

# **‘No gaps’ health insurance: A gain for consumers or a windfall for specialists?**

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## **Abstract**

*Attempts to introduce contracts between the purchasers and providers of Australian health services in the 1990s in order to reduce the gaps, or ‘copayments’, that patients pay have met with limited success. However, the Harradine requirement that health funds introduce ‘no gap’ or ‘known gap’ policies by the middle of the year 2000 has raised a political storm within the AMA and set the funds and doctors in an adversarial position. This paper traces the history of ‘gaps’ and gap insurance, provides an interpretation of the present situation and speculates about likely outcomes.*

## **Introduction**

Australia has been relatively free of controversy over the way doctors are paid because no government since the 1940s has seriously challenged the autonomy which practitioners claim to set their own fees. At the present time, however, a storm appears to be brewing. The Commonwealth, the private funds and the profession may be on a collision course over fee-setting. The catalyst is the requirement, put forward by Senator Harradine as a condition of his support for the 30% private health insurance rebate, that health funds must be able to offer ‘known gap’ or ‘no gap’ policies for in-hospital medical services by the middle of the year 2000. To do this, funds and practitioners will have to enter into agreements on fee levels, a development opposed by the Australian Medical Association (AMA) and by some groups of specialists.

It is in the interests of consumers, of course, that fees be kept to a reasonable level. It is also in the interests of the Commonwealth and health insurance funds, both of which want to promote the attractiveness of private insurance. Under these circumstances, we might expect to see the funds, supported by the Commonwealth, driving a hard bargain

with specialists over fees. Such a stand would almost certainly lead to an intense dispute with the profession.

There is, however, an alternative strategy, which would avoid dispute: health funds could simply agree to pay whatever level of fees specialists ask for. This scenario seems the more likely because in-hospital medical costs are a small proportion of total fund expenditures. Moreover, recent events demonstrate that the Commonwealth is unwilling to grasp the nettle on this issue. The Health Insurance Amendment Bill (No. 4) 1998 proposed to allow funds to offer 'no gap' or 'known gap' insurance for both in-hospital and out-of-hospital specialist medical services, provided that contracts had been agreed between funds and specialists. At the request of the AMA, however, Cabinet agreed in February 1999 to withdraw the relevant sections of the Bill. If the Commonwealth and the health funds fail to bargain over fee levels, the result of the Harradine requirement will be a windfall gain in specialist incomes, which will be paid for by health insurance consumers.

## **The history of gaps and gap insurance**

Controversy over gap insurance has a long history. A 'gap' is the difference between the insurance benefit and the fee set by the doctor or, in other words, the out-of-pocket expenses or 'co-payment' borne by the patient. The gap emerged as an issue in the early 1950s when the Commonwealth entered the health insurance business, providing public subsidies for private health insurance and putting fee-for-service medicine on a firm financial footing for the first time. From the beginning of the voluntary health insurance scheme, the AMA insisted that insurance should not fully cover the gap. The ostensible reason was that if medical services were 'free', people might use them frivolously. Insurance funds were required to abide by a rule that the combined Commonwealth subsidy and fund benefit should not exceed 90% of the medical bill (Sax 1984, p 65). In fact, the AMA was aware that if benefit levels were to reach 100% of the fee, pressure would emerge for fee standardisation, a development which the profession did not want.

In practice, the gap or patient co-payment was always considerably more than 10% of the fee, hovering around 35% in the early 1950s and never falling below 30% (Deeble 1970, pp 55–6). The voluntary health insurance scheme operated according to a vague and unspecified rule of thumb called the 'one-third' formula. Approximately one-third of the fee was to be covered by private insurance, one-third by the Commonwealth benefit, with the remaining gap of around one-third to be met by the patient (Deeble 1982a, p 431). Over one-third of the fee for an expensive service was a heavy co-payment, which caused hardship for many people. In fact, for specialist care, especially procedures, the gap was frequently much more than one-third.

Thus, by the second half of the 1960s the health insurance system had become a hot political issue. At the centre of the debate was the large and unpredictable gaps that

patients were required to pay for both medical and hospital services. Deebie (1982a, p 432) has explained the medical side as follows:

*While most services were provided by GPs charging traditional, stable fees, these proportions [the 'one third' formula] could be maintained but specialisation produced increasing divergences. In the absence of a formal fee schedule or procedures for setting and adjusting fees, both the government and the insurance funds were reluctant to increase their benefits in the correct belief that it would simply induce further rises. By the early 1970s, the distribution of benefits was quite perverse – coverage was highest for the inexpensive and relatively predictable GP services, lowest for expensive and episodic specialist treatment.*

Out of the controversy of the 1960s emerged two major enquiries into the health system and a Labor Party proposal for national health insurance, later to be named Medibank. An independent Commonwealth Committee of Inquiry into Health Insurance (1969), chaired by Mr Justice Nimmo, reported in 1969. It made a plethora of recommendations, including a proposal that a set of 'most common' medical fees be established and incentives put in place to encourage doctors to adhere to them (Kewley 1973, p 505). The report gave rise to the Gorton reforms of 1970, the first attempt in Australia to regulate the size of the gap for medical fees.

