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Transcript: AMA Vice President, Dr Chris Zappala, ABC Radio Brisbane, *Mornings with Terri Begley*, Monday, 18 November 2019

Subject: Private Health Insurance

TERRI BEGLEY: Back in April, the Government released a new set of rules to help make private health insurance simpler for everyone. And, for consumers, it does seem to have worked. But it's also exposed the relationship between private health insurers and doctors, which is quite an interesting one. There are reports, though, that doctors are concerned about insurers who are starting to dictate clinical care for their patients. And, as you can imagine, this could be quite a worrying situation for doctors, who only want to work in the best interests of their patients.

Well, Dr Chris Zappala is Vice President of the Federal Australian Medical Association. And we thought we'd get him on to explain what's happening. Dr Zappala, good morning.

CHRIS ZAPPALA: Good morning, Terri.

TERRI BEGLEY: First up, can you give us a summary of how the relationship between doctors and private health insurers usually works?

CHRIS ZAPPALA: Well, look, obviously when doctors are treating patients in private hospitals, they then bill the fund for a portion of that care, and you're very correct - and that's been a very amicable and reasonable relationship over some time - but you're very correct in saying that the health funds, as they are driven more towards making profits, because remember, about 70 per cent of the private health insurers in the country now are for profit compared to less than 10 per cent approximately 20 or so years ago. So there's a new stimulus in there for them.

While they're driven to make profits - and they are very profitable - they do limit care choices. Now, that can be through a preapproval process, so sometimes doctors will have to ring and say ‘this is what I want to do to a patient, or this is the procedure I want to do’, and the fund can say no, and sometimes do. They can do it obviously in the nature of the contractual arrangements that they have with doctors. In other words, they say ‘we're not going to send any of our members to you unless you agree to these contractual terms’, which will include also the fee that they're going to be paid, as well as what they can do. And then the third way that they do it is that the health funds have contracts with hospitals, and that's a very fraught space and you can I think understand that it's all commercial-in-confidence and closely guarded.

But there are clauses in those relationships which restrict what can happen. And so health funds are dictating a little bit more over time what can be done. And this of course moves us inexorably closer to an American-style system, which no one wants.

TERRI BEGLEY: Absolutely, because if there's any hint that this could impact on the health outcome of a patient that a doctor only wants to see the best quality care for them, that's concerning.

CHRIS ZAPPALA: Look, it is concerning, and of course no doctor wants a bad outcome for their patient. They're all trying to do the right thing. But we must accept that medical care, particularly high-quality modern medical care, is expensive. And part of our job, obviously, is to convince funds that that needs to happen. But part of it also is for Government to fund the health care appropriately, and to also put in place regulation and standards that hopefully - I can't say compel, it's probably the wrong word - but make it more seamless and easier for funds to offer good rebates for doctors, which of course reduce gaps for patients, so that they can get the care that they need.

TERRI BEGLEY: Now, one of those three ways you said that this can happen is relationship between doctors and private health insurers. You said that a doctor can ring an insurer and say 'can my patients be covered for this course of medical treatment?'. And the insurer can actually say no. Can you give us an example of where that might happen?

CHRIS ZAPPALA: Well, it can happen in, for example, someone's got a particular cardiac arrhythmia, so their heart is out of whack. And there are a range of different techniques that can be used to manage that, from medications to different types of ablation or burning techniques. Now, some of those are more expensive or cheaper than others, and they have different outcome success rates, and it can be the case where health funds will say, 'well, we're not going to cover the more expensive thing', even though it might have a better outcome.

The other way that happens, for example, someone's had an operation, they need rehabilitation and a patient might be expecting that they're covered for rehabilitation, but then the health fund will say 'no, no, no, we're not covering you for rehabilitation in the hospital independently under the direction of a rehabilitation physician. We're covering you for rehabilitation done in our program, with our people, done in our way. And that's all we're covering you for'. So there's many ways that they can do it, but that's just two examples of what they are currently doing.

TERRI BEGLEY: Where does this leave the patient, Dr Zappala, in all of this?

CHRIS ZAPPALA: Well, it's tricky for patients because they're, to be honest, never going to get through the fine print and the detail of their health policies to understand. And you can say, 'look, ring the health fund and they can tell you', but that's sometimes a little bit confusing as well. I think the best thing to do is to have an open and frank discussion with your treating doctors and, from our point of view, that includes informed financial consent. So I think patients can expect to know at least the approximate cost of what's going to happen to them and the procedures that are planned and so on. But as part of that discussion, in advance of them receiving care, the discussion with the doctor can include mapping out some of these options and issues as well, and some of the pitfalls.

