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AMA Submission on the Exposure Draft Subordinate Legislation Private Health Insurance (Reforms) Amendment Rules 2018 August 2018

Introduction

The AMA welcomes the opportunity to provide comments on the proposed new rules that will underpin the reformed private health insurance system. Australia's health system relies on the dual pillars of public and private health. The two complement each other. It should be noted that nearly 70 per cent of elective surgery occurs in private hospitals. Our public hospitals would not survive without the support of our private health system.

The AMA has been at the table working alongside Government, insurers, consumers, hospitals, experts and other health practitioners, in an attempt to ensure that these reforms deliver clarity, fairness and transparency. We need to get these reforms right – if we don't, consumers will continue to leave private health insurance, undermining the viability of the private health system, and increasing pressure on our public hospitals, they are already facing a funding crisis that is rapidly eroding their capacity to provide essential services to the public[1].

The proposed *Private Health Insurance (Reforms) Amendment Rules 2018* (the Rules) contain some strong positives that the AMA welcomes:

- That the Rules bring clarity about what medical conditions are covered in each tier of benefits;
- That the Rules provide full mandatory cover for the medical conditions in each tier; partial cover is not permitted (except in Basic cover and for Psychiatry, Rehabilitation and Palliative Care – except in Gold cover where there are no exclusions);
- The inclusion of gynaecology, breast surgery, cancer treatment, and breast reconstruction in bronze tier products;
- The use of standard clinical categories across all private health policies (however these standard clinical definitions need to be sense-tested by doctors to ensure they address usual clinical pathways with no essential elements for a condition overlooked);
- That a clinical category covers the entire episode of hospital care for the investigation or treatment, including treatment for a condition found during investigation that would otherwise be out of scope; and

[1] https://ama.com.au/ama-public-hospital-report-card-2018

- That an episode of hospital treatment covers the miscellaneous services allied to the primary service.

The AMA believes these steps will go a long way to making private health insurance a simpler and fairer system.

However, there are still considerable issues that need to be resolved in such a major overhaul. The AMA is deeply disappointed that after two years of hard work the Government has allowed less that three weeks to look at the details of this new system. Good policy development should be done in a thorough and considered manner. Adequate time and good modelling are critical to ensure that usual clinical pathways have been adequately addressed, and that essential elements for a condition have not been overlooked – without adequate public exposure we cannot be sure this is the case here. The consultation on the Rules has been entirely inadequate – the AMA believes this has significantly increased the risk of failures in the new system.

But there is still time. The primary legislation for these changes has not yet passed Parliament and the AMA has recently made a submission to the Senate regarding the amendments[2]. The AMA again[3] calls on the Government to take the time to get this stage right. A small investment in both time and research regarding this work is likely to reap substantial dividends down the track.

Restrictions

The AMA is disappointed to see that restrictions are still included in basic cover. The AMA has repeatedly called for the banning of so-called junk policies that do not clearly show consumers the limited level of cover offered, and which are simply designed to avoid the Medicare Levy Surcharge. Including restrictions at this level runs the risk of confusing consumers about the limited value of basic cover in comparison with bronze or silver policies, where restrictions are not allowed. The limitations of this cover will need to be made very explicit so that consumers understand the very restricted nature of the cover. We will watch closely to ensure that with the roll out of this restricted 'Basic' level policy, consumers understand that it provides very limited coverage.

Pregnancy

The AMA continues to call for pregnancy cover to be included from Bronze policies upwards – matching it alongside coverage for female reproductive policies. It's a natural part of life. Half of all pregnancies are unplanned[4]. The AMA believes it should be covered properly with the cost spread appropriately, making it affordable for more people.

[2] AMA Submission to the Senate Community Affairs Legislation Committee inquiry into the Private Health Insurance Legislation Amendment Bill 2018 and related Bills | Australian Medical Association

[3] AMA Submission: Department of Health Consultation on the draft standard clinical definitions for private health insurance hospital treatment policies | Australian Medical Association

[4] https://www.mja.com.au/journal/2012/197/2/current-contraceptive-management-australian-general-practice-analysis-beach-data#0_i1149769

Cataracts, joint repairs

Cataracts and joint repairs are currently covered in a range of mid-level (equivalent to silver) insurance policies. Consumers who are covered under current policies will be dismayed to find that these common procedures are now restricted to Gold level coverage only. The AMA calls for consideration of the impact of these changes, and whether these categories should be considered for the Silver tier of coverage.

