



AUSTRALIAN MEDICAL
ASSOCIATION

ABN 37 008 426 793

T | 61 2 6270 5400

F | 61 2 6270 5499

E | info@ama.com.au

W | www.ama.com.au

42 Macquarie St Barton ACT 2600

PO Box 6090 Kingston ACT 2604

AMA submission – ACCC report to the Senate on private health insurance

The Australian Medical Association (AMA) welcomes the opportunity to inform the ACCC about anti-competitive and other practices impacting on consumers and their medical practitioners.

In previous submissions to the ACCC, the AMA stated its concerns that patients do not understand their health insurance policies and, as a result, do not receive treatment when they need it. The AMA welcomes the Federal Government's response to calls for greater clarity by establishing a Private Health Ministerial Advisory Committee. This committee has been tasked with simplifying private health insurance (PHI), making it more transparent for consumers, and taking costs out of the system to ease pressure on premium rises. It is anticipated that this will improve the value of private health insurance. This submission will therefore focus on other practices impacting upon the level of competition within the private health industry.

This is not an insubstantial task.

In Australia, the public and private systems work together as a part of a health system that provides patients with universal access to affordable health care. The balance between the private and public system cannot be overlooked.

The private health sector is a large contributor to the system. In 2014-15, 42% of all hospital separations were funded by private health insurance; where 50% were public patients and the remainder were self-funded¹. Not only is it a large contribution, but it is a cost effective one. In 2014-15 there were 4.1 million privately insured hospital separations for approximately \$12 billion in outlays², or around \$3000 per separation, compared to 5.9 million³ separations in the public sector for a combined government outlay of \$48.1 billion (or \$8,100 per separation)⁴. While the service mix and complexity may differ between the sectors, the private sector very efficiently complements the public sector. If consumers withdraw from the private sector, these services will need to be provided by the public sector. Under current capacity, the public sector will either not meet the additional demand, or will only do so at a higher cost to governments.

We need to ensure that as private health insurers interact with patients and hospitals, the underpinning regulation promotes the efficient supply of health services. PHI has specific features

¹ Australian Institute of Health and Welfare: *Australia's Hospitals – at a Glance 2014-15*, page 7

² Australian Institute of Health and Welfare: *Australia's Hospitals – at a Glance 2014-15*, page 8

³ Australian Institute of Health and Welfare: *Admitted patient care 2014-15*, Table 2.22

⁴ Australian Institute of Health and Welfare: *Health Expenditure Australia 2014-15*, Table A10

that make the design of efficient regulation especially complex. This is further compounded by the specific historical development and place of PHI in the Australian context – as a form of supplementary insurance to Medicare, with the primary purpose of providing private hospital cover. Current regulation, as well as defining the scope of the cover PHI provides, includes restrictions on premiums through Community Rating and Lifetime Cover, means tested subsidies for PHI take-up (the PHI rebate which is among the top 20 most expensive Federal Government programs⁵), along with means tested tax penalties (the Medicare Levy Surcharge) for the failure to take out cover, and price controls over increases in PHI premiums.

The AMA has been watching the operations of the private sector - both private hospital and private health insurers for a while. There has been a noticeable shift from funds acting as passive payers to 'active funders'. Health insurers have traditionally focused on minimising their expenditure through creating barriers to utilisation and reducing management expenditure. However they are now increasingly focussed on managing the provision of services. Through this change, some disturbing trends have been developing, albeit slowly, and these behaviours have the ability to undermine both the private and public systems if left unchecked.

This submission will discuss how a combination of changes being implemented by the private health insurers are shifting the regulatory environment from one of a payee insurer model to one of managed care. It advocates that market power is slowly shifting in favour of the insurers, as evidenced by the funds ability to determine who is able to provide services and how they are to be provided under their contracts. In particular, these contracts now provide for the publication of practitioner details, allow for the establishment of closed shop referral databases and have no-pay clauses for adverse events. It then argues for the maintenance of the minimum benefits and second tier default benefits regime to protect those hospitals and day facilities that are not in a strong negotiating position. Finally, the AMA has concerns about the current media speculation of deregulating of premium setting and would not support a completely deregulated system. The current system is heavily subsidised by the Australian taxpayer, and as such, the Government should maintain an active role in private health insurance in order to ensure that it delivers on community expectations.