## Regulating the gap

Under pressure to take action on behalf of consumers, especially in the light of Labor proposals, Prime Minister Gorton announced in his 1969 election policy speech that a scheme would be introduced under which the gap would be no more than \$5 where a doctor charged the 'most common' fee. While the AMA cooperated in the compilation of a set of common fees, it had no power to force members to abide by such fees. Moreover, a severe rift emerged within the profession, resulting in a group of general practitioners breaking away from the AMA to form the General Practitioners Society in Australia. Disagreement centred upon different fees for specialists and general practitioners for the same services, such as confinements and simple operations (Kewley 1973, pp 509–12). When asked what the situation would be when a doctor chose not to charge the most common fee, the Prime Minister issued what became known as his 'famous clarification':

*The AMA agrees with us, or I believe will agree with us, that its policy, and it will be its policy, to inform patients who ask what the common fee is, and what their own fee is, so that a patient will know whether he is going to be operated on, if that's what it is, on the basis of the common fee or not.*

Despite these problems and intense controversy within the AMA itself, the landmark Gorton reforms came into operation on 1 July 1970 (Sax 1984, pp 89–92).

Initially, between 75 and 80% of doctors adhered to the new fee schedules. Compliance, however, was bought at a price. One of the instructions given to the health department by the government was that the new schedule be set at a level higher than at least 70% of fees. It was anticipated that those doctors charging less than the schedule would raise their fees but there was no requirement for downward adjustment. It has been estimated that the average increase in fees for specialist services in the year between 1970 and 1971 was 36.7% (Scotton & Macdonald 1993, p 81). Moreover, no mechanism for fee negotiation had been put in place and, from 1971 onwards, the AMA recommended further large fee increases, much to the discomfort of the government (Kewley 1973, pp 518–25; Sax 1984, pp 92–5).

The result was a sharp rise in the cost of medical services. In the two years between 1969–70 and 1971–72, total expenditure on medical services more than doubled, from \$56 million to \$127 million. The proportion met by the insurance funds remained stable, but the proportion met by the Commonwealth increased from 29.8% in 1969–70 to 44.5% in 1971–72 (Kewley 1973, pp 524–5). Thus for the privately insured patients of those doctors who chose to adhere to schedule fees, gaps were reduced to an average of 19% in 1972–73 and became predictable for the first time (Deeble 1982b, p 715). The uninsured, about 20% of the population at the time, derived no benefit. However, medical cooperation was bought at a high cost to the public purse. As Sax (1984, p 912) has argued:

*By injecting large amounts of federal funds, a politically attractive scheme was devised and the reluctance of doctors was overcome.*

## **Gaps under the Whitlam and Fraser governments**

If a government is to be able to offer health insurance under which gaps are known and predictable, it needs to have control over increases in medical fees. Where there is no control, governments are forced either to increase expenditure whenever fees rise or to allow gaps to increase. In this respect, the Whitlam Government was in no better position than its predecessors, the Gorton and McMahon governments. As Scotton and Macdonald (1993, p 85) have argued, Labor's 'capacity to provide effective health insurance depended on its willingness to raise benefits in line with fees over which it had no control'. The AMA knew this and continued to adopt 'an aggressive stance on fees' (Sax 1984, p 110) in the 1972–75 period. Acting unilaterally, increases of 25–29% over 1972 fees were announced in May 1973. Further increases came into effect in late 1974 and early 1975 and, in April 1975, the AMA announced a further 12.5% rise to take effect from 1 July. During the same period there was a sharp decline in the number of doctors adhering to the list of schedule fees. One of the outcomes was that, by 1975 when Medibank was about to come into operation, the gaps between the fees actually charged and the schedule of benefits were much wider than intended (Sax 1984, pp 108–13).

And so it is that even under national health insurance, first under Medibank and now under Medicare, patients still face unpredictable and often large gaps between the schedule of benefits and the fee charged, in cases where the doctor does not 'bulk bill'. (Bulk billing is the system whereby the doctor does not charge the patient but instead sends the account directly to the Health Insurance Commission which pays a reimbursement of 85% of the schedule fee.) Unlike Canada, which outlawed billing in excess of the schedule fee under the *Canada Health Act 1984*, Australian doctors are permitted to charge whatever fee they choose for services to both publicly and privately insured patients (Gray 1991). In Australia, by contrast, the issue of the gaps faced by Medicare patients has not become political.