Failing this, there must be better mapping to support the transition to the new system. The AMA again[5] calls on the Government to undertake such a mapping exercise. Our limited work in this area shows that, for many people, the medical conditions for which they currently have coverage may not be covered in their new policies. If the Government and private health insurers want the public to have the clarity and certainty they require to trust this new system, this work is essential.

Additionally, we should also look at emerging issues such as sleep medicine – restricting new areas of practice to the Gold tier only without having a future review mechanism outlined should be reconsidered. A set time frame for a future review would seem sensible. Medical practice changes with increasing evidence. This system must be able to adapt as well.

Private Health Insurance (Reforms) Amendment Rules 2018

Amending Schedule 1 – Amendments to implement Age-Based discounts

The AMA acknowledges that private health insurance margins are under stress, and there are real upward pressures on health insurance premiums from costs associated with an ageing insured population, the changing burden of disease and new health technologies. However, in an effort to make insurance more affordable for younger Australians, community rating must also be protected to maintain equity of access to private health treatment. When the policy objective is to support a strong private health sector to take pressure off the public sector it makes no sense to financially discourage patients most likely to need access to private health. The AMA views community rating as essential in maintaining the delicate balance between the public and private sectors in the Australian healthcare system.

Charging premiums according to "risk" undermines the central tenet that supports the community rating system for private health insurance. The community rating system ensures that private health insurance is equitably available to all in the community who seek it (and can afford it). It is important that any regulatory adjustment does not move from a community rating system, to one based on risk where different premiums are charged based on a combination of age, gender, and other factors. Undermining community rating could lead to the development of a true risk rating system which will leave people uninsurable who are deemed by insurers to be 'high risk'.

[5] AMA Submission: Department of Health Consultation on the draft standard clinical definitions for private health insurance hospital treatment policies | Australian Medical Association

Amending Schedule 2 – Standard Information Statements and Private Health Information Statement; and Amending Schedule 6 – Information Provisions

Private health insurance products need to clearly state whether the consumer will or won't be covered for a particular service. This should not be difficult for any consumer to understand or work out. Accordingly, the AMA strongly supports the proposed increased information provisions and agrees that, when combined with the application of standard clinical definitions across all private health insurance products, this should reduce confusion for consumers.

Currently the full information for private health insurance products is often segmented into multiple documents. This requires the consumer to go searching for the full scope of information and have to analytically pull together the piecemeal advice, across various documents, to develop an accurate understanding of their cover.

The AMA supports the better provision of information to consumers. The AMA believes that insurers should be required to use standard consistent definitions across all their products - all their documents that explain benefit entitlements. Insurers should include definitions in all consumer documentation in which a term is used. Additionally, insurers should be required to provide up to date Fund Rules on their websites (not all insurers do this - some insurers only provide access to Fund Rules if requested in writing).

Varying benefit amounts paid by private health insurers

Each insurer has its own schedule of benefits for admitted medical services, but this is not always publicly available. For admitted hospital treatments, the level of benefits paid by the insurer will depend on the insurer, the particular insurance policy, and the insurer's arrangements with the treating doctor, and, after the latest insurer-initiated changes, the treating hospital. Private health insurers will generally aim to set premium levels to cover the expected costs of benefits, plus the insurer's management costs.

The benefit that a medical practitioner may receive varies by insurer, policy, and procedure. When there is a difference between the doctor's fee and the insurance benefit, an out-of-pocket cost can occur. It is a common misunderstanding that the doctor's fee is the reason for an out-of-pocket cost. Yet, there can be a significant difference in the amount an insurer will pay towards a medical service, and it varies from insurer to insurer and from procedure to procedure. Occasionally it varies from State to State, as well.

Consumers need the right information to help choose the right cover, noting that what is important in a health insurance product differs for each individual or family. Consumers need to be able to compare what proportion of hospital and medical costs are covered by each fund, examples across a number of common procedures of the different levels of benefits provided by funds, and Government data on complaints made about funds. These features can help consumers see the likelihood of facing out-of-pocket costs, and the ease of interacting with a

fund. These differences can have a significant impact on the support a patient might experience from their health fund when they undergo treatment[6].

Amending Schedule 3 – Product Tiers and Naming of Insurance Policies and Schedule 4—Clinical categories

The ability for funds to change coverage through differing benefit schedules, co-payments, excesses, limitation periods, and procedures covered, has created a system where there are 70,000 policy variations around the country. Without reform, consumers will continue to leave private health insurance, undermining the viability of the private health system, and increasing pressure on the public health system.

