Australian Competition & Consumer Commission

Report to the Australian Senate on anti-competitive and other practices by health funds and providers in relation to private health insurance

for the period
1 July 2003 to 30 June 2004

... eliminating gaps for hospital accommodatio services and in-hospit medical services ...

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Glossary

30% rebate	The Federal Government offers members of registered health funds a 30% rebate on their premium payments. This rebate is not means-tested and may be claimed through a person's tax return, as a direct payment from Medicare, or as a discount on the premium as it is paid.
ACCC	Australian Competition and Consumer Commission
Ancillary cover	A form of private health insurance that covers the cost of some non-hospital services such as physiotherapy or dental treatment.
Credentialing	The process used by health care providers to evaluate the qualifications and experience of health care professionals. Providers employ this process to ensure that health care professionals are fit to be appointed with regard to their training, skills, experience and level of competence.
Department	Australian Department of Health and Ageing
Gap	The difference between the benefit payable by a health fund and the cost of treatment.
Hospital cover	A form of health insurance that covers the costs of hospital treatment such as accommodation or medical fees for in-hospital services.
HPPA	Hospital Purchaser Provider Agreement. Refers to an agreement between a health fund and a hospital in relation to the price payable as full payment by the fund for the episode of care.
Lifetime Health Cover	Under this initiative, people who take out hospital cover with a registered health fund earlier in life pay lower premiums in comparison to those who join at an older age.
MBS	Medical Benefits Schedule. A schedule of medical fees set by the government. People can claim a rebate of 75 per cent of the MBS fee for in-hospital medical fees and 85 per cent of the MBS fees for medical fees incurred out of hospital, regardless of whether or not they are members of a health fund.
Medicare Levy Surcharge	An additional 1 per cent surcharge on the taxable income of high income earners who are eligible for Medicare and who do not have an appropriate level of hospital insurance with a registered health fund.
No gap/known gap	Arrangements by which a health fund covers all of the gap, or requires a member to contribute towards the gap but informs the member in advance of the amount that he or she will need to pay.
Ombudsman	Private Health Insurance Ombudsman
Part IV	Part IV of the *Trade Practices Act 1974* which prohibits a range of anti-competitive conduct.
Part IVA	Part IVA of the *Trade Practices Act 1974* which prohibits unconscionable conduct.

Part V	Part V of the *Trade Practices Act 1974* which provides for the protection of consumers including through the prohibition of misleading, deceptive or otherwise false trading practices.
Patient election	All Australian residents or eligible overseas visitors are entitled to elect to be treated as a public patient (free) or a private patient (responsible for paying fees) in a public hospital. National standards in relation to the forms used for this election have been developed.
PBS	Pharmaceutical Benefits Scheme
PHIAC	Private Health Insurance Administration Council
Private Patients' Hospital Charter	A guide issued by the Minister for Health and Ageing that sets out what it means to be a private patient in a public, private or day hospital. The charter also establishes what private patients can expect from doctors, health funds and hospital.
Second tier default benefit	An Australian Government initiative that sets the level of benefit payable to a hospital that does not have a contract with a health fund at 85 per cent of the average benefits currently paid by that health fund for the episode of care in comparable private hospital facilities with which the health fund has contracts.
The Act	*Trade Practices Act 1974*

Summary

This report is the sixth report prepared by the Australian Competition and Consumer Commission (ACCC) in compliance with an order agreed to by the Australian Senate on 25 March 1999 and amended on 18 September 2002. This Senate order requires the ACCC to provide a report of 'any anti-competitive practices by health funds or providers, which reduce the extent of health cover for consumers and increase their out-of-pocket medical and other expenses'.

This report covers the period 1 July 2003 to 30 June 2004. During this period the ACCC:

- commenced proceedings against the suppliers of a health-related product and finalised court action against a number of health funds
- authorised a small network of private hospitals to negotiate collectively with health funds
- commenced its review of the training and accreditation practices of specialist medical colleges
- made a significant contribution to the Health Services Advisory Committee.

In writing this report the ACCC sought contributions from 118 stakeholders and received 21 submissions. Some of the key issues raised are discussed below.

Key features guides

A number of funds queried the usefulness to consumers of key features guides. The ACCC believes that it is important that information provided to consumers allows them to make comparisons of different funds and products. This is particularly important where consumers transfer between funds.

If, as appears from the consistently adverse comments over several years, the key features guides are not an effective means of providing information to consumers, the ACCC would support the development of an alternative mechanism.

Exclusions and restrictions

The Private Health Insurance Ombudsman (the Ombudsman) also raised concern that consumers may not be receiving adequate information about the restrictions and exclusions applicable to particular health insurance products.

The ACCC considers that it is particularly important that health funds provide clear, straightforward information about health insurance products that are subject to restrictions and exclusions. Providing this information protects consumers against the problems associated with misunderstandings about the nature and extent of their insurance coverage, and minimises the likelihood of a dispute between members and funds.

Health insurance intermediaries

During the reporting period the ACCC became concerned about the conduct of some health insurance intermediaries. Intermediaries provide advice to consumers about health insurance products.

Some intermediaries represent to consumers that they are ‘independent’ or provide ‘impartial’ advice. It may be, however, that the advice provided by an intermediary is confined only to those health funds that provide a financial benefit to the intermediary. As a result, consumers may believe that an intermediary reviews the policies of every health fund when in fact it reviews only the policies of a very small number of funds.

The ACCC considers that this may raise concerns under the consumer protection provisions of the *Trade Practices Act 1974* (the Act), particularly those dealing with misleading or deceptive conduct. The ACCC has written to health insurance intermediaries, their industry association and health funds (who sometimes engage intermediaries as agents) raising these concerns and will continue to monitor the activities of intermediaries in this regard.

In addition, the ACCC understands that the health insurance industry is currently developing a code that would require private health insurance service providers—including funds, brokers and agents—to provide quality advice to consumers.

Portability

Portability of health fund membership was raised as a significant issue by a number of stakeholders this year. The ACCC supports the principle of portability and considers that it is an essential feature of the private health insurance system.

However, some stakeholders indicated that the practical operation of portability may be problematic in some circumstances.

For example, a number of stakeholders commented on an apparent problem with the use of portability during contractual disputes between hospitals and health funds. During one such dispute, members of a fund in dispute with a particular hospital group began transferring to other funds.