The gaps faced by the privately insured, however, and the availability of private gap insurance have been controversial issues since the Whitlam period. Under national health insurance (both Medibank and Medicare), private insurance for out-of-hospital medical services is not allowed. However, private insurance for the gap between the benefit and the schedule fee has been available for in-hospital medical services for most of the period. This form of insurance has the support of the AMA but has been frequently opposed by health policy-makers. The reason is that the existence of a gap to be paid by the patient is thought to be a deterrent to steep rises in medical fees. Under insurance, fee increases are paid for indirectly through higher health insurance premiums, rather than directly and visibly in the form of a payment to the doctor. For this reason, one of the recommendations of the Health Insurance Planning Committee (HIPC) 'Green Paper' in 1973 was that private medical insurance be prohibited. However, as a concession to the medical profession, which was fighting strenuously against the introduction of Medibank, the government decided not to accept the recommendation (Commonwealth of Australia 1973, pp 21–2, the 'White Paper'). As Scotton and Macdonald (1993, p 87) record:

*In setting the stage for the White Paper, Hayden also endeavoured to conciliate the medical profession by eliminating the features of the HIPC report which had attracted the most bitter opposition from the AMA. On 18 September he issued a press statement to the effect that, contrary to the proposal of the planning committee, private medical gap insurance be allowed.*

This provision remained in force until the introduction of Medicare in 1984, despite a recommendation in 1980 by the Fraser Government-appointed Jamison Committee of Inquiry that gap insurance be abolished (Sax 1984, p 168).

## **Gap insurance under Medicare**

Under Medicare, gap insurance was initially prohibited for all services, a policy strongly opposed by the AMA and procedural specialists. The reintroduction of gap insurance thus became one of the key demands of the profession for the settlement of the 18-month long New South Wales doctors' dispute in 1984–85. Once again, the government conceded and insurance was allowed for the gap between the benefit and the schedule fee for privately insured, in-hospital services (Pensabene 1985, pp 74–6).

In the early 1990s, controversy again broke out, this time over the size of the gaps that had opened up between schedule fees and the fees actually charged by many doctors. At the time, the decline in private insurance coverage had accelerated, due to recession. Supporters of a strong private sector were concerned that the size of gaps was undermining the attractiveness of private insurance. The health minister of the day, Senator Graham Richardson, was sympathetic to this argument and to other claims made by the private health insurance lobby. In December 1993 he took to Cabinet a set of proposals designed to bolster levels of private insurance. However, the package failed to gain the full 'in principle' support that was sought (Gray 1996, pp 594–6).

Subsequently, a discussion paper outlining the main proposals was circulated and a private health insurance task force was established in the then Department of Human Services and Health. Also formed was a Federal Labor Party Caucus – Australian Council of Trade Unions (ACTU) Working Group on Health to examine the proposals. The Minister's plans to introduce reforms, however, were curtailed when he suddenly resigned from politics in March 1994. The new minister was Dr Carmen Lawrence. Nothing was heard of the proposals from her office for several months.

In the meantime, the Labor Party Caucus – ACTU Working Group examined the policies in the discussion paper and was highly critical of them. On the question of gap insurance, the working group argued that it 'would allow most doctors to put their fees up...and would increase premiums by at least 9 per cent' (Labor Party Caucus – ACTU Working Group on Health 1994, p 28).

The Labor Government did not endorse the introduction of full gap insurance. However, in 1995, reforms designed to make private health insurance a 'better product' were introduced (Lawrence 1994). The legislation allows for the introduction of 'preferred provider' arrangements, under which health insurance funds may negotiate contracts with physicians and private hospitals to provide services at predetermined prices. The AMA, the Council of Procedural Specialists and the Australian Association of Surgeons strongly oppose the introduction of contracts (Gray 1996, pp 598–9). In the four years since it was enacted, the Lawrence legislation has had little impact on the health system. Only a small number of contracts with individual doctors have been negotiated and a few private hospitals, such as the Melbourne Private Hospital, have entered organised provider arrangements.

Although high out-of-pocket expenses continued to be thought to be a major factor in decisions to drop private insurance, no further action took place on either gaps or gap insurance until December 1998, when the Commonwealth introduced the Health Insurance Amendment Bill (No. 4) into Parliament. The Bill, designed to promote private insurance, initially proposed four main changes: that funds be allowed to offer loyalty bonuses; that gap insurance be allowed for in-hospital pharmaceutical services; that for certain procedures, insurance be extended to cover approved facilities owned by medical practitioners; and that full gap insurance for both in-hospital and out-of-hospital specialist services be available under specific conditions.