The AMA has argued for minimum standards that simplify the offerings for consumers:

- *Gold*: products must cover all hospital services, with insurers precluded from charging excesses or co-payments. No restrictions or exclusions allowed.
- *Silver*: products must cover all hospital services but insurers may impose any combination of excesses or co-payments (up to a limit). No restrictions or exclusions allowed.
- *Bronze*: products may include exclusions, excesses or co-payments. No restrictions allowed, and accidents should be covered.

The AMA is gratified that the Government appears to have heeded this advice in the design of the new categories, at least in part. The AMA supports the application of a consistent naming convention for tiers of insurance with no provisions to move outside this naming convention. We note the work done by the Department of Health (in particular the focus group testing) in the development of the naming of the clinical categories and also support these. We note that the Silver category is different from what we suggested.

Draft Clinical Categories

Standard clinical definitions are a critical underpinning of the reformed system, and the AMA asserts these require thorough clinical pathway mapping to ensure that changes to private health insurance categorisation do not result in consumers unexpectedly finding they are not covered and facing out-of-pocket costs.

The biggest challenge to implementing the new private health insurance categories is to clearly define and describe the insurance products on offer so that families and individuals – many of whom are facing considerable cost of living and housing affordability pressures – have the confidence that their investment in private health delivers the cover they are promised and expect when they are sick or injured. Also, that they can compare insurance policies with a level of certainty – knowing that they will be properly covered by the different insurance products.

[6] AMA Private Health Insurance Report Card 2018 | Australian Medical Association

The allocation of MBS items to clinical definitions ultimately determines the value proposition of private health insurance, when a patient is covered for a service, and when a benefit will be received. The clinical definitions for privately insured patients can therefore impact the clinical scope of practice. This can influence where a patient is treated, the level of medical services provided and whether there is a private health insurance benefit paid for the service.

The AMA has spoken with several Medical Colleges, Associations and Societies (CAS) over the consultation period, and we are not confident that the relevant clinical leaders across the CAS had sufficient time to work through the impacts of the draft clinical categories in the in-depth manner that is required to identify potential future issues. Likewise, the short timeframe has meant the AMA has only been able to conduct a first glance consultation with its wider membership. But even so we have unanswered questions. Questions about the instances where a procedure may have MBS items for in both the multiple categories, or if an MBS item is not attributed by the regulations to any category will it be up to the insurer to allocate it – won't this again lead us down a pathway to inconsistency.

The AMA's position has always been to defer recommendations relating to specific clinical items to the relevant CAS groups, and comment on the broader policy issues and intervene where necessary. We do so again here. However, even in the brief window of consultation allowed by the Department of Health our members have raised a number of issues, listed at Attachment A. More time and more work is needed to get these details right.

Mapping

The AMA is concerned that when the public compares what is covered in each tier with their existing cover, coverage remains uncertain. The AMA again[7] calls on the Government to undertake a thorough mapping exercise. Our limited work in this area shows that for many people conditions for which they currently have coverage (eg., cataracts, pregnancy, joint replacement) may not be retained in the new policies at the same level. If the Government and private health insurers want the public to have the clarity and certainty they require to trust the new system, this work is essential.

MBS Reviews

The MBS Review Taskforce is considering how to align the more than 5,700 listed services with contemporary clinical evidence and practice, and improve health outcomes for patients. This a major review the like of which the health sector hasn't seen for decades. It is concerning to the AMA that in neither the exposure draft of the Rules or the supporting material, is there any mention of the MBS review. However, the tiers and clinical categories are linked to specific MBS item numbers in the delegated legislation. The only way these can be altered is passage through Parliament (albeit as a disallowable instrument).

[7] AMA Submission: Department of Health Consultation on the draft standard clinical definitions for private health insurance hospital treatment policies | Australian Medical Association

In May 2018 Professor Robinson (Chair of the MBS Review Taskforce), informed the AMA that the Minister for Health had agreed to accelerate the clinical review portion of the MBS Review, with recommendations from all remaining clinical reviews being made to the Minister by the end of 2018. Professor Robinson expects a 'long tail of implementation' which would undoubtedly commence from the beginning of 2019.

