Royal Australian College *of* General Practitioners

The role of private health insurance in primary healthcare

Position statement – January 2022

1. Position

The RACGP's *Vision for general practice and a sustainable healthcare system* (the Vision) sets out a model for high-performing general practice care and notes that many elements of this model are not supported by existing funding sources. However, the RACGP does not support amendment of the *Private Health Insurance Act 2007* to allow private health insurers to fund services for which Medicare rebates are available, or to cover gap payments, as this threatens universality of access to general practice and primary healthcare more broadly.

There is an opportunity for private health insurance to support patient access to the model of general practice care described in the Vision. This may include general practice and primary care services that are not funded under the Medicare Benefits Schedule (MBS).

The RACGP shares member and community concerns that the expansion of private health insurance in the primary healthcare setting could undermine the autonomy of the treating practitioner and the options available to patients in the formulation of their individualised management plans. Adequate safeguards to maintain the separation of Medicare and private health insurance must therefore be enforced.

Services facilitated by private health insurance must integrate with, and augment, GP-led care. Services already being provided by a patient's usual GP, such as chronic disease management, should not be duplicated by private health insurers, as this will lead to fragmentation and inefficient use of health resources.

Further discussions about how private health insurance can support the delivery of high-quality and efficient patient services in the future should be held with the general practice sector and patient groups. Private health insurers should also collaborate with the sector to evaluate current programs and identify opportunities for improved service delivery.

2. Background

2.1. Private health insurance uptake

As of 30 September 2021, almost 55% of the Australian population were covered by a general treatment private health insurance policy.[1]

Although there has been an increase in the uptake of private health insurance amongst Aboriginal and Torres Strait Islander consumers, available data suggests that overall uptake is lower than for non-Indigenous Australians. In non-remote areas, only 20% of Aboriginal and Torres Strait Islander adults had private health insurance in 2012–13.[2] Among Aboriginal and Torres Strait Islander peoples, the main reasons cited for not having private health insurance included 'can't afford it or too expensive' and 'Medicare cover is sufficient'.[2]

2.2. Broader Health Cover

The 2007 reforms to private health insurance introduced the concept of Broader Health Cover (BHC). Changes to legislation at this time allowed private health insurers to provide a broader range of services, including:

- disease management
- health and wellness programs
- hospital-substitute services (eg wound management and intravenous therapy).[3]

Use of BHC services has steadily increased since the reforms and is higher among older age groups. The growing prevalence of chronic disease suggests there will continue to be increased uptake into the future.[3]

2.3. Private health insurance and chronic disease management

Although private health insurance funds have been paying benefits for chronic disease management services for more than 10 years, evidence suggests insurers are struggling to expand their role in this area.[4]

One Australian study found that insurers are still in the early stages of implementing and evaluating chronic disease management services.[4] Insurers reported a number of challenges in providing these services, including identifying target groups and collaborating with other healthcare providers. Hospital claims data is currently used to identify participants for chronic disease management activities, meaning activities are focussed on patients who already have a diagnosis rather than on prevention.

3. Ways in which private health insurers could support general practice

Under strictly defined parameters, there are opportunities for private health insurers to support general practice, patient access to required services and health system efficiency in line with the model of care set out in the Vision.

Any involvement of private health insurance in general practice should not extend to Medicare-funded services, as there is a risk this will threaten equitable patient access to essential care.

Possible services that could be funded by private health insurers without encroaching on Medicare/government insured services include:

- assessment and management plans for patients not eligible for Medicare-funded General Practitioner Management Plans (GPMPs) and Team Care Arrangements (TCAs) due to a lack of chronicity or complexity
- GP referred allied health services such as dietetics, exercise physiology and physiotherapy (eg for patients identified as being at increased risk of diabetes)
- evidence-based chronic disease prevention programs
- targeted chronic disease management and hospital avoidance programs (eg hospital in the home)
- care coordination and team care – supporting patients to access nurse services, additional allied health visits and programs to assist patients transitioning between healthcare settings, including hospital pre-admission or post-operative care
- coordination payments to GPs for privately insured patients with multimorbidities and comorbidities[5]
- general practice modernisation – supporting the use of newer technologies such as point-of-care testing
- other support for GPs and general practices to flexibly meet the needs of their patients and support local solutions to local challenges.