It was suggested that smaller funds may have found it difficult to accommodate a large number of transferring members, particularly where those members are already scheduled for hospital treatment.

In an attempt to address this difficulty, some funds may seek to impose restrictions on transferring members in these circumstances. Some stakeholders expressed concern that these restrictions may undermine the principle of portability.

The Ombudsman has prepared a discussion paper on issues relating to portability and it is currently the subject of industry consultation. The ACCC supports the Ombudsman’s efforts to work with the industry to reach a solution in this area.

Contracting between hospitals and health funds

As in previous years, a number of stakeholders (both funds and hospitals) expressed concern at ongoing difficulties in the contracting environment including:

- delays in the commencement of negotiations
- inappropriate negotiating tactics, such as the use of publicity
- 'take it or leave it' offers taking the place of genuine negotiation.

The ACCC understands that relativities in bargaining power may affect the outcome of Hospital Purchaser Provider Agreement (HPPA) negotiations. This is common in commercial dealings in all sectors and is not, in itself, unlawful.

However, in some circumstances the outcome of negotiations characterised by differences in bargaining power may support an inference that the Act has been breached, particularly where no legitimate commercial reason for certain outcomes is apparent. The provisions of the Act prohibiting the misuse of market power and unconscionable conduct in commercial transactions exist to ensure that parties do not use their bargaining power improperly. Parties who consider that such an improper use has occurred are welcome to contact the ACCC.

Again, as in previous years, concerns were raised about the efficacy of the Code of Practice that seeks to regulate contract negotiations between hospitals and health funds.

1 Introduction

1.1 Senate order

Section 29(3) of the Act provides that the ACCC shall comply with a requirement from either House of Parliament or a committee of either house or both houses to furnish information concerning the performance of the ACCC's function under the Act.

On 25 March 1999 the Australian Senate issued an order requiring the ACCC to table a report assessing anti-competitive or other practices by health funds or providers in relation to private health insurance. These reports were to examine six month periods.

The ACCC tabled its first report on 12 April 2000. Three other reports were tabled in accordance with the original Senate order.

On 18 September 2002 the Australian Senate amended its order. The order now reads that:

> [t]here be laid on the table as soon as practicable after the end of each period of 12 months ending on or after 30 June 2003, a report by the Australian Competition and Consumer Commission containing an assessment of any anti-competitive or other practices by health funds or providers which reduce the extent of health cover for consumers and increase their out-of-pocket medical and other expenses.

This report has been prepared in compliance with that order. It updates the ACCC 's five previous reports and focuses on conduct that has occurred during the period 1 July 2003 until 30 June 2004. Where indicated relevant developments since the end of the reporting period have also been included.

1.2 The ACCC

The ACCC is the statutory authority responsible for ensuring compliance with the Act. The ACCC also has responsibilities under other legislation.

1.2.1 The *Trade Practices Act 1974* (the Act)

Broadly, the objective of the Act is to enhance the welfare of Australians through the promotion of competition and fair trading and provision for consumer protection.

The Act prohibits certain anti-competitive conduct (including anti-competitive mergers) and unconscionable, misleading, deceptive or otherwise false trading practices.

In addition, the ACCC is able to 'authorise' parties to engage in conduct that might otherwise breach some of the competition provisions of the Act where it is satisfied that the proposed conduct results in a net public benefit. Authorisation provides immunity from legal action under the relevant provisions of the Act.

The ACCC or other parties may take action under the Act.

1.2.2 Application of the Act to the health sector

Since it was enacted in 1974, the Act has applied to incorporated medical and other health professionals' businesses. Unincorporated medical/health professionals and their associations are also subject to the competition provisions of the Act and the state and territory equivalent, the competition codes.

With regard to consumer protection, unincorporated medical and health professionals' businesses are caught by the operation of the state and territory fair trading acts that substantially mirror the consumer protection provisions of the Act.

1.3 Consultation process

The ACCC consulted relevant stakeholders in the preparation of this report. A list of the parties contacted, identifying those parties that provided a submission, is at Attachment A.

In total the ACCC contacted 118 interested parties including:

- private health insurance funds and related associations
- participants in the private hospitals sector
- consumer groups
- medical associations
- allied health organisations
- government agencies.

The ACCC also met with five key stakeholders.

The ACCC received twenty-one submissions. Seven submissions were received from private health insurance funds or related associations; three from the private hospitals sector; two from medical associations; two from allied health organisations; one from a medical supplier organisation; and six from government agencies.

This report has been prepared based on information contained in the submissions received or otherwise obtained by the ACCC during the normal course of its work.

2 Private health insurance in Australia

2.1 Private health insurance

Funding for Australia's health care system comes from a range of sources including the Australian Government, state and territory governments, health funds, individuals and other payers such as compulsory motor vehicle third party insurers.

Australians are able to elect to be treated as either public or private patients in the Australian health system. For public patients, the government's universal health care system, Medicare, will cover the cost of hospital care.

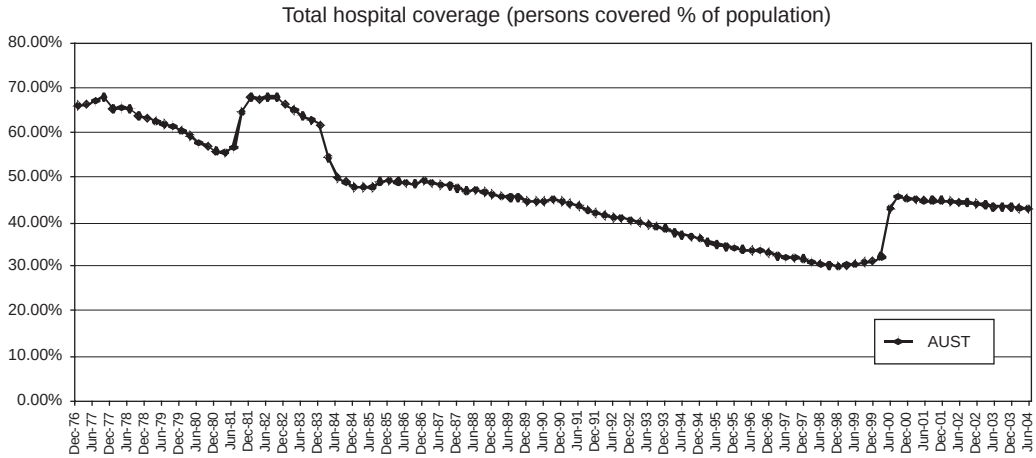
Australians may also elect to be treated as private patients. Private patients have, in general, more choice about certain aspects of their health care experience. For example, private patients may be able to choose their own doctor and decide whether to go to a public or to a private hospital attended by that doctor.