The AMA is unable to find any evidence of demonstrated consultation with the MBS Review Taskforce or the relevant clinical sub-committees, in order to transfer this knowledge into the private health insurance clinical definitions design. Considering the level of disruption both processes will have on the health sector, the AMA firmly believes there must be consultation between these two high priority projects which are both being run by the same Department. The AMA calls on the Government to explain to medical practices around the country, the plan to manage the impact on claiming and billing for Medicare and private health insurance from 1 April 2019, when the proposed changes come into effect.

Is the Government expecting practices, and insurers to continuously update their medical and administrative practices each time the Minister accepts another tranche of MBS recommendations? It will of course take further time to mirror in the private health insurance rules, and then be reflected in insurance offerings. Understanding what happens to patients with pre-booked procedures, and the synchronizing of timeframes between MBS item implementation, adoption in the Private Health Insurance Rules, then in insurer policy, and finally therefore in a patient's private coverage is essential.

For example, if after the introduction of the new tiers of cover, a patient elects a particular tier because they are planning to have a procedure later in 2019 based on the existing MBS item number (which they have checked will be covered under their insurance product) - what happens if the MBS item number changes or is removed as a result of the MBS review, and the new item number is in a higher tier? While patients have portability in the first half of next year, the significant changes in the MBS item structure will complicate ongoing transparency and consumer/clinician understanding. The result, in a worst case scenario, could be that patients may not be insured for their pre-booked procedures, even when they undertake appropriate due diligence. Portability will be meaningless and confidence in private health insurance further diminished without clear timelines, processes and communication.

Amending Schedule 4 – Second Tier Administrative Reforms
Private Health Insurance (Benefit Requirements) Rules 2011

The AMA supports the proposed administrative amendments, given the main quality criterion (the National Safety and Quality Health Service Standards) is now a requirement of all hospital accreditation. It is sensible for the Department of Health to assess second-tier eligibility as part of the Commonwealth hospital declaration process with appropriate review processes.

There has been a noticeable shift among private health insurers from funds acting as passive payers to 'active funders'. The AMA is concerned that if this shift is allowed to flourish, it may undermine both the private and public systems. Increasingly, private health insurers are

determining who is able to provide services and how they are to be provided under their contracts[8]. This means that the patient has a difficult choice – to see their medical practitioner at their choice of facility and pay an increased out-of-pocket expense, or see their insurer's contracted provider at the insurer's contracted facility. The AMA asserts that this is gaming and a pathway to managed care.
Australians do not support a US style managed care health system, and the AMA asserts that recent actions from some private health insurers are taking Australia closer to such a system.

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. The AMA believes that any further consideration of the second-tier benefit must be about protecting consumers' choice and protecting them from high out-of-pocket costs.

The AMA strongly opposes any dilution of the second-tier benefit rate itself, or its current application to facilities that do not have a contract with a health fund. The second-tier rate ensures that consumers, who have duly paid their insurance premium, have access to the hospital and doctor of their choice – regardless of whether that doctor or hospital has been successful in securing a contract from a health fund.

The AMA believes that provision of second-tier benefits means that private health insurance funds cannot dictate the health landscape. Without second-tier rates, organisations that cannot contract may not be able to survive, as insurers will essentially be able to direct traffic to their contracted facilities. This will see Australia heading down a path of managed care and closed provider networks, limiting choice of doctor and facility (and therefore reducing the value proposition of private health insurance), as well as impacting on clinical referral/decision making.

Private health insurers should never determine who provides medical services in Australia. Australians do not support a US-style managed care health system. Neither does the AMA.

Amending Schedule 5 – Removal of Coverage of Some Natural Therapies

The AMA supports the removal of coverage for some natural therapies from both hospital treatment and general treatment. The AMA supports evidence-based health practices and acknowledges the expertise and work conducted by the National Health and Medical Research Council and the Department of Health in this area.

[8] AMA Submission - ACCC report to the Senate on private health insurance | Australian Medical Association

Private Health Insurance (Complying Product) Amendment (Terminating Products) Rules 2018 Amending Schedule 1 - Terminating Products

The AMA acknowledges the requirement to legislate for the transfer of currently insured people to the new Gold, Silver, Bronze and Basic products. However, beyond this limited circumstance, the AMA has reservations about the private health insurers being given the ongoing ability to terminate a product and transfer all the people insured under that product to new policies.