Managed care

In Australia, health care relies on a mixture of services funded by the Government (both State and Commonwealth) and PHI. Our system is based around the National Health Care Act of 1953 which regulates how medical, dental and pharmaceutical services are provided.

Australians can choose to obtain their health care solely from Medicare or use a combination of Medicare and PHI to meet their medical needs.

PHI offers several advantages over the public system: a patient has the option of being treated by their own doctor, they have more control over when and where they receive medical care and the waiting times for elective surgery tend to be considerably shorter. In short, PHI provides choice for the patient and without that choice, its value is diminished.

⁵ http://www.budget.gov.au/2016-17/content/bp1/download/bp1_bs5.pdf , p 5-12

Yet there is a subtle, and defined shift from a system of patient control to managed care occurring in Australia. Australians do not want US-style managed care imposed on a system that currently produces superior health outcomes at lower cost (USD\$4420 compared with \$9451 in the United States⁶). Managed care, in terms of healthcare, means a person agrees to only visit certain doctors and specialists within their health care plan – limiting their choice of practitioner. Australia and Australians have not had a public conversation about whether they agree to relinquish control over their health and their health system to the private health insurers. This change has occurred through the change to the contracting with hospitals with no-pay clauses; publication of practitioner details; establishing closed shop referral databases; and demanding pre-approvals prior to surgery.

Contracts with Hospitals.

The level of competition along the supply side of private health services impacts upon the competition between private health insurers. Both insurers and providers (hospitals and practitioners) have indicated that competition is not as effective as it might be⁷.

Some of the inputs to the provision of health can be influenced or controlled by the Private health insurer. These are generally limited to hospital contracts, but do stretch to the pre-approving of surgery. As a result, contracting between the insurers and hospitals (large groups through to day surgeries) has become more vexed and publicly acrimonious at times⁸.

Contracting is a voluntary, deliberate, and legally binding agreement between two or more competent parties⁹. However, it can be argued that firms are not operating in a competitive market and the factors at play are such that agreements are not voluntary. Hospitals need to have a contract with the major private health insurance funds (suppliers). Some insurers have such a strong market position that they would be considered price makers, where others are considered to be smaller, and thus price takers¹⁰. Smaller insurers are beginning to contract as a collective to improve market power and the Australian Health Service Alliance now represents 28 of the 36 registered health funds, creating what they claim is the third largest buying group¹¹. In addition, market power in one state may be substantial enough to extract a suitable contract for medium sized insurers. There are therefore notionally only nine private insurance health funds for hospitals to contract with.

Furthermore, a small day surgery that may be practitioner led may not have an equal power relationship when entering a contracting arrangement, not the ability to undertake the detailed financial modelling that insurers can use to gain a more attractive contracting outcome – this can effectively provide the ability for insurers to determine what small day practices remain viable.

⁶ Derived from Health expenditure and financing. OECD (Organisation for Economic Co-operation and Development)

⁷ <https://www.accc.gov.au/system/files/Private%20Health%20Insurance%20Report%202007-08.pdf>

⁸ <http://www.canberratimes.com.au/act-news/calvary-health-care-and-medibank-heal-rift-over-contract-negotiations-20150830-gjavxl.html4>

⁹ <http://www.businessdictionary.com/definition/contract.html>

¹⁰ Private Health Insurance Administration Council: *Competition in the Australian Private Health Insurance Market* 2013

¹¹ <https://www.ahsa.com.au/web>

This is problematic as small day surgeries can remove cases from the higher cost environment of overnight hospitals, as well as be areas where innovation can flourish.

As a result of this imbalance, the AMA is beginning to see variations in contracts that shift the nexus of control from the provider/patient to the private health insurance fund - managed care.

Contracts with no-pay clauses

The first of these shifts is the creation of contracts with no pay clauses. These effectively limit readmission to hospitals through the creation of exclusions by the private health insurers. The most prominent case has been that of the largest health insurer Medibank Private which tried to impose a contract with non-payment clauses with the Calvary group that contained a list of 165 preventable adverse events¹². Medibank has contracts with more than 120 (or 70 per cent) of Australia's private hospitals with non-payment clauses.

Financial penalties should not be imposed for events outside the control of hospitals. Whether a complication in hospital was "preventable" by the hospital can, in almost all circumstances, only be determined after a clinical review of the case (not by back office paper reviews conducted by a third party).

