The Senate

Community Affairs Legislation Committee

Private Health Insurance Amendment (GP Services) Bill 2014

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44th Parliament

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Participating members for this inquiry

Senator Richard Di Natale	Victoria, AG
Senator the Hon Jan McLucas	Queensland, ALP
Senator Claire Moore	Queensland, ALP

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ABBREVIATIONS

Act	*Private Health Insurance Act 2007*
ADA	Australian Dental Association
AMA	Australian Medical Association
Bill	Private Health Insurance Amendment (GP Services) Bill 2014
Consumers Health Forum	Consumers Health Forum of Australia
Department	Department of Health
GP	general practitioner, as defined in section 3 of the *Health Insurance Act 1973*
GP Access program	The pilot project commenced in November 2013 by Medibank, currently involving 26 medical centres and 145 general practitioners throughout Queensland
IPN	Independent Practitioner Network Pty Ltd
PHF	private health funds
PHI	private health insurance

LIST OF RECOMMENDATIONS

Recommendation 1

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

Chapter 1

Introduction

1.1 On 17 June 2014, the Senate referred the Private Health Insurance Amendment (GP Services) Bill 2014 (Bill) to the Community Affairs Legislation Committee (committee) for inquiry and report by 4 September 2014.[1] The Bill was introduced into the Parliament as a private senator's bill by Senator Richard Di Natale on 27 March 2014.[2]

Purpose and key provision

1.2 The Bill seeks 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.[3]

1.3 Item 1 in Schedule 1 of the Bill inserts new Part 3-7—GP Services into the Act, including proposed new section 105-5 (key provision):

> (1) A private health insurer must not enter into an agreement or arrangement that provides for:
>
> (a) GP services to be rendered to persons insured under *private health insurance policies issued by the private health insurer; or
>
> (b) persons insured under private health insurance policies issued by the private health insurer to have preferential access to GP services;
>
> Example: Access to a GP out of hours, when uninsured patients do not have access to the GP out of hours.
>
> unless the Private Health Insurance (Health Insurance Business) Rules provide otherwise.[4]

1.4 'GP Service' will mean a service rendered in Australia by a 'general practitioner' (GP) (as defined in section 3 of the *Health Insurance Act 1973*), which is *general treatment (disregarding subsection 121.10(3) of the Act) and for which a *Medicare benefit is payable.[5]

1.5 In his second reading speech, Senator Di Natale argued that, due to Medicare, equity, efficiency and quality are features of the Australian health system. However, there are 'some worrying signs to indicate that Medicare as we know it is under threat'.

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1 *Journals of the Senate*, No. 31–17 June 2014, pp 888-889.

2 *Journals of the Senate*, No. 26–27 March 2014, p. 749.

3 Explanatory Memorandum (EM), p. 2.

4 An asterix preceding a term–for example '*private health insurance'–denotes that the term is defined in the Dictionary in Schedule 1 of the *Private Health Insurance Act 2007*.
Other examples of preferential treatment might include earlier access to appointments or access to cheaper appointments: see EM, p. 2.

5 Proposed new subsection 105.5(2) of the *Private Health Insurance Act 2007*.

Senator Di Natale was expressly concerned at the potential for the creation of a two tiered system and the possibility of escalating health care costs should private health insurers enter the sphere of primary care.[6]

1.6 Senator Di Natale referred specifically to a trial being conducted in Queensland by Medibank (GP Access program).[7] The GP Access Program comprises three key elements:

> 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.
>
> 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.
>
> After-hours GP home-visits – members in metro areas can access an after-hours home GP visit within three hours.[8]

Conduct of the inquiry

1.7 Details of the inquiry, including links to the Bill and associated documents, were placed on the committee's website.[9] The committee also wrote to 12 individuals and organisations, inviting submissions by 18 July 2014. Submissions continued to be accepted after that date.

1.8 The committee received 10 submissions, which are listed at Appendix 1. All submissions were published on the committee's website.

1.9 The committee held a public hearing in Sydney on 20 August 2014. A list of witnesses who appeared at the hearing is at Appendix 2, and the *Hansard* transcript is available through the committee's website.

Acknowledgement

1.10 The committee thanks those organisations who made submissions and who gave evidence at the public hearing.

Note on references

1.11 References to the committee *Hansard* are to the proof *Hansard*. Page numbers may vary between the proof and the official *Hansard* transcript.