This change may enable insurers to offer products with incentives added in addition to the base level of product, (ie., Silver "+") but after a period of time move them to a new product without the incentives (ie., Silver). For example, an insurer could promote a Silver product but add a Gold level service to attract customers. However, after a period of time they could move the consumer to the basic Silver product by simply informing the customer of this move. Indeed, this type of scenario is outlined in the details provided through the draft Rules[9]:

The information that an insurer must provide to affected adults includes:

- *details about the new policy such as:*
  - *any services that are covered under the terminating policy that will not be covered under the new policy;*

The capacity of private health insurers to chop and change their policies in this way can only reduce transparency and certainty for consumers. As such we would ask that the Private Health Insurance Ombudsman be tasked with monitoring this specific issue, once the new categories are implemented.

Private health insurance rebates and out-of-pocket expenses

An issue not currently covered by the amendments to the legislation or regulations is the adequacy of fee payments to medical practitioners under the private health insurance system. The AMA is very concerned with the levels of benefits that are paid to doctors by the health funds through the private health insurance schedules. These amounts have been largely based on MBS rates where the Medicare schedules have been frozen for the last five years, and prior to which were not indexed appropriately for many years. Currently the table of rebates bears no resemblance to the actual cost of providing good quality health care in our country.
The amount paid under the private health insurance schedules (the amount paid over the MBS rate for each item) is determined individually by each fund. With the failure of indexation of the amounts paid by insurers under gap cover, many medical practitioners are struggling to keep their fees to the no gap or known gap level. When specialists exceed the gap level, the amount paid by insurers reduces to the MBS rate, causing greater out-of-pocket costs to patients.

Finally, after prolonged and consistent advocacy from the AMA, the Government agreed that on 1 July 2018 the Medicare freeze will be lifted for consultations. On 1 July 2019, the rebates for surgery and other procedures will be indexed. Indexation for the majority of pathology and

[9] Department of Health | Release of Exposure Draft subordinate legislation Private Health Insurance (Reforms) Amendment Rules 2018

diagnostic imaging items will remain frozen. It is very important to note that when indexation recommences it will not be backdated to 2014 – meaning the Medicare rebates will continue to lag behind the true cost of providing a medical service[10].

Lower benefits paid by the insurer generally mean higher out-of-pocket costs for patients. To reduce out-of-pocket expenses the AMA is calling for consideration be given to an increase in the known gap rate allowed by private health insurance funds. The AMA acknowledges that this package of reforms will not reduce premium costs for consumers, and that the Government has also allowed for the lifting the excess thresholds (given that they have not been reviewed for many years). However, not addressing this problem will result in increasing out-of-pocket expenses further, as a result of the way fund payments are reduced once the known gap rate has been exceeded.

In Conclusion

The AMA believes that these reforms are a step in the right direction. We don't agree with every single detail in them. But we will keep working with the Government to ensure that private health insurance offers Australians greater choice in their doctors and location of their treatment and delivers shorter waiting times for services.

Finalising this major piece of health reform work is a complex exercise. To ensure that we produce a quality product, to ensure that we have a strong and viable private health sector, to ensure that we maintain the reputation of the Australian health system as one of the world's most effective, will require our best efforts. For this next phase of work on the private health insurance reforms, the AMA calls on the Government to:

- Properly engage with the full range of stakeholders and clinical experts;
- Underpin the development of clinical definitions and rules with quality evidence and modelling; and
- Provide adequate time for meaningful consultation and consideration.

Only then will we ensure that the final result delivers the change Australian health consumers are expecting.

[10] AMA Private Health Insurance Report Card 2018 | Australian Medical Association

Attachment A

Concerns with the proposed Rules raised by individual AMA members

The following feedback illustrates the need for clinician review of the proposed MBS mapping. The comments represent a small sample from AMA committee members, many whom are renowned specialists in their field and have experience with MBS reviews and insurance policies. Due to the short time frame provided for the consultation on the Rules it does not represent AMA formal views but provides a good level of detail and should be considered.

- The separation of the treatment of spinal conditions between Silver and Gold Cover will have disastrous unintended consequences for thousands with spinal conditions. Splitting cover for spinal conditions will directly influence health care decisions within the doctor patient relationship.

- The 1 November MBS changes to spinal items don't have the cause listed (ie cancer, scoliosis, etc), so how can you know the procedure is eligible for gold v silver coverage? There will be no way of knowing from the bill.

- Patient admitted for a procedure but during stay degenerates to paraplegia. The patient is transferred to public hospital. Does the insurer pay for the ambulance in this case?