Patients are not aware that these exclusions exist in their policies.

These clauses have potential unintended consequences.

- Private hospitals may no longer accept the more complex and therefore higher risk cases, which mean these people will have to rely on the public hospital system for their care;
- Patient out of pocket costs will increase substantially, and those who can't afford those costs will also have to rely on the public hospital system for their care;
- Adverse events will be hidden from the data, thereby undermining continuous improvement processes currently operating in the healthcare system;
- Hospitals and doctors will hesitate to openly disclose to patients when their care doesn't go according to plan given the known risks of their condition and treatment;
- Patients will be kept in hospital for longer to avoid readmissions that won't be covered.

There is now a financial incentive for private hospitals to not contract with Visiting Medical Officers whose practice is complex or higher risk due to the patients they treat. This effectively will start to limit the choice by patients of where they can have a procedure, and who can treat them. For some patients, it will mean that their insurance will not cover them and they will need to be treated in the public system – fundamentally undermining the value of PHI for consumers.

Publication of a practitioner's details

¹² <http://www.abc.net.au/news/2015-08-25/medibank-private-and-calvary-talks-at-stalemate/6723932>

Private health insurers offer gap cover schemes to provide their members with certainty about out-of-pocket expenses for their privately insured medical care. Medical practitioners electing to participate in a gap cover scheme must agree to the terms and conditions that are set by the insurer. One of the common terms and conditions is that the medical practitioner agrees to information about them being published including their name, practice address, contact details, gap agreement usage and participation rate, and average gap charges.

BUPA has a 'Find A Healthcare Provider' section of its website. It provides information on the gap payment that may apply with providers it is contracted with, as well as information on the percentage of services, roughly, under which providers participate in its gap scheme.

Nib, BUPA and HBF are major shareholders of a system called Whitecoat which owns a database that provides information on practitioner charging patterns using data gleaned from the HICAPS system. Under the Whitecoat system, a provider's agreement with the payment processing system (HICAPS) will lead to publication in the directory. The directory is segmented by insurer, and only a customer of Nib can find Nib data about a practitioners billing practices or percentage of services provided under a no-gap or known-gap scheme.

Not unlike Trip Advisor, the Whitecoat site also allows consumers to search, find and book a clinical provider as well as review and share their experience. Whitecoat has stated that the customer reviews are vetted to ensure they do not contain clinical details, however members have raised concerns that the vetting process is not full proof.

Already it hosts over 40,000 providers (thus far mainly allied providers such as dentists) and shares 250,000 patient reviews. Around 6 million private health insurance members will have access to this information.

However, these types of websites have the potential for significant unintended consequences. Far from helping health consumers, posting outcomes of treatment online could lead to reduced access to care, particularly for patients with chronic and complex health problems.

If practitioners become concerned about adverse comments being published on the internet, they are more likely to begin to avoid high risk cases. For example, practitioners may become reluctant to operate on diabetics or people who are morbidly obese, or perhaps patients who reside in rural areas because it is more difficult to provide the same level of after care.

These patients, having already purchased PHI, may need to be treated in the public system.

Referrals databases for consumers and general practitioners.

Medibank has announced it is providing information to the referrals database Healthshare that will allow general practitioners to identify specialists who charge gap fees.

This initiative will provide information to approximately 85% of general practitioners as to which doctors are part of Medibank's 'no gap' or 'known gap' schemes. The converse of this is that general practitioners will therefore know which doctors are not part of Medibank's 'no gap' or 'known gap' schemes as they will not be on the Medibank list.

Effectively this action by Medibank (which will undoubtedly be followed by the other large funds) could have a detrimental impact upon the referrals received by practitioners who are not part of Medibank's 'no gap' or 'known gap' schemes, as patients are increasingly weighing gap charges into their decision on which specialist they choose. It is a closed shop, and it means that who the most appropriate clinician for the referral, based on medical advice, may not be the consumer's driving motivation¹³.

Again, this is a private health insurer influencing the provision of services and determining who may provide a service and, since they set the 'no gap' or 'known gap' amounts, at what price.

Under the Whitecoat system, if a general practitioner wanted to know in order to refer a patient, they would need to log in using the customer's details. It is expected that some patients would prefer to use a no-gap specialist rather than the general practitioner's recommended specialist. This may price some specialists, those who specialise in complicated or cases with multiple co-morbidities out of the market.