TERRI BEGLEY: What happens, though, if a patient then realises that there's going to be a much bigger gap than they expected for a certain level of treatment that a doctor has recommended, and the patient doesn't take up that treatment because of the cost? I mean, that's where it would impact on someone's health.

CHRIS ZAPPALA: Hopefully, those circumstances are rare, because we can all accept that variation and complications and so on can occur, and so costs can change unexpectedly. But hopefully, those circumstances are rare. I think if there has been a genuine surprise, you can always go back to the doctor and, I would like to think and I do believe, that most doctors would say, 'look, that was unexpected; let's do something here; I can help you'. And that's no different from the discounting that all of us do to a degree anyway. So, go back to the doctor.

And then the other thing would be, provided that the care hasn't been consumed fully yet, is to say, 'well what are my other options here? Do I have, for example, if it's an expensive pharmacological or drug treatment, do I have another option here and to talk through those possibilities to help defray the costs?'.

TERRI BEGLEY: What about the local doctor with a small practice? Are they struggling a little bit with this, when you see private health companies taking over other practices and, you know, being able to cut their costs more?

CHRIS ZAPPALA: Well, the survivability of the lone doctor practice, particularly the GP lone doctor practice, is definitely under threat. And that's not just from health funds buying up practices, which currently are thankfully not many, but also from big corporates doing exactly that as well. Now, there is some benefit in doing that in terms of economies of scale and getting access to better infrastructure and computer systems and being more efficient that way. But, yes, there is a loss of, I think, clinical independence and clinical ownership and running of those practices in those scenarios.

So, we have no problems; that is we the AMA, have no problems with corporate ownership of any stripe of practices, but it must never frustrate clinical decision making and or clinical running of those practices. So for example, if all the doctors and nurses at a clinic get together and say 'we need this bit of equipment to do our job more effectively', they're not going to have a bean counter, no offense to the bean counters, come in and go, 'sorry, you can't have that', particularly if the money's there. So, you know, the clinicians working in those practices need to have freedom to treat their patients properly.

TERRI BEGLEY: So, just in summary, Dr Zappala, what sort of changes would you like to see come into play? So doctors aren't feeling the pressure from the cost of the medical treatment they want their patients to have?

CHRIS ZAPPALA: Well, there does need to be greater regulation in the private health insurance space. Minister Hunt and the Government have already signalled that there is a preparedness to do this and that discussion is underway, but some boundaries around these practices and where there are lines that cannot be crossed in terms of dictating care for profit must be as much as possible enshrined in regulations and become the norm.

In terms of payouts to patients, which of course is a very big frustrating problem, there should be absolute transparency. In other words, why should one fund offer, for example, $1000 for exactly the same procedure that another fund is going to offer $500 for? That makes no sense whatsoever, but that happens everywhere all over the system every day. And there needs to be transparency and regulation around that so that fair rebates are offered that don't disadvantage

both doctor and patient. And one way, for example, to do that is, as happened in the Affordable Care Act in America, minimum payout ratios from the health funds. So over there they said: 'look, this percentage of 85 per cent it was of the health fund income must be spent on health care of the people who hold the policies', and that made a big difference.

Now, we can do something like that here in Australia that would help, you know, increase some of those rebates and stop that disadvantage to both doctor and patient, and hopefully get rid of some of that really nonsensical variability that exists between funds and between States and policyholders for exactly the same service. So patients really need to be wise and informed themselves as much as possible.

TERRI BEGLEY: Is there a one-stop shop where they can do that now? Today in Brisbane?

CHRIS ZAPPALA: Well the Government does – no, is the short answer. The Government does run a private health insurance website, but the information keeping that up to date is a little bit difficult. Some information can lag a little bit.

I think always your best answer to that question is if you're being referred, for argument's sake, a knee replacement with an orthopaedic surgeon from your general practitioner, then have a really good chat with your general practitioner, who you hopefully know very well. 'What are my options? How much is this going to cost? You know, what's the rehab sort of time? Etcetera, etcetera. What are the rebates?' And go online and have a look at what some of the variable rebates and so on are because it's publicly available - you just have to find them and make a decision about where you're going to go to from there.

TERRI BEGLEY: Good to hear from you this morning on this, Dr Zappala. Thanks for your time.

CHRIS ZAPPALA: Good morning, Terri.

TERRI BEGLEY: Dr Chris Zappala, he's a respiratory specialist with the AMAQ, and also happens to be Vice President of the Federal Australian Medical Association.

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