People may choose to insure against the potentially high cost of being treated as a private patient. Private health insurance also covers some health care costs not ordinarily covered by Medicare, such as chiropractic and dental treatment.

2.1.1 Percentage of Australians with private health insurance

As of 30 June 2004, 42.9 per cent of Australians held private health insurance hospital cover. Figure 1 demonstrates the change in this percentage over time.

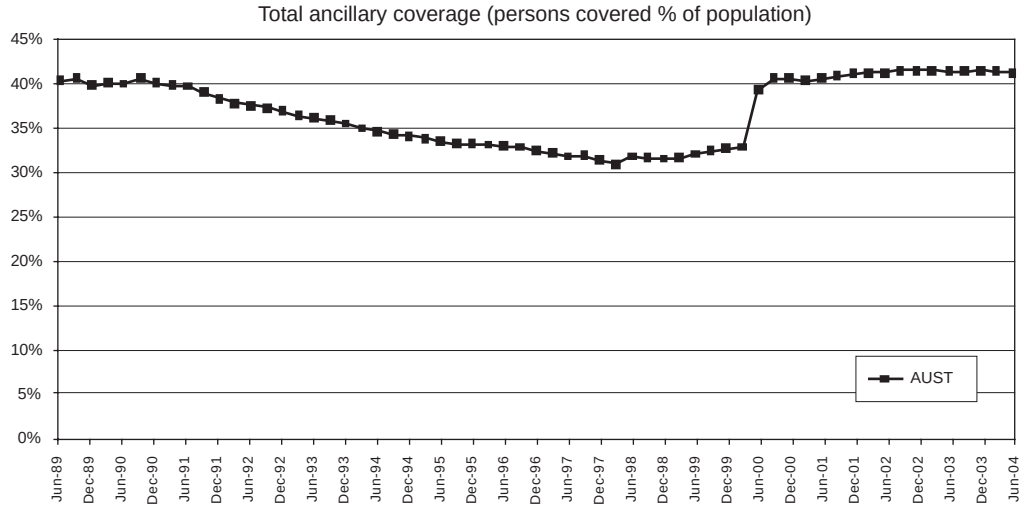
Figure 1 Australians with private health insurance (hospital cover)



Source: PHIAC, *Statistical Trends: Membership and Benefits*, June 2004.

As of 30 June 2004, 41.2 per cent of Australians held private health insurance ancillary cover. Figure 2 demonstrates the change in this percentage over time.

Figure 2 Australians with private health insurance (ancillary cover)



Source: PHIAC, *Statistical Trends: Membership and Benefits*, June 2004.

2.2 Health fund market

Private health insurance is provided by health funds registered under the *National Health Act 1953*. As at 1 September 2004 there were forty registered health funds. Five registered health funds operated on a 'for-profit' basis.[1]

Health funds are regulated by the Australian Government. The current regulatory regime adopts the principle of 'community rating'. This means that health funds cannot discriminate against people because of their age, sex or level of health risk. Health funds must therefore impose the same premium upon all members who purchase the same insurance product.

In addition, a 'reinsurance pool' operates to equalise risk within the industry. Health funds with a younger and 'healthier' customer base subsidise those with an older or less healthy profile.

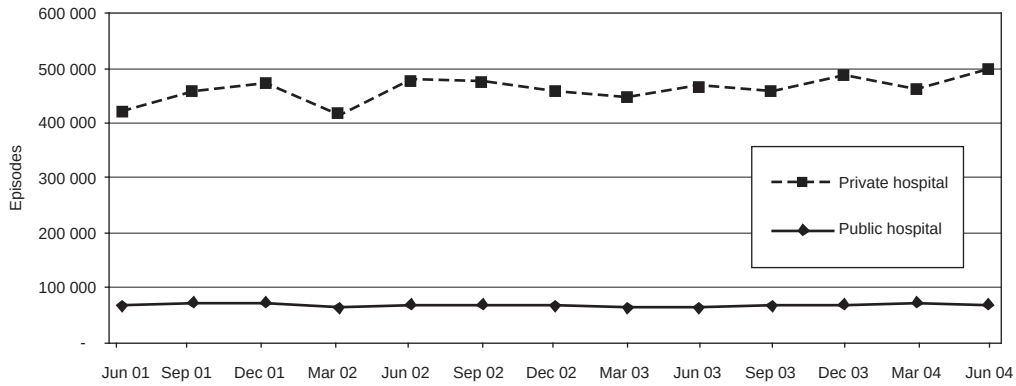
Finally, the Australian Government is able to regulate health funds through conditions imposed upon registration that relate to matters such as waiting periods, portability between funds, categories of membership and the types and levels of benefits. If the requirements are not met, a fund can be de-registered.

[1] Information sourced from PHIAC.

2.2.1 Number of insured hospital episodes

Figure 3 shows that while the number of privately insured hospital episodes in private hospitals appears to be rising again, the number of such episodes in public hospitals continued to decline slowly during the reporting period.

Figure 3 Privately insured hospital episodes (public and private hospitals)

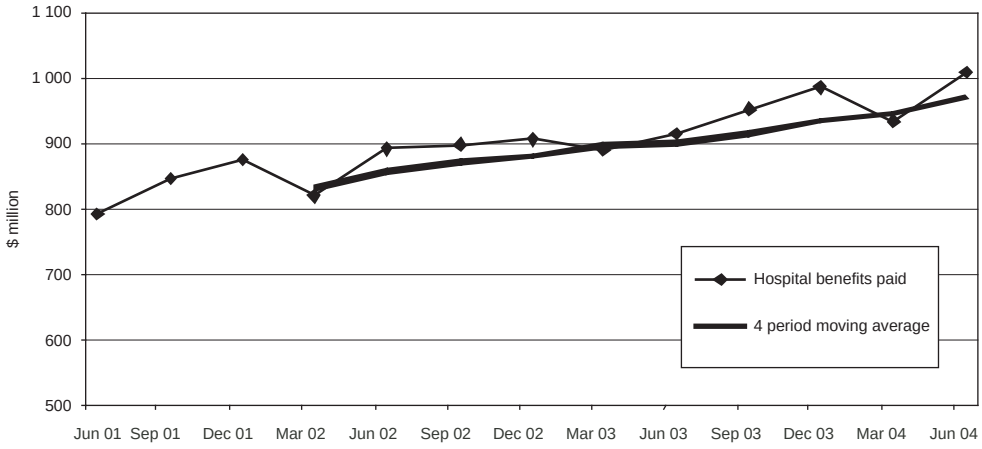


Source: Australian Department of Health and Ageing

2.2.2 Total hospital benefits

Figure 4 shows that irrespective of a drop in March 2004, the total hospital benefits paid by health funds including public, private, acute and nursing home type patients have increased over the reporting period.