Australian Health Service Alliance has recently changed its conditions for practitioners who wish to participate in the Access Gap Cover scheme. Information such as medical charges and patient gaps will now be disclosed as AHSA is introducing a new business rule to Access Gap Cover entitled 'Collection, Disclosure and Use of Information Provided'. If a practitioner participates in the Access Gap Cover scheme after the new rule comes into force:

- their name, address, specialty and other contact details will be made available on the AHSA and participating funds' web-based doctor searches; and
- AHSA and participating funds may also publish information relating to the charges that have been rendered, the services that are provided and level of participation in the Access Gap Cover scheme.

AHSA included in the terms and conditions the ability to publish details regarding quality of service. However it is currently not clear how 'quality of service' will be determined – as patient outcomes, safety and quality standards and medical guidelines are complex and require an astute medical understanding.

¹³ <https://www.medibank.com.au/content/about/media-centre/2017/02/medibank-improvestr.html>

Pre-approvals for surgery

Under section 72-1 of the *Private Health Insurance Act 2007* (the PHI Act) private health insurers are required to pay benefits for hospital treatment for which a Medicare benefit is payable, subject to a health fund member having an up-to-date policy with no relevant exclusions.

The largest private health insurers are circumventing their obligations under the PHI Act by rejecting the payment of PHI benefits prior to procedures being performed through newly introduced 'pre-approval' arrangements for certain procedures. These arrangements require treating doctors to submit forms providing clinical details of the underlying medical condition, its severity and impact on the patient, and how the surgery will address the condition.

This practice of the health fund determining who is paid has recently spread to the management of malignant and non-malignant lesions. The Banding classifications were changed by the Department of Health for some MBS skin items and practitioners are now not allowed to admit their patients into a private hospital setting for the day for these items. Under the new 'banding' changes made by Government, patients may no longer automatically be eligible for PHI coverage for this hospital stay.

To compensate for inadvertently catching some patients who do require admission, practitioners must apply for payment from a fund. However funds are rejecting these requests and there is mounting qualitative evidence to suggest that there is inconsistency between the funds approving claims with some funds rejecting the claims outright. These items relate to correcting skin lesions, often as a result of removing a melanoma.

Whether to remove a suspected melanoma (and repair the area) should not be a decision left to the health insurance funds.

The AMA has been told that these processes have extended to other parts of the health system in a worrying trend of the private health insurers determining who is eligible for treatment. This undermines a doctor's independent clinical decision. Consumers expect coverage for what a doctor deems medically necessary formed by their doctor's application of the best available evidence to their individual clinical and social circumstances.

Contracting arrangements and default benefits

Since 1995 private health insurers have been able to purchase health services pro-actively through negotiating contracts with hospitals, but little is publicly known about the contracting experience.

In 1996, the then Coalition federal government feared that selective tendering could jeopardise the financial viability of private hospitals that failed to win contracts. This fear was not without some foundation, given the relative imbalance in market power between the health insurance and private hospital sectors in most states at the time¹⁴. As a result a set of regulations to provide

¹⁴*Health Affairs* 20, no.3 (2001):152-161 Promoting Private Health Insurance In Australia S Wilcox

financial security (through a benefit that is higher than the default benefits, but lower than contracted rates) was enacted.

The minimum and second tier default benefit regulations stipulate that in the absence of a contract between a hospital and an insurer, the insurer is required to pay a benefit of at least the basic default benefit or the second-tier default benefit (if the facility is eligible for second tier benefits), but only for private hospitals and day hospital facilities that meet certain criteria.

The ability to selectively contract represents a major shift in the power dynamics between insurers and private hospitals, providing the insurers with the power to be 'purchasers of health services' rather than 'passive bill-payers'.

Pro-active purchasing of health services involves the ability to select providers on the basis of criteria such as quality and efficiency (price) in service delivery. However, this effectively equates to some restriction in choice of service providers for members.

However, this has been extended beyond quality and into managing who enters the service provision market. The ability to selectively contract means that insurers will not provide coverage for facilities if these facilities do not meet the insurer's business needs. Insurers have commenced not contracting with facilities if they feel they have sufficient coverage in the area to satisfy members, or if there is too little demand¹⁵.

