal advice on this issue.[29]

Provision for pilot projects in the Act

2.25 A few participants in the inquiry argued that the GP Access program (and presumably like programs) is not consistent with the spirit and intent of the Act.[30] However, Private Healthcare Australia and Bupa Australia disagreed, stating that the Act specifically provides for pilot projects of this nature.

2.26 Currently, section 55-15 of the Act allows a PHF to conduct a pilot project in accordance with the Private Health Insurance (Complying Product) Rules 2010 (No. 2) (Rules). Rule 17 permits a PHF to develop and trial, with a limited group of policy holders for a set period, new models of service delivery or health care, while Rule 18 sets out the requirements for these pilot projects:

> (a) an insurer must not charge a person to participate in the project;
>
> (b) participation in a pilot project must be voluntary;
>
> (c) a pilot project may be conducted for a maximum of two years;
>
> (d) an insurer may only limit participation in a pilot project on the basis of where a person lives;
>
> (e) an insurer must develop a written plan for a pilot project, including a timeline and evaluation process;
>
> (f) written notice of the details of the project, including a copy of the written plan referred to in (e), must be provided to the Department at least 28 days before the pilot project commences.

---

25 *Submission 7*, p. 5. In addition, Medibank noted that it and participating GPs are highly respectful of regulatory obligations and 'the financial arrangements are well within these requirements': see pp 5-6.

26 *Submission 10*, p. 1. The Department highlighted also that the administrative payments are made from the PHFs' management funds.

27 *Submission 2*, p. 1.

28 Mr James Connors, Medibank, *Committee Hansard*, 20 August 2014, p. 6.

29 Mr Shane Porter, Assistant Secretary, Private Health Insurance Branch, Department of Health, *Committee Hansard*, 20 August 2014, p. 37.

30 For example: AMA, *Submission 1*, p. 1; Dr Tim Woodruff, Vice President, Doctors Reform Society, *Committee Hansard*, 20 August 2014, p. 9.

2.27 Private Healthcare Australia concluded that the Act clearly accommodates 'trials' which could result in beneficial 'new treatment or care models [which] are put on public display where their effectiveness can be evaluated' for broader application.[31]

> This Bill, if passed, would stifle opportunities for innovation in the healthcare space. With both Federal and state/territory budgets already struggling to meet community expectations for healthcare funding, [PHFs] represent possibly the only feasible source of new funding for integrated care models.[32]

2.28 Bupa Australia added:

> It is well accepted that the private sector is often better placed to drive innovation with access to capital, high appetite for risk and high levels of flexibility. Furthermore, innovative programs developed and tested by the private sector can then be taken up by the public system.[33]

2.29 The Department agreed that the intent of pilot projects is to allow for the sharing of information and exploration of better healthcare outcomes: 'There is a range of pilot projects that people have run and that is broadly what they have been trying to achieve'.[34]

Possible unintended consequences of the Bill

2.30 The Bill may have a number of unintended consequences for the wider operation of health initiatives.

2.31 In its submission, the Department warned 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].
>
> …
>
> 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.[35]

2.32 Bupa Australia provided in its submission:

> If this Bill passes, successful programs that have been shown to improve our members' health outcomes could be deemed to be providing

31 *Submission 6*, pp 1 and 3.

32 *Submission 6*, p. 2.

33 *Submission 8*, pp 2-3.

34 Mr Richard Bartlett, Acting Deputy Secretary, *Committee Hansard*, 20 August 2014, p. 42.

35 *Submission 10*, p. 1.

> 'preferential treatment' to some patients. This is because while a GP refers a patient into various programs, eligible Bupa members can participate in some programs at no cost, while non-members are likely to face out of pocket costs to take part.[36]

2.33 Bupa submitted that its Integrated Osteoarthritis Management Program is an example of a program that may be affected by the Bill:

> This specialised program combines weight loss, lower limb muscles strengthening and pain management strategies to help people with knee and hip osteoarthritis to improve joint mobility and improve pain management.[37]

Term 'private health insurance policies' within the Act

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 [by Medibank]. 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[.][39]

2.35 The AMA acknowledged that access to health care is important for visa holders,[40] and Private Healthcare Australia considered that 'it would clearly be a major negative to have those people denied access because of [the Bill]'.[41]

2.36 A departmental officer agreed that the way in which the Bill has been drafted could have a broader effect than the Act on students and overseas visitors:

> If private health insurance policies was the form that went forward in any sort of bill then it would impact much more broadly than complying health insurance policies, which includes those insurance policies you have referenced for overseas student health cover, which is some 300,000 students and overseas visitors health cover, as well.[42]

---

36 *Submission 8*, p. 3.

37 *Submission 8*, p. 3.

38 *Submission 7*, p. 7.

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

40 Associate Professor Brian Owler, AMA, *Committee Hansard*, 20 August 2014, p. 24.

41 The Hon. Dr Michael Armitage, *Committee Hansard*, 20 August 2014, p. 29.

42 Mr Shane Porter, *Committee Hansard*, 20 August 2014, p. 41.

2.37 Another officer confirmed that the Bill could potentially result in overseas students and overseas visitors breaching the conditions of their visa, as well as directing such people away from the primary care setting:

> What happens with these people is a condition of their visa. They have to take out these policies, which in effect give them Medicare equivalent coverage. If we have a piece of legislation that says the Medicare equivalent coverage cannot be Medicare equivalent, I am not quite sure what the solution to that is.[43]

2.38 The officer noted that amending proposed new Part 3-7—GP Services of the Bill to refer to 'complying health insurance policies' would eliminate the concern regarding overseas students and visitors. However:

> It will not fix the question about the non-hospital-based programs that are covered under the private health insurance legislation: all the [chronic disease management], hospital substitute, things like that. There is certainly…a risk that this changed legislation would call into question whether those programs can continue.[44]

Committee view

2.39 The committee agrees that it is important for private health funds to be able to trial and develop new models of service delivery or healthcare. In this regard, the committee notes that the Department monitors the implementation of such projects with a view to ensuring that projects comply with the Act.[45] The committee considers that the Bill, which would prohibit such projects, is not in the best interests of Australian healthcare consumers. This Bill has the serious potential to undermine private healthcare, affect life-saving treatments such as chemotherapy and stop the development of preventative healthcare strategies. Accordingly, the committee does not consider that the Bill should be passed by the Senate.

Recommendation 1

2.40 The committee recommends that the Senate does not pass the Bill.

Senator Zed Seselja

Chair

---

43 Mr Richard Bartlett, *Committee Hansard*, 20 August 2014, p. 41.

44 Mr Richard Bartlett, *Committee Hansard*, 20 August 2014, p. 42.

45 Mr Richard Bartlett, *Committee Hansard*, 20 August 2014, p. 36.