Figure 4 Total hospital benefits paid

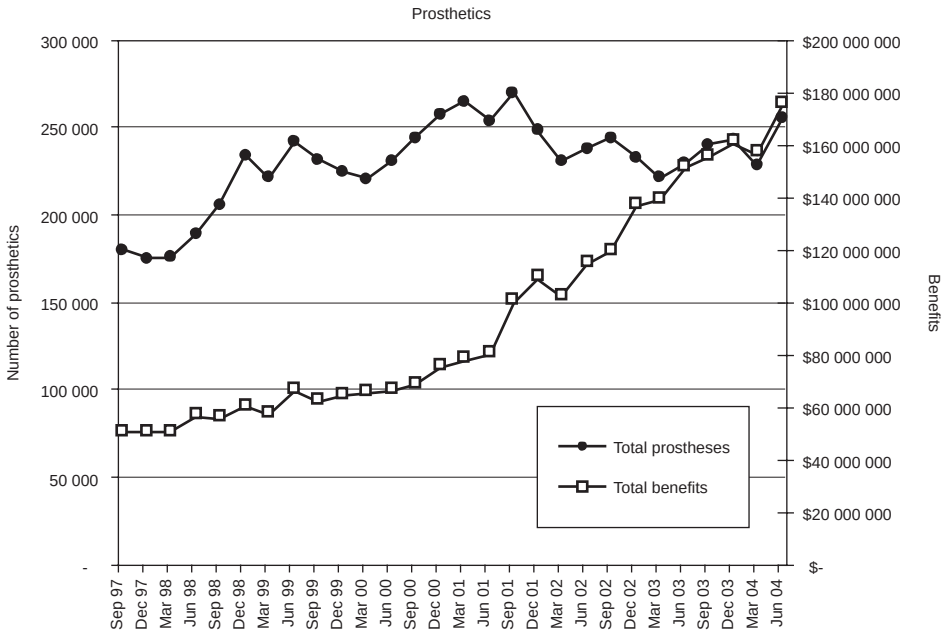


Source: Australian Department of Health and Ageing

2.2.3 Benefits paid in relation to prostheses

Figure 5 shows that the cost of the benefits paid in relation to prosthetic devices continues to escalate. Concerns about the increasing costs of prostheses and initiatives to address these concerns are discussed in chapter seven of this report.

Figure 5 Benefits paid in relation to prostheses



Source: PHIAC, *Statistical trends in membership and benefits*, June 2004

2.3 Developments in the regulation of private health insurance

In February 2004 the *Health Legislation Amendment (Private Health Insurance Reform) Act 2004* was passed. The Act provides for a number of changes to the regulatory framework for private health insurance. These changes and other developments that have occurred during the period are outlined below.

2.3.1 Lifetime Health Cover

The Health Legislation Amendment Act made the following changes to the operation of the Lifetime Health Cover initiative:

- a 'standard' birthday of 1 July is now used to calculate any Lifetime Health Cover loading
- veterans who hold a Gold Card issued by the Department of Veterans Affairs are deemed to have had hospital cover for the period they have had the card for the purposes of calculating any Lifetime Health Cover loading

- new migrants have a twelve-month period of grace in which to take out hospital cover without incurring a Lifetime Health Cover loading.

In addition, Australian citizens or permanent residents who spend time overseas or residents of Norfolk Island:

- do not incur a Lifetime Health Cover loading for any period greater than twelve months spent overseas provided they held hospital insurance before they went overseas
- do not incur a Lifetime Health Cover loading if they are overseas on their 31st birthday and purchase hospital cover by 23 April 2005 or the first anniversary of their return to Australia, whichever is later.

2.3.2 Increased powers of the Ombudsman

Since 27 February 2004 the Ombudsman has had increased powers to investigate complaints and resolve disputes and the power to make recommendations on matters arising from an investigation. The Ombudsman is also now required to produce an annual 'state of the health funds' report which will provide information on the performance of health funds.

The 'state of the health funds' report, and the Ombudsman's Annual Report, deal with a number of the issues considered by the ACCC in this report.

2.3.3 Rule changes

Health funds are now no longer required to submit non-premium related rule changes to the Department for approval before implementation. The approval process has been replaced with a system of monitoring based on performance indicators that aim to identify health funds in breach of their obligations under the *National Health Act 1953* and alert the Minister for Health and Ageing to practices that may be contrary to health policy.

2.3.4 Second tier default benefits

Second tier default benefits enable certain hospitals that do not have an HPPA with a particular fund to receive a default benefit of no less than 85 per cent of the average scheduled benefit payable by that fund to comparable hospitals.

In April 2003 the Minister for Health and Ageing announced that second tier default benefits would be phased out by 30 June 2004. However, the minister has now decided to retain second tier default benefits, subject to some changes designed to prevent the use of second tier default rates as a 'floor price' for contract negotiations between funds and hospitals.

Under the revised arrangements health funds will no longer be required to provide copies of their second tier rates to hospitals on request nor will they be required to provide their rates to other funds.

This issue was commented on by a number of stakeholders and is discussed further in chapter four of this report.