The private health insurers are effectively choosing who may provide a service and the conditions imposed upon the facilities. For example, BUPA insists that Members First Day Facilities providers will ensure that the BUPA member does not pay a gap for any treatment provided at that facility, including the medical services. Therefore the facility needs to control how much the practitioner charges. However, only a select few day facilities may be contracted with, even if practitioners wish to and have made genuine efforts to contract with insurers. This issue has been raised in a previous ACCC senate review by other professions¹⁶.

As a result, it is important that the second tier default benefits and basic default benefits regulation continues to operate to protect providers who do not have enough market power to negotiate on equal terms with the private health insurers. It is not the role of the insurers to determine if a private hospital or day hospital facility should commence or cease operation. If they are allowed to do so, by extension patients and referring doctors may no longer be able to choose the best specialist for their situation – rather be restricted to one in the insurer's network. This has the potential to undermine decisions made on clinical best practice and the patient's medical circumstances.

All of these behaviours, whilst appearing beneficial in order to limit exposure to costs to PHI providers are actually transferring risk to consumers through imposing conditions on health providers and practitioners. Private health insurers are limiting competition between providers.

¹⁵ <https://anzhealthpolicy.biomedcentral.com/articles/10.1186/1743-8462-2-6>

¹⁶ https://www.accc.gov.au/system/files/981_Private%20Health%20Report_2013-14_web%20FA.pdf

Thus providers of choice conduct their enterprise in a market knowing that their market share will not diminish.

Vertical integration

In moves to make our system similar to the US health care system, there have been attempts at vertical integration between insurers and providers (for example, Medibank Private's move into primary care¹⁷). The AMA supports a strong separation between insurers and providers of care. We do not believe that it is possible to reconcile the conflict of interest inherent in a vertically integrated organisation that spans both the funding and the provision of care.

PHI funds are currently not allowed to provide cover for General Practice care but they are looking at methods to expand into primary care through a variety of initiatives. BUPA acquired two GP clinics, one in George Street in Sydney, another in Chatswood as it begins exploring "how we could deliver primary care better", its managing director Dwayne Crombie says. The fund also owns 200 dental and 30 optical businesses¹⁸.

In addition, in 2013 Bupa introduced a new model of integrated care whereby General Practitioners are employed as a part of their aged care home teams¹⁹. In 2016, Bupa and St Vincent's Private Hospital Brisbane began conducting a two-year pilot program to deliver a model of home-based palliative care²⁰.

Bupa now own businesses in each of the areas of three main segments of the health care system, primary, tertiary and aged care.

Setting of premiums

The regulation of PHI premiums sits on top of this complex regulatory environment. It has a dual goal of protecting consumers from excessive pricing and the Commonwealth from fiscal risk. However, it has been argued by the PHI sector that this regulation provides an inefficient outcome²¹.

Annually the Health Minister announces the average increase for health insurance premiums following the Government's assessment of applications from health insurers. This attracts considerable media attention. Insurers that then announce premium rises larger than the figure announced by the Minister, may attract consumer complaints to the Private Health Insurance Ombudsman. The role that such a public discussion has in informing consumers about PHI, and forthcoming premium rounds, should not be dismissed lightly – the public discussion, over a

¹⁷ <https://www.medibank.com.au/content/about/media-centre/2015/05/medibank-targetspri.html>

¹⁸ <http://www.news.com.au/lifestyle/health/why-your-health-insurance-is-declining-in-value/news-story/10caf1939789fa9b52f223c7932e7c85>

¹⁹ <https://www.bupaagedcare.com.au/careers/gp-opportunities>

²⁰ <https://www.bupa.com.au/about-us/media-centre/media-releases/st-vincents-health-australia-and-bupa-to-help-improve-end-of-life-choice>

²¹ http://www.theaustralian.com.au/national-affairs/health/leave-price-rises-to-us-to-decide-private-health-insurers-tell-greg-hunt/news-story/629be21273e7a4e48768c759220f3372?from=htc_rss

number of weeks likely has a considerable education effect on the public, which noting the sheer complexity of PHI offerings, is sorely needed.

Many stakeholders are of the view that the compliance costs of the premium setting process are out of proportion to the benefits that are obtained. These concerns tended to focus on the process being too long, the amount of information required, and claims that outcomes would be the same even if the requests for increases in insurance were not reviewed.