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6 *Senate Hansard*, 27 March 2014, p. 2268.

7 The Department of Health noted however that there are other private health insurers who have engaged external providers to arrange GP services for their members (HCF, Bupa, Healthscope): see *Submission 10*, p. 1.

8 Medibank, *Submission 7*, p. 5.

9 See: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs

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]

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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

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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:

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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:

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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.

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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]

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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

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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.

Labor Senators' Additional Comments

1.1 Labor Senators agree that there is potential benefit where private health funds work with bodies, such as Medicare Locals, to partner and trial models of healthcare that promote prevention and better coordination of chronic disease but have concerns that the payment of an 'administrative fee' by Medibank Private directly to general practices goes well beyond this and could lead to an inequitable health system.

1.2 Labor Senators are of the view that the trial has the potential to unfairly disadvantage Australians who choose not to or cannot afford private health insurance and to undermine Australia's universal health insurance scheme - Medicare.

1.3 Labor Senators are also of the view that the Medibank Private trial has the potential to act in an inflationary manner on fees currently charged by general practice over and above the MBS fee.

1.4 Given the contentious nature of this trial the Government should release the legal advice obtained by the Department of Health that demonstrates that the trials are compliant with the *Private Health Insurance Act 2007* and *Health Insurance Act 1973*.

1.5 If it is unable to do so then the Minister for Health should make a Ministerial Statement as to why he believes the trials are compliant with the existing legislation.

1.6 Labor Senators agree however, that the Bill may have unintended consequences and whilst supporting the intent of the Bill cannot support it in its current form.

1.7 Labor Senators do not share the Government Senators' view that the Bill is not in the best interests of Australian healthcare consumers. Labor Senators agree with some of the principles of the Bill and its intent to protect Australians who cannot afford or choose not to have private health insurance. Labor Senators note some of the unintended consequences of the Bill and have concerns about the manner in which it has been drafted.

Senator Carol Brown **Senator Nova Peris OAM**

Senator the Hon Jan McLucas

Senator Claire Moore

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.
>
> 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.
>
> 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.
>
> 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.
>
> 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:
>
> *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.
>
> 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.
>
> 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.
>
> 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?
>
> 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.
>
> Senator DI NATALE: That is a pretty big allegation to make.
>
> Mr Boyd-Boland: Yes.
>
> 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.
>
> 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].
>
> …
>
> 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**

APPENDIX 1

Submissions and additional information received by the Committee

Submissions

1 Australian Medical Association (plus an attachment)
2 Consumers Health Forum of Australia
3 Australian Council of Social Service
4 Doctors Reform Society
5 Australian Dental Association
6 Private Healthcare Australia
7 Medibank
8 Bupa Australia
9 Australian Nursing and Midwifery Federation
10 Department of Health

Answers to Questions on Notice

1 Answers to Questions on Notice received from HCF, 25 August 2014
2 Answers to Questions on Notice received from HCF, 25 August 2014

APPENDIX 2

Public hearings

Wednesday, 20 August 2014

The Portside Centre, Sydney

Witnesses

Medibank
CONNORS, Mr James, Manager Government and Regulatory Affairs
KELLY, Ms Natalie, Head of Strategy and Corporate Development
O'BRIEN, Mr Dan, General Manager Corporate Affairs

Doctors Reform Society
WOODRUFF, Dr Tim, Vice President

Australian Council of Social Service
VASSAROTTI, Ms Rebecca, Acting Deputy Chief Executive Officer

Services for Australian Rural and Remote Allied Health
WELLINGTON, Mr Rod, Chief Executive Officer

Australian Dental Association
BOYD-BOLAND Mr Robert, Chief Executive Officer
IRVING, Mrs Eithne, Policy and Regulation Manager

Australian Medical Association
OWLER, Associate Professor Brian, President
TRIMMER, Ms Anne, Secretary-General

Private Healthcare Australia
ARMITAGE, Hon. Dr Michael, Chief Executive Officer

Hospitals Contribution Fund of Australia Ltd
LARKIN, Mr Shaun Maurice, Managing Director

Department of Health
BARTLETT, Mr Richard, Acting Deputy Secretary
PORTER, Mr Shane, Assistant Secretary, Private Health Insurance Branch