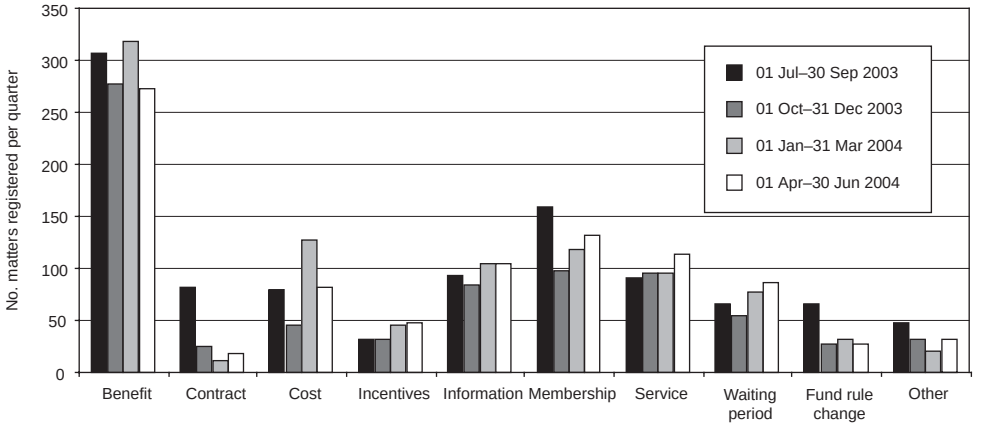
3 Complaints

The ACCC is one of a number of organisations consumers may complain to about health related issues. Consumers with complaints or inquiries about private health insurance—or health funds, medical practitioners or hospitals—can also approach the Ombudsman and complaints about health care can be made to the health complaints offices in each state or territory.

3.1 Complaints to the Ombudsman

Figure 6 illustrates that the majority of complaints received by the Ombudsman during the reporting period related to the benefits payable to health fund members. Complaints about the cost of insurance (which typically peak around the time that premium increases are introduced) have dropped significantly since the ACCC's last report.

Figure 6 Complaints received by the Ombudsman



3.2 Complaints to the ACCC

Generally, the ACCC relies on complaints to draw its attention to possible breaches of the Act. Complaints received in relation to the health sector during the reporting period are shown in Table 1.

Table 1 Health related complaints received by the ACCC

1 July 2003 – 30 June 2004	Part IV	Part IVA	Part V	Other	Total
Health fund complaints	24	1	101	17	143
Hospital (including psychiatric hospital) services and nursing homes	25	2	44	14	85
General practice medical services	21	0	45	16	82
Specialist medical services	28	0	89	13	130
Dental services	5	0	28	4	37
Pathology services	3	0	2	0	5
Optometry and optical dispensing	5	1	47	4	57
Ambulance services	1	0	1	3	5
Physiotherapy and chiropractic services	8	1	8	3	20
Community health centres	1	0	6	0	7
Other health services	27	0	152	24	203
Total	**148**	**5**	**523**	**98**	**774**

During the last reporting period of 18 months duration, 1725 complaints about the sector were received, including 13 in relation to GST which is not included in this year's results. It appears that complaints about the sector have decreased significantly, taking into account the reduced duration of this reporting period (12 months instead of 18).

The main areas of complaints received during this reporting period were:

- advertising by health funds or statements by health fund staff
- premium increases or benefit changes by health funds, including inadequate notification of premium increases or benefit changes
- suspected arrangements between competing health funds, medical practitioners or other providers of health services.

3.2.1 Consumer protection complaints

Part V of the Act provides for the protection of consumers. During the reporting period, almost one fifth of the Part V complaints received by the ACCC about the health sector related to health funds. These complaints mainly alleged misleading or deceptive conduct by funds in their advertising and other promotional activities, and oral misrepresentations by health fund staff.

4 Health funds

This chapter examines competition issues in relation to the conduct of health funds and discusses consumer concerns relevant to the provision of private health insurance. Issues relating to hospitals, medical practitioners and suppliers are discussed further in subsequent chapters.

4.1 Consumer information

4.1.1 Premium increases

The number of complaints received about premium increases by both the ACCC and the Ombudsman declined during the period. The Ombudsman submitted that:

> A number of factors contributed to this decline, including the fact that increases were more in line with consumer expectations, there were few major changes to benefits and funds improved their letters to members advising of the increases.

4.1.2 Exclusions and restrictions

The Ombudsman submitted that:

> [h]ealth insurance is complex and complaints to the [Ombudsman's] office suggest that funds need to do more to ensure their members understand the product they have purchased.

Of particular concern to the Ombudsman were products that include restrictions or exclusions. The Ombudsman noted that the complaints received suggest that many consumers do not understand the restrictions or exclusions applicable to their policies.

> The Ombudsman believes that funds need to provide new and prospective members with an information sheet which explains any restrictions or exclusions in greater detail and a separate document or section in the membership application requiring an additional signature as the member's acknowledgement of the restrictions or exclusions applying to the product.

The ACCC considers that it is particularly important that health funds provide clear, straightforward information about health insurance products that are subject to restrictions and exclusions. Providing this information protects consumers against the problems associated with misunderstandings about the nature and extent of their insurance coverage and minimises the likelihood of a dispute between members and funds.

In addition, both the Ombudsman and the Australian Private Hospitals Association (APHA) raised concerns about the provision of exclusionary or otherwise restricted health insurance products to particular patients. For example, the Ombudsman suggested that exclusionary products may be suitable for younger members but may not meet their needs over time as the risk of particular health problems increases.

In light of these concerns the ACCC supports the Ombudsman's suggestion that funds should draw any restrictions or exclusions to the attention of members in the annual statements provided to them.

4.1.3 Quality of advice code

During the period the ACCC became concerned about the conduct of some health insurance intermediaries. Intermediaries provide advice to consumers about health insurance products.

Some intermediaries represent to consumers that they are 'independent' or provide 'impartial' advice. It may be, however, that the advice provided by an intermediary is confined only to those health funds that provide a financial benefit to the intermediary. As a result, consumers may believe that an intermediary reviews the policies of every health fund when in fact it reviews only the policies of a very small number of funds.

The ACCC considers that this may raise concerns under the consumer protection provisions of the Act, particularly those dealing with misleading or deceptive conduct. The ACCC has written to health insurance intermediaries, their industry association and health funds raising these concerns and will continue to monitor the activities of intermediaries in this regard.

In September 2002 the Australian Government agreed that the health insurance industry would develop a code that would require private health insurance service providers (including funds, brokers and agents) to provide quality advice to consumers. The Department of Health and Ageing submitted that:

> [t]he purpose of the code is to more closely align the practices of the private health insurance industry with those of other financial service providers, such as life and general insurers, who are subject to the Financial Services Reform provisions of the Corporations Act 2001.