The main conditions were that there should be a contract or purchaser–provider agreement between a fund and a doctor, that there must be either no gap or a gap of a

known amount, and that contracts be open for public scrutiny (meaning that individual doctors would not be able to enter into secret deals with funds without the knowledge of colleagues or professional associations). Gap insurance was also to be offered as a separate product, in addition to existing packages (Senate Community Affairs Legislation Committee 1999).

The gap insurance provisions of the legislation were strongly opposed by the medical profession. The government is reported to have dropped plans to announce the policy during the 1998 election campaign, due to opposition from surgeons (*Sunday Times* 1999, p 2). In the first months of 1999 the AMA conducted a public campaign against the proposals and met with the Minister for Health to voice its concerns. A press article reports Federal President Dr David Brand's views that 'the AMA had fought a long battle against the introduction of contracts', and his warning that they 'could compromise the doctor-patient relationship by giving funds a greater say in clinical decisions' (Crouch 1999, p 13).

Perhaps more to the point, Dr Brand has publicly acknowledged that opposition to contracts centres upon the fact that 'they limit the fees that doctors can charge' (Coorey 1999, p 31). As Dr William Coote, Secretary General of the AMA, told the Senate Community Affairs Legislation Committee:

*The AMA has a longstanding policy that people should be able to buy insurance beyond that which is currently available [but] ever since the medical purchaser provider option was introduced into the act by Dr Lawrence when she was minister ... we have opposed that type of arrangement ... what we have labelled in our press releases as US style managed care. We have opposed that for the last four or five years and we still oppose it (Hansard, Community Affairs Legislation Committee, CA8).*

In response to the profession's opposition, the government withdrew the gap insurance provisions from the legislation in February 1999 (*Daily Telegraph*, 18 February 1999, p 2). Thus, for the moment, gap insurance has been taken off the centre of the political agenda. However, less than a year remains before the Harradine provisions must be implemented.

In the meantime, a dispute is raging within the AMA on an appropriate response to the present dilemma. The problem is as old as health insurance itself: neither governments nor health funds can offer insurance products with predictable and known gaps while doctors insist on complete autonomy to set their own fees. The present leadership of the AMA is consulting widely on opinions but a more militant group within the profession is dissatisfied with the stance being taken. Former President, Dr Bruce Shepherd, campaigned to unseat the President, Dr Brand, (Coorey 1999, p 31) but was defeated in this effort in August, 1999. The policies supported by the AMA will be decided in the coming months, but it seems certain that the introduction of contracts will continue to be vehemently opposed.

The health insurance funds, of course, would like to be able to offer more attractive insurance products and would welcome the expansion of private insurance to cover 100%

of medical fees. The present Commonwealth Government supports a strong private insurance sector but it is unwilling to meet the cost of raising benefits to reduce or eliminate medical gaps. The stage thus seems set for a political battle over the next 12 months. For the medical profession, the stakes are high: its aim is to retain full private, entrepreneurial practice rights, built on a foundation of large taxpayer subsidies. This anomalous but privileged position has long been lost in most other OECD countries.

Nevertheless, in Australia, indications are that the profession may yet again win a struggle over fees. As pointed out earlier, the government's recent withdrawal of gap insurance legislation shows an unwillingness to confront the profession. And the health insurance funds may well decide to pay what doctors ask rather than risk confrontation, because the amount of money involved is a small proportion of total business. In-hospital medical care costs are 17% of all Medicare payouts. Fund benefits for the gap between the Medicare benefit and the schedule are one-third of this sum, or approximately \$230 million, not a large amount of money. If funds were to agree to pay AMA fees, which is what the profession is asking for, the total sum involved would be \$790 million, a small proportion of health fund business but an average rise of about 80% in net specialists' incomes (calculations by Professor JS Deeble, Canberra, 28 April 1999).

Meanwhile, in relation to the gaps faced by patients, not a lot has changed since the 1960s. Gaps are still smallest for general practitioner services and largest for high-cost, episodic specialist services. And the gaps are growing wider, despite the huge increase in specialist incomes since the 1970s. In 1984–85, 76.9% of general practitioner services Australia-wide were billed at or below the schedule fee. Adherence increased to 83.5% by 1997–98. In contrast, specialist adherence to schedule fees has continued to decline from 73.8% to 56.4% during the same period (Commonwealth Department of Health and Aged Care 1998). If the profession wins its battle to have gap insurance arrangements based on AMA fees rather than schedule fees, then the income gain situation will be similar to that of 1970, when large percentage fee increases were built into the basis of the system. As Thelma Hunter (1968) argued about Australian health politics between the 1940s and the 1960s, 'the more it changes, the more it stays the same'.

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