A relevant consideration to the process and its ongoing appropriateness is whether market failures exist in the PHI market that justify the current suite of regulations. There are 36 PHI entities competing in the market, however the Australian industry is highly concentrated. The two largest insurers, Medibank and BUPA, have 55.4% of the market²². The Private Health Insurance Administrative Council in 2013 indicated that there does not appear to be ‘unbridled competition’.

Premiums are a key driver in the choice of insurance for consumers. The increase in exclusionary products has not been at the expense of growth in excesses and co-payments that are also used to mitigate premium costs^{23 24}. This indicates that consumers are purchasing products with excesses, co-payments and exclusions to minimise their premiums. Therefore any methodology to set premiums must ensure that this product remains viable and attractive to consumers.

PHI used to be run mainly by not-for-profit funds, however around 70 per cent of the insured population are now covered by ‘for-profit’ funds. The shift to a for-profit industry has created a greater need to ensure that there are sufficient profits to allow a respectable return to shareholders. It would appear that the private health insurers are not averse to increasing premiums in order to ensure a sufficient return for their shareholders. APRA data show an industry surplus (before tax) of \$1.56 billion for the 2015-16 financial year²⁵ (up from \$1.45 billion for the previous year²⁶). Nib's 2017 half year results showed a sizable return on equity of 31.7 per cent²⁷.

The Federal Government has a decided stake in ensuring participation in PHI. The Government’s regulatory environment of incentives and penalties all but guarantees customers to private health insurers and has ensured that the PHI industry is one of the Australian economy’s more protected industries²⁸. However, it also has the effect of undermining consumer confidence in the product. Allowing an industry with limited competition to set its own premiums may contribute to a further decline in confidence.

²² http://www.ombudsman.gov.au/_data/assets/pdf_file/0034/39895/2015-State-of-the-Health-Funds-Report.pdf

²³ Private Health Insurance Administration Council: Operations of the Private Health Insurers – Operations Report 2013-14 Data, Table: Policies by type

²⁴ Private Health Insurance Administration Council: Private Health Insurance Membership and Benefits – June 2015, Table: Australia

²⁵ APRA: Operations of the Private Health Insurers Annual Report 2015-2016

²⁶ APRA: Operations of the Private Health Insurers Annual Report 2014-2015

²⁷ <https://www.nib.com.au/shareholders/financial-results>

²⁸ <http://www.smh.com.au/business/banking-and-finance/forget-the-banks-health-insurance-makes-them-look-like-amateurs-20170224-gukprj.html>

Summary

In Australia, the public and private systems work together as a part of a health system that provides universal access for patients to affordable health care. If consumers withdraw from the private sector, demand for these services will move to the public sector, which under current capacity, will not meet the additional need or only at a higher cost to governments.

The AMA has been watching the operations of the private sector - both private hospital and private health insurers for a while. There has been a noticeable shift from funds acting as passive payers to 'active funders'. If this shift is allowed to flourish, it has the ability to undermine both the private and public systems.

The balance of power within the market is slowly shifting in favour of the insurers. This is evidenced by the funds' ability to determine who is able to provide services and how they are to be provided under their contracts. The terms and conditions between the private health insurers and providers now arrange for the publication of practitioner details, allow for the establishment of closed shop referral databases and have no-pay clauses for adverse events.

The health insurance funds now have the ability to selectively contract meaning that insurers will not provide coverage for facilities if these facilities do not meet the insurer's business needs. Given this imbalance within the market, it is important that the second tier default benefits and basic default benefits regulation continue to operate to protect providers who do not have enough market power to negotiate on equal terms with the private health insurers. Private health insurers should not determine who provides services in Australia.

Finally, the current regulatory framework provides a level of protection for private health insurers that is not commonly found in other sectors of the Australian economy. The Federal Government's regulatory environment of incentives and penalties effectively guarantees that consumers will purchase PHI. The Federal Government has a stake in improving consumer confidence in the product and allowing an industry with little competition to set its own premiums may contribute to a further decline in confidence.

The current regulatory environment, and the moves towards managed care have resulted in product offerings that serve the needs of the PHI industry and not the needs of health consumers. In short, PHI should provide choice for the patient and without that choice, its value is diminished.

Contact

Jodette Kotz
Senior Policy Advisor
Medical Practice Section
02 6270 5492
jkotz@ama.com.au

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