4. Principles for the involvement of private health insurers in primary healthcare

The broad range of private health insurers and available policies may create challenges for GPs, as they need to be able to establish if a patient is insured and what services they are eligible for. Integration of private health insurance programs with the general practice sector is key to the effective coordination of care.

4.1. Continuity of care is key to preventing fragmentation

The provision of comprehensive, continuous care is central to the role of GPs and means they are best placed to formulate and coordinate patient management, including multidisciplinary care teams and a range of service providers where indicated. Aboriginal and Torres Strait Islander patients value and prefer care provided by Aboriginal Community Controlled Health Organisations (ACCHOs).

Chronic disease management programs offered by private health insurers have often taken place in isolation from the patient's usual GP, who is best placed to understand the patient's needs, including all comorbidities as well as social and emotional factors, and make recommendations for appropriate treatment.[6] Care plans developed by GPs are able to be individualised according to these factors, and adapted as required because of their ongoing therapeutic relationship with patients.

When care is facilitated through a patient's private health insurer, integration with GP-led care and regular communication with the patient's usual GP is necessary to ensure continuity of care and prevent fragmentation.

4.2. Allow patients to choose their providers

Private health insurers must not require or encourage patients to see 'preferred GP providers' based on the GP or general practice's participation in a private health insurance pilot project or program. When choosing a GP or general practice, patients should be free to choose based on quality of care, access, convenience, an established relationship and other preferences. However, the RACGP acknowledges that patients may choose to attend a GP based on their participation in a private health insurance pilot project or program.

4.3. Recognise and support the clinical judgment of GPs

Private health insurers must not require or encourage GPs to refer patients to certain providers of care because of their participation in a private health insurance pilot project or program. Similarly, GPs should not be required to adhere to rules, regulations or protocols regarding treatment options for individual patients specified by a private health insurer, unless it is in the best interests of the patient to do so. GPs must be able to refer patients to other providers of care and provide treatment as clinically appropriate, based on their professional judgement and the patient's needs.[7]

4.4. Support equity of access to primary healthcare services

Patients in Australia can currently access primary healthcare services regardless of their private health insurance status. Some private health insurance programs have focussed on ensuring faster access to GPs for their customers.[8] Future private health insurance pilot projects or programs must not result in patients who are insured being given priority or preferential access to primary healthcare services over patients without insurance who may have greater need. The RACGP supports equity of access to services for all patients regardless of income or insurance status.

4.5. Support high-quality general practice modelled on the 'medical home'

High-quality general practice modelled on the 'medical home' facilitates partnerships between individual patients, their GP and the extended healthcare team.[9] It allows for better targeted and effective coordination of clinical resources to meet patient needs.[10] Any pilot projects or programs should support this model, as it provides a sound basis for the integration of care.

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5. References

[1] Australian Prudential Regulation Authority. Quarterly private health insurance membership and coverage September 2021. Sydney: APRA, 2021.

[2] Australian Institute of Health and Welfare. The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2015. Cat. no. IHW 147. Canberra: AIHW, 2015.

[3] Biggs A. Chronic disease management: the role of private health insurance (research paper). Canberra: Australian Parliamentary Library, 2013.

[4] Khoo J, Hasan H, Eagar K. Emerging role of the Australian private health insurance sector in providing chronic disease management programs: current activities, challenges and constraints. AHR 2019;43(5):572–77. doi: 10.1071/AH18164.

[5] Department of Health and Ageing. The national evaluation of the second round of coordinated care trials: Final report. Canberra: DoHA, 2007.

[6] Australian Medical Association. Private health insurance and primary care services. Canberra: AMA, 2006 (updated 2014).

[7] Section 172-5 of Act supports this principle. It sets out that agreements between a medical practitioner and an insurer must not limit the medical practitioner's professional freedom, within the scope of accepted clinical practice, to identify and provide appropriate treatments.

[8] Parnell S. Medibank Private to pick up GP costs in trial. The Australian. 10 January 2014.

[9] The Royal Australian College of General Practitioners. What is General Practice? East Melbourne, Vic: RACGP, 2022. Available at www.racgp.org.au/education/students/a-career-in-general-practice/what-is-general-practice

[10] The Royal Australian College of General Practitioners. Standards for Patient-Centred Medical Homes. East Melbourne, Vic: RACGP, 2016.