The government also indicated that if the industry is not able to develop this code in a timely fashion, it is prepared to regulate this aspect of the industry. At this stage, an industry consultation process coordinated by the Australian Health Insurance Association (AHIA) has produced a draft version of the code to be considered further.

4.1.4 Key features guide

The department convened a working group to develop a template for a 'key features guide' to be produced by each health fund. The template and accompanying guidelines were released on 15 August 2001. The aim of these guides is to outline the key features of the products offered by a particular health fund, to allow consumers to compare the products available more easily. Most health funds have elected to produce a key features guide.

As in previous years, a significant number of health funds which made a submission indicated that the production of key features guides is an onerous burden on funds and of little benefit to consumers.

The department and other key stakeholders have agreed that a review of consumer documentation, including the key features guide, is necessary and will commence in 2004.

The ACCC believes that it is important that information provided to consumers allows them to make comparisons of different funds and products. This is particularly important where consumers transfer between funds.

If, as appears from the consistently adverse comments over several years, the key features guides are not an effective means of providing information to consumers, the ACCC would support the development of an alternative mechanism.

4.2 Health fund conduct affecting allied health practitioners

4.2.1 Preferred provider schemes

As in previous years, some allied health providers raised concerns about the operation of preferred provider schemes. In particular, these concerns related to:

- the process by and basis upon which providers are selected to participate in preferred provider schemes
- the process by and basis upon which providers' participation in such schemes is terminated
- the imposition of administrative burdens upon preferred providers, such as audit processes
- the information provided by funds to members in relation to preferred provider schemes.

As stated in a number of its earlier reports, the ACCC considers that preferred provider schemes are, in themselves, unlikely to breach the Act. Further, the decision to include or exclude a provider from a scheme can be a legitimate commercial decision for the health fund.

It is important that funds do not mislead consumers about the operation of preferred provider schemes. It is particularly important that health funds provide accurate information and do not misrepresent the benefits of preferred provider schemes when members who may have obtained a quote from a non-preferred provider approach the fund seeking rebate information. One particular concern that has been raised with the ACCC outside of the consultation process for this report is that funds may promote preferred provider schemes in a way that suggests attending a preferred provider will be cheaper for a health fund member.

It has been put to the ACCC that attending a preferred provider—and thus receiving a higher rebate—may mean that annual limits on benefits for a particular kind of treatment may be reached more quickly than would be the case if the member attended a non-preferred provider and received a lower rebate. This may support an inference that in some circumstances it may be misleading for a fund to promote preferred provider schemes to consumers as being a more cost effective option.

Finally, the ACCC is aware that during the reporting period at least one fund substantially rationalised its network of preferred providers. The ACCC did not receive any adverse comments on this during the consultation process for this report, nor did it receive any complaints about the process during the course of its normal work.

4.2.2 Regulation of allied health practitioners

In previous years stakeholders have raised concerns about the regulation of allied health practitioners. This year these concerns were less prevalent, although the Health Insurance Restricted Membership Association of Australia submitted that it saw

> some advantage to contributors for a government registration scheme that would determine the efficacy of alternative therapies and providers so that consumers could make a sound judgment on the provider of a service.

On 16 September 2003 the Minister for Health and Ageing wrote to the AHIA requesting that it consider developing a framework for the assessment of therapies to be covered by ancillary health benefits. A draft framework has been prepared by the AHIA and considered by the Department of Health and Ageing.

4.3 Portability

Portability arose as a significant issue during the reporting period with problems emerging in the practical implementation of the principles of portability.

4.3.1 Portability when HPPAs end

A number of stakeholders commented on an apparent problem with the use of portability principles during contractual disputes between hospitals and health funds. During one such dispute, members of the fund in dispute with a particular hospital group began transferring to other funds. One fund sought to impose certain restrictions on new members transferring from the fund in dispute.

The difficulties associated with accommodating a large number of transferring members was of particular concern to smaller funds. For example, St Luke's Health submitted that:

> [i]f a small to medium sized health fund is exposed to an unusually high number of transferring members with pre-existing conditions or even pre-booked hospitalisations, the effect on the fund could be catastrophic. The portability rule needs to include a high level of protection for the fund and its existing membership base.

At the same time, members are entitled to transfer between funds and expect to be able to obtain the same coverage from the fund to which they transfer. If a receiving fund imposes restrictions on those transferring members, this appears to undermine the principle of portability (see discussion of rule changes below).

In addition, some funds raised concerns that private hospitals going out of contract may encourage members to transfer to other funds with which that hospital has a contract. In this respect, BUPA Australia submitted that 'portability should not be able to be used as a weapon against health funds during contract negotiations'.

The department stated that:

> [t]he ability of gaining funds to withstand the financial impact of a large, unexpected increase in the number of claiming members is a valid concern raised by funds following a recent contract dispute. Managing the impact of contract disputes while simultaneously protecting the interests of consumers and funds, as well as improving the contract negotiation process to minimise disputes, are complex issues which the government is looking to the industry to address.

In view of these concerns, the Ombudsman advised that he has distributed a discussion paper on portability and has consulted with a number of stakeholders. The industry is now considering the Ombudsman's draft recommendations before they are finalised by the Ombudsman.

The ACCC supports the principle of portability and considers that it is an essential feature of the private health insurance system. However, the ACCC would be concerned if portability occasionally, in practice, undermined other important principles such as community rating or reasonable contract negotiations. The ACCC supports the Ombudsman's efforts to work with the industry to reach a solution.

4.3.2 Rule changes and portability

During the reporting period, one health fund introduced benefit limitation periods for psychiatric and rehabilitation benefits for members transferring from other funds. This occurred prior to the introduction of the new system for implementing rule changes without prior approval by the department. Some stakeholders expressed concern that this undermined the principles of portability.

The ACCC would be concerned if rule changes such as this were to have an adverse impact on portability and suggests that the department may wish to consider the interaction between such rules and the principles of portability.

4.4 Notifications

The notification process is a means by which immunity from legal proceedings in relation to some of the provisions of the Act may be obtained. For example, notifications may be lodged in relation to third line forcing or other forms of exclusive dealing.

Each notification received by the ACCC is assessed having regard to its effect on competition and the public benefits that are likely to flow from it. The ACCC will revoke a notification where it considers that it is not in the public interest to allow it to stand, pursuant to the statutory tests provided by the Act.