- A patient is brought to private hospital emergency department for a fractured femur (but not formally admitted to hospital). If the fracture is too high he needs a hip replacement and so is transferred to public hospital. Again, who pays for the ambulance especially as they are not formally admitted to the first hospital.

- There should be a restricted benefit for oncology and endoscopy in the basic tier. For example, a patient would only be covered for starting chemotherapy first cycle etc. and colonoscopy in certain indications like definite mass on large bowel on imaging like Pet or CT but needs confirmation and histopathology. Or if patients need to have endoscopy before commencing chemotherapy for another cancer in suspicion of synchronous cancer.

- With respect to the Private Health Insurance Reforms and the various Tiers of Hospital Treatment Products, it is of concern that Sleep Studies appear only in the Gold Cover bracket. The effect of this is likely to increase pressure on the public system which is already overly stressed and with prolonged waiting times, as obviously people with non-Gold Cover would then gravitate into the public system. The area of Sleep Medicine is still evolving, and sleep disorders of many types occur frequently. These are often not very well recognised by non-Sleep Physicians. For this reason alone, and quite apart from considerations of further pressure on the public system, sleep studies should be included in all Tiers of hospital treatment products.

- For years it has been of concern to me that all medical insurers abuse their financial clout to direct patients to particular practitioners/services. This happens regardless of how long the patients have been cared for by their provider.
- The most obvious problems are the conspicuous carve-out of joint replacement surgery and cataract surgery under the proposed changes. I'll confine my analysis to just these two items.

- Modern medicine is showing clearly that one of the biggest contributors to snowballing medical care costs is increasing obesity levels. Since osteoarthritis is one of the greatest limiters of physical activity in older people, part of the solution for the obesity crisis is exercise and mobility. To downgrade joint replacement to "luxury item" status is an incomprehensible move which is all about short term budget considerations and completely ignores medical science and the needs of patients.

- Cataract surgery is NOT a lifestyle choice or indulgence. Cataract surgery has been shown to be highly cost-effective as a medical intervention (1). Further, cataract surgery has been shown to reduce all-cause mortality (2) and by extension to significantly prolong life (3) further underscoring how ludicrous this proposal is. Words fail me regarding the fact the Government has decided (for purely budgetary reasons) that blindness is not important in health care, nor for that matter is being crippled. My recent experience is that patients referred locally for public surgery wait a year for an appointment and potentially another year for an operation. The likely consequence of de-funding cataract surgery is that those will blow out and we'll all see increasing numbers of people parting with their dwindling retirement money in the private system (if they can afford it) or continuing in a variably disabled state for years. In my area which is of relatively low average socioeconomic status, this will degrade an already overstressed system. The insanity is further underscored by the fact that they have deliberately "carved out" cataracts. A pterygium can get you private care on "silver" or "bronze" tiers; but with actual vision loss due to cataract, you're on your own.

- One of the most insidious exclusions practised in the main by some private health insurers is the exclusion of plastic surgery. Most clients think this means ex-schedule aesthetic surgery and are devastated to learn they are not covered for MBS items including reconstruction of most types after skin cancer or burns, and no maxillofacial surgery including bone grafting and facial fracture management! The whole exclusion needs to be a whole lot more transparent if exclusions are allowed to remain in the "basic" category, as this is the level at which many 30-year olds enter (reluctantly and pressured to do so by the threat of future loadings) and often never upgrade – finding themselves without adequate cover as they age.

- Private insurers should not be able to choose for their members either their doctor or hospital if the doctor or hospital has appropriate accreditation. Privately managed hospitals need to be transparent with their policies of how they manage gaps for doctors who are either employed by them or work as VMOs or other alternative arrangements. This will be an important industrial matter in the long term as private hospital chains seek to bring

enormous downward pressure on doctor's income by both direct employment contracts and by directing work to preferred doctors on the basis of gap only. For both points made, my "bottom line" is that there be a level playing field in terms of hours of work required, skills required and remuneration between all specialties and between the medical profession and others in the work place with correspondingly high levels of responsibility, education and skill.

- A group of Orthopaedic Surgeons noted the inclusion of Podiatry Surgery. These Orthopaedic Surgeons have advised that Podiatric Surgeons are not trained to Australian orthopaedic standards and indeed change a higher fee that is not linked to Medicare rebates as all surgical fees are currently. This would appear to be an issue the Department of Health should take up.