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Transcript: AMA President, Dr Michael Gannon, with Gareth Parker, 6PR, *Mornings*, 21 August 2017

Subject: Private Health Insurance

GARETH PARKER: The AMA today is blowing the whistle on private health insurance policies that it's describing as junk. Effectively, it doesn't cover you for things that you should be covered for. That seems to be the suggestion.

Michael Gannon is the AMA President. Michael, good morning.

MICHAEL GANNON: Good morning, Gareth.

GARETH PARKER: What is the concern here?

MICHAEL GANNON: The concern is that, all too often, patients find themselves or their loved ones sick and they're not covered, and this is leading to a crisis in terms of the reputation of private health insurance, and potentially compromises that key arm of our health system.

GARETH PARKER: So what aren't they covered for? What sorts of things?

MICHAEL GANNON: All sorts of things. There is a bewildering number of policy options out there for patients; we've counted 20,000 variations. Now, we would say that this system is deliberately confusing. We are participating, as are the insurers, in a Ministerial advisory committee that's looking at perhaps simplifying things down to gold, silver, and bronze. But very simply, our aspiration is that there are bronze policies that are not only affordable, but you can have a fair idea that if you get sick you are covered for treatment in a private hospital.

GARETH PARKER: So Michael, is it about pre-existing conditions not being covered? Is it about amounts being set too low, or threshold amounts of repayment set too low, compared to what the actual costs are being charged by specialists? I mean, can you be more specific about the sort of gaps that people are finding with these junk policies?

MICHAEL GANNON: Well, it's a bit of everything. So there are some policies that are literally designed to do no more than avoid the tax penalty if you don't have health insurance. There are some policies which say you can have treatment in a public hospital and that's all you get. Now, that affords nothing over what you have as an uninsured patient. There are policies that tell women, you've had a baby but your baby's got a heart problem, that's not covered, your baby has to be transferred to the public hospital. There are elderly men who are told – and I'm not joking – there are elderly men who are told you're covered for maternity, but you can't have your hips or knees done. This is tricky, it's mean, it's silly, and it's got to stop.

GARETH PARKER: That last example is nonsensical.

MICHAEL GANNON: It is. And we're all in this industry together, although it needs to be pointed out that the private health insurance industry has changed. Fifteen years ago, it was absolutely dominated by mutuals where members held insurance policies.

GARETH PARKER: [Talks over] So the HCFs of the world?

MICHAEL GANNON: Well, that's right. The dominant insurer here in Western Australia is a mutual, where those of us who have policies are members. And if they run their admin lean and tight, it means that every cent we put into the bucket of money gets redistributed for patient care. But the two biggest insurers Australia-wide now are for-profit. Between them, the for-profit insurers made $1.3 billion last year – good for their shareholders, not so good for their policy holders.

GARETH PARKER: So you're suggesting that for-profit insurers are more apt to offer these underweight policies than mutuals?

MICHAEL GANNON: Well, I think what is happening is- well, first of all, let's state the obvious, is that the for-profit insurers have a fiduciary responsibility to deliver a dividend for their shareholders. And we are not against anyone making a buck, this is a legal industry and, fair enough, if they need to make a profit they need to make a profit.

GARETH PARKER: And it's also a highly regulated industry. I mean, government has a lot of intervention, even in that part of the market.

MICHAEL GANNON: Well that's an important point you make as well, is that the Government has skin in this game. They distribute $6.1 billion worth of taxpayers' money into our private health insurance incentive; they have to sign off on the fee increases each year. They pay a significant amount every time a private patient goes into a private hospital. The Government pays 75 per cent of the scheduled fee every time someone has an operation in a private hospital. So the Minister has an interest in getting the policy levers right. I'm not going to assert that the for-profits are the bad guys and the mutuals are pure as the driven snow, but the truth is that the for-profits have to deliver profits to their shareholders. They need to find a way that does that that sustains the industry and doesn't lead to people recognising that their product is no longer worth it, beyond their ability to afford it in a time when disposable incomes are going down, and they leave the system. That's bad for everyone.

GARETH PARKER: So a bronze, silver, gold system of which the likes the AMA is touting, how would that work? Would there be kind of minimum guaranteed provisions that would have to apply set by government, or how would you see it working?

MICHAEL GANNON: Well, I think that's what we need to look at. We need to look at what defines bronze versus silver, what defines silver versus gold, and that will come down to things like fair and reasonable, and visible, transparent exclusions. It might come down to co-payments that people have to pay. People will be familiar with that, with lower tables of insurance now. But what we're determined to see is that it is illegal to sell a product that is useless or junk. So the expectation people would have if they have an unforeseen mental health crisis that they're looked after. If they're reproductive-aged women and they find themselves pregnant, they're looked after. Very simply, most people would have the expectation that if you get sick, that's when you get looked after, and too often people find out that their insurance policy is rubbish in their most desperate hour.

GARETH PARKER: We've covered a lot of stories on the program this year in the private versus public health realm, specialists versus insurers. There's a fair bit of argy-bargy going on in this area; I don't need to tell you that, Michael, you know that better than anyone. But recently, private health insurers put the spotlight on medical specialties and suggested that there wasn't enough transparency around pricing, and that that was resulting in big out-of-pocket costs for people who found that their insurance didn't cover the cost of a specialty, which might vary wildly in terms of its price from one specialist to another. Is this all part of a bit of a tit for tat as insurers go head to head with medicos and with specialists about who profits from health care?

MICHAEL GANNON: Well, it might be tit for tat, but I would assert that they're simply not right. When you look at outlays for private health insurance, the doctor's fee comes in at about

15 or 16 per cent. Eighty-six per cent of doctors' fees in private hospitals are provided under no-gap policies. So people talk about fee transparency, I can tell you what the number is for 86 per cent of operations: it's zero dollars. Another 6.5 per cent is provided under known gap polices of less than $500. That means 93 per cent of operations are no-gap or known gap. And you know what; I'm not going to defend the so-called heroes of my profession who charge $40,000 for an operation. The AMA, the College of Surgeons, stand out and say we do not agree with egregious fee-setting. But simply, there's been a failure from both Government and the insurers to index. That's why a small minority of doctors do charge more than the insurers' schedules. But to say that doctors are the problem in the PHI affordability game is simply dishonest and it's time to call them out on that.

GARETH PARKER: And there's a bit of commentary around over the weekend as well about the issue of – and again, this gets to who bears the burden of all this – patients in public State hospitals calling on their private insurance. And there's a pushback from some of the private insurers, saying, well hang on, we don't think we should pay for this, this is a service being delivered under the State system. Does the AMA have a position on that whole argument?

MICHAEL GANNON: Well, again, this is why I felt the need to speak out. You've got the insurers on the one hand developing policies that say you can only go to a public hospital, and then at the same time they're saying one of the problems is patients with insurance going into public hospitals. That's a bit too cute for my liking. Now, we are keen to look at reasons why the public hospitals are inducing people to use their insurance, and some of these are fairly tricky as well. But sadly, that reflects the inter-generational failure of successive governments to properly fund public hospitals, that they're using these various inducements. Put simply, though, private patients in public hospitals, there should be the flexibility for those arrangements to be maintained. If people need specific sub-specialist care, if they're in the bush where there is no fancy private hospital, or if just that's where their doctors works. But the public hospital system gouging the insurers doesn't add to universal care. If a patient is going to be in the bed, insured or not insured, that does not add to universal health care.

GARETH PARKER: Thanks Michael. Michael Gannon the President of the AMA.

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