
Private Health Insurance and Primary Care Services

2006

Preamble

The limited expansion of services by private health insurance providers into primary care services may, where the patient is privately insured, positively impact on the access of care services for such patients, provide general practitioners with more options for patient care, particularly preventative care, improve the continuity of care and serve to better medicalise insurers products.

The AMA has concerns, however, that given the benefits to be derived from coverage of additional services in terms of patient outcomes these should be in the first instance insured by Medicare. Limiting certain services to those who can afford private health insurance, particularly those related to preventative health measures represents the establishment of a two tiered system.

The AMA notes that there are inherent risks in supporting an expansion of health insurance fund services into primary care medical services and any arrangements or program design that create such risks will be rejected by the medical profession. In particular, these risks are associated with:

- A focus on cost reduction rather than quality and continuity of care;
- Imprecise patient-selection techniques;
- The development of fund holding models that lead to rationed care by insurers;
- Access to appropriate and quality information and education for patients related to their health needs;
- Absence of quality monitoring of outcomes on health status and reductions in hospitalisation or readmissions, particularly elderly patients;
- Overall cost effectiveness
- The establishment of a two-tiered system of access in primary care.

The AMA believes there are, however, reasons to consider support for the limited expansion of private health insurance to provide or pay for primary medical care and other health services that are acceptable to the profession on the basis that they meet a range of specific criteria. The types of services/coverage that may be acceptable include:

- Preventative health programs;
- Provision of health information to members
- General practitioners attendance on their patients in public hospitals;
- Development of a medical model for private health insurance list of extras, and;
- Programs that improve equity of access to rural and disadvantaged patients (eg rural patient travel to medical care).

The provision of private health insurance coverage for primary medical care services has the potential to compromise the quality of care and must be considered against a range of criteria that focus on maintenance of the quality of care, particularly associated with independent clinical decision making of the doctor.

Policy Resolution

The AMA supports the limited expansion of private health insurance to provide or pay for medical and other health services in primary care that are not currently covered by Medicare. Such programs or services must meet the following essential criteria in that they:

- *provide access by the patient on the basis of a clinical decision initiated by the patient's usual general practitioner;*
- *maintain the quality and standards accepted by the profession;*
- *are developed in consultation with the AMA and other relevant GP organisations*
- *allow patient choice*
- *ensure that access for patients is fair and equitable;*
- *support good patient care;*
- *encourage continuity of care through the patient's usual general practitioner;*
- *incorporate processes that contribute to continuity of care;*
- *recognise the general practitioner as central to the patient care team.*

There are inherent risks in supporting the expansion of health insurance fund services into primary care medical services including, in particular:

- *A focus on cost reduction rather than quality and continuity of care;*
- *The development of fund holding models that lead to rationed care by insurers;*

and in that context a program or service that private health insurance funds cover in the primary medical care sector will be deemed unacceptable to the profession if it incorporates one or more of the following criteria:

- *it incorporates or is likely to leave the general practitioner open to any influence or pressure that compromises independent clinical decision making or the manner of practice;*
- *it allocates decision making on patient care to a medical practitioner "employed" by the fund rather than an "independent" or the patient's usual general practitioner;*
- *it incorporates any means or strategies by which the private health insurer might control or manage the care of the patient;*
- *it incorporates or is likely to incorporate any "rating" of general practitioners either within the fund or publicly;*
- *it compromises or threatens to compromise the quality and standard of patient care;*
- *it places any limits on the level of patient MBS rebates;*
- *it undermines the universality and equity of the MBS;*
- *it forms the basis of any future decision on the patients' access to insurance coverage with that insurer (the patient who participates in a diabetes management program for example must not be subsequently discriminated against by that insurer because they have diabetes);*
- *it involves fund holding or funds pooling that is inconsistent with AMA policy, limited or otherwise, by any entity;*
- *it limits or provides access to services on the basis of capitation*;*
- *it limits the right of doctors to set their own fees.*

**Capitation - a fixed per capita payment made periodically to a medical service provider by a managed care group in return for medical care provided to enrolled individuals (Merriam-Webster's Dictionary of Law)*