Immunity in relation to third line forcing conduct commences 14 days after the date on which the notification is lodged. Immunity in relation to other forms of exclusive dealing commences on the date on which the notification is lodged.

During the reporting period, the ACCC examined the following notifications in relation to health funds.

Australian Unity Health Ltd

On 13 November 2003 Australian Unity Health Ltd (Australian Unity) lodged a notification in respect of its proposal to offer consumers who purchase an Australian Unity health insurance policy a $50 voucher for Collingwood Football Club merchandise.

The notification was allowed to stand on 2 December 2003.

Buteyko Institute Method

On 1 September 2003 Michelle Debra Watson, a practitioner of the Buteyko Institute of Breathing and Health, lodged a notification in respect of her proposal to offer consumers who are members of Australian Unity a discount on the fee for a course in the Buteyko Institute Method.

The notification was allowed to stand on 10 September 2003.

Medibank Private and others

On 1 October 2003 Medibank Private lodged a notification seeking immunity for any potential liability it may have in relation to the proposal of several suppliers to offer goods or services (or discounts on goods or services) to Medibank Private PackagePlus members. Each of the suppliers also lodged a notification in respect of its involvement in the proposal.

The notifications were allowed to stand on 20 October 2003.

CBHS Friendly Society Ltd

On 21 June 2004 the CBHS Friendly Society Ltd (CBHS) lodged a notification seeking immunity for any potential liability it may have in relation to the Teachers Federation Health Ltd proposal to offer a discount on optical goods and services to CBHS members.

The notification was allowed to stand on 26 July 2004.

4.5 ACCC enforcement action

Medibank Private

The ACCC, under a delegation from the Australian Securities and Investments Commission, instituted proceedings against Medibank Private in the Federal Court on 26 October 2000, alleging false, misleading and deceptive advertising of its health insurance products around the time that lifetime health cover was introduced.

The ACCC alleged that:

- From early March 2000 Medibank Private advertised ‘no rate increase in 2000’ when the rates on these products increased on 1 July 2000.
- In August 2000 Medibank Private ran advertisements which offered 30 days free cover if members of competing health funds transferred to Medibank Private and questioned whether competing health funds waived waiting periods for members. A fine print disclaimer stated that conditions applied to the offer of 30 days free cover and that the only waiting periods waived were the two month waiting period and the six month waiting period for optical services. This advertisement ran for a two week period and only applied to new memberships within a stated period.

On 13 May 2004 the Federal Court declared by consent that Medibank Private's conduct in relation to both advertising campaigns was false misleading and deceptive or likely to mislead or deceive in contravention of the relevant sections of the *Australian Securities and Investments Commission Act 1989*.

The Federal Court also made orders by consent which required Medibank Private to publish corrective advertising in 13 newspapers. Medibank Private also agreed to establish a fund of $5 million. This fund will provide benefits to be paid to Medibank Private members for leading edge clinical intervention procedures normally ineligible for claims and which would not be likely to be funded from another source.

4.6 Mergers

MBF/NRMA Health

On 29 July 2003 the ACCC decided not to oppose the proposed acquisition of NRMA Health Insurance Pty Ltd (NRMA Health) by the Medical Benefits Fund of Australia Pty Ltd (MBF).

The ACCC considered that the proposed acquisition was unlikely to substantially lessen competition for a number of reasons including that the proposed acquisition would not appear to remove a vigorous and effective competitor and that customers had alternative sources of supply.

5 Hospitals

This chapter examines competition and other issues relevant to the relationship between health funds and hospitals, both private and public.

5.1 HPPA contracting with health funds

5.1.1 Background

Hospital purchaser provider agreement (HPPA) contracting allows funds to offer their members 'no gap' or 'known gap' policies for hospital services. A voluntary Code of Practice seeks to ensure that HPPA negotiations between health funds and hospitals are conducted in a fair and reasonable manner and aims to improve the efficiency of business arrangements between health funds, private hospitals and day hospital facilities. The code also provides for a dispute resolution process.

Common trade practices issues arising in contracting have been summarised in previous reports.

5.1.2 Current situation

A number of stakeholders—both funds and hospitals—expressed concern at ongoing difficulties in the contracting environment, including:

- delays in the commencement of negotiations
- inappropriate negotiating tactics, such as the use of publicity
- 'take it or leave it' offers taking the place of genuine negotiation.

The Australian Private Hospitals Association stated that it was:

> most concerned at the continuing deterioration in the contracting environment. The basic problem is that the regulatory structure that underpins the contracting environment is flawed and requires fundamental reform.

Some funds and hospitals complained that they were specifically disadvantaged in terms of their bargaining power, e.g. where a smaller party is negotiating with a larger party.

The ACCC understands that relativities in bargaining power may affect the outcome of HPPA negotiations. This is common in commercial dealings in all sectors and is not, in itself, unlawful.

However, in some circumstances the outcome of negotiations characterised by differences in bargaining power may support an inference that the Act has been breached particularly where no legitimate commercial reason for certain outcomes is apparent. The provisions of the Act prohibiting the misuse of market power and unconscionable conduct in commercial transactions exist to ensure that parties do not use their bargaining power improperly. Parties who consider that such an improper use has occurred are welcome to contact the ACCC.

5.1.3 The Code of Practice

As in previous years stakeholders questioned the efficacy and coverage of the Code of Practice in their submissions to the ACCC. A number of health funds noted with concern that a significant number of private hospitals are still not signatories to the code.

The Health Insurance Restricted Membership Association of Australia (HIRMAA) submitted that:

> [t]here is a need for an overhaul of the Code and certainly a need for a higher level of participation within the industry as signatories to the Code.

Some funds also questioned the efficacy of the code, with St Luke's Health submitting that:

> [t]he code of conduct as it currently stands is not a useful tool in the contracting negotiations and is very seldom, if ever, used as a support in negotiations.

The Australian Private Hospitals Association suggested that the code should be reviewed and that compliance with its provisions should be mandatory.

5.1.4 Second tier default benefits

The decision to retain second tier default benefits, through which hospitals that do not have an HPPA with a fund can obtain 85 per cent of the average benefits currently paid by that health fund for the episode of care in comparable private hospital facilities with which the health fund does have a contract, was criticised by funds but welcomed by private hospitals.

The Australian Private Hospitals Association submitted that:

> the 2nd tier default benefit can be considered as an essential safety net for consumers, who will otherwise be faced with substantial out-of-pocket costs for their hospital care and treatment.

While health funds considered that the new arrangements were an improvement on the previous arrangements, they still expressed concerns that the second tier default benefit creates a floor price for hospital services and has had an inflationary effect on prices.

Concerns were also raised that some day hospitals may prefer to accept second tier default benefit rates and charge patients a co-payment rather than have ongoing contractual obligations to funds.

5.2 Patient election processes

Patients who are admitted to public hospitals can elect to be treated as private patients. Private patients who so elect are responsible for the payment of hospital charges, either personally or through their health insurance.

In previous years concerns have been raised with the ACCC about the administration of the patient election process by public hospitals. This year NSW Health advised that it has recently issued a standard in-patient election form and supporting information sheet to NSW public hospitals.

State health departments submitted that some public hospitals continue to have difficulty accessing timely eligibility information from health funds that is necessary if patients are to understand the financial consequences of their election decision.

Some public hospitals have also had difficulty with some funds refusing to accept apparently invalid or incomplete patient election forms. Queensland Health submitted that:

> [t]his is particularly concerning in cases where the patient clearly expresses their intention to be treated privately using their private health insurance, but their claims are rejected based on technical details. There needs to be some flexibility in the completion and acceptance by health funds of patient election forms given the circumstances of admission often involve trauma and stress and interfere with a person's ability to complete forms accurately on admission.

5.3 Authorisations

NSW Department of Health

On 1 November 2000 the ACCC received two applications for authorisation from the NSW Department of Health in relation to its policy requiring private in-patients in NSW public hospitals to obtain pathology services from NSW Health pathologists.

On 27 June 2003 the ACCC issued a final determination proposing to grant authorisation subject to conditions for a period of five years. The conditions imposed required NSW Health to allow doctors to seek second opinions from private pathology laboratories where this is in the best interests of the patients and to charge private in-patients the relevant Medicare benefit payable to the patient for pathology services.

On 17 July 2003 both NSW Health and the Australian Association of Pathology Practices (AAPP) lodged applications for review of the ACCC's decision with the Australian Competition Tribunal.

On 7 April 2004 the tribunal granted conditional authorisation for five years. The tribunal found that the detriments arising from the conduct, as varied by the condition, are likely to be minimal. The tribunal concluded that the conduct generates significant public benefits in the form of efficiency gains and funding of education and research, as well as the pathology service more broadly.

The condition allows doctors to refer to and seek second opinions from private pathologists where it is considered in the best interests of the patient and, unless impractical for medical reasons, the patient accepts that he or she will accept any out of pocket expenses associated with the test or second opinion.

Sisters of Charity Health Service, Mercy Health and Aged Care and Holy Spirit Care Services

On 21 October 2002 the Sisters of Charity Health Service Limited lodged applications for authorisation of a proposed agreement between:

- the Sisters of Charity
- Mercy Health and Aged Care (Mercy Health), and
- the Holy Spirit Care Services

to negotiate collectively HPPAs with health funds, to negotiate collectively with the Department of Veterans' Affairs and to negotiate collectively the purchase of a range of goods and services from suppliers.

On 5 March 2004, the ACCC granted authorisation for:

- a network of private hospitals to collectively negotiate with health funds and the Repatriation Commission (RC). The network initially includes hospitals owned by the Sisters of Charity, Sisters of Mercy and Holy Spirit Sisters, but may be expanded to include other Catholic private hospitals, subject to conditions—for example, that the network not comprise more than 40 per cent of a relevant market
- a subset of this network, being the five Sisters of Charity hospitals, to collectively boycott health funds and the RC
- the whole network of healthcare facilities including private hospitals to negotiate collectively with and collectively boycott their suppliers
- the members of the HPPA and joint purchasing networks to exchange fee, cost, price and other information.

Authorisation was granted for a period of five years.

6 Medical practitioners

This chapter focuses on the conduct of, and ACCC activities relating to, medical practitioners.

6.1 No/known gap arrangements

Since 1995 health funds have been permitted to pay benefits to members in excess of the MBS fee for medical services received in hospital and thus cover the medical gap where a negotiated agreement between the doctor and the fund, or the doctor and the hospital, existed and specified the price of the medical procedure.

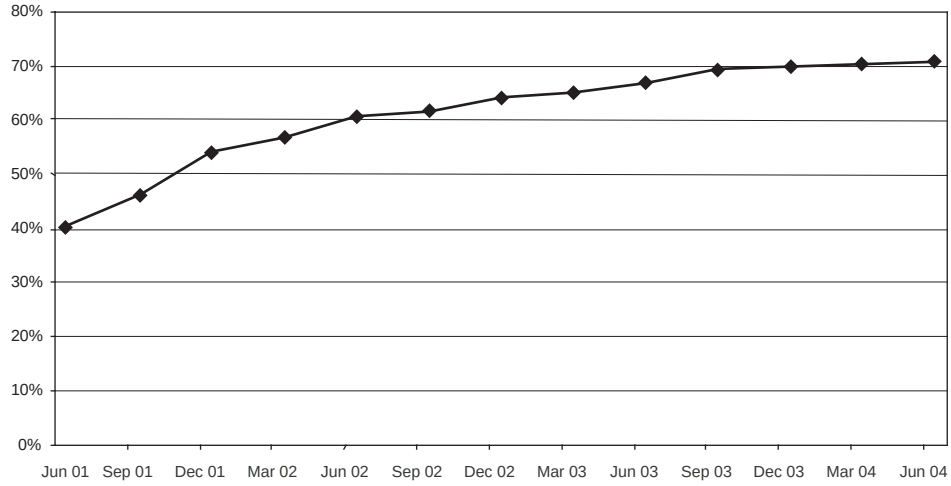
In addition, the *Health Legislation (Gap Cover Schemes) Act 2000* enables funds to cover the medical gap without the need for a negotiated agreement between funds and doctors. The Minister for Health and Ageing must approve gap cover schemes before they become operative.

This means that consumers can choose from a range of schemes, some of which cover the gap in its entirety (no gap) and some of which require consumers to meet part of the gap but inform them in advance of the amount that they will be required to pay (known gap).

6.1.1 No/known gap services

Figure 7 shows that the proportion of insured in-hospital medical services provided on a no or known gap basis has increased significantly over the past four years and now appears to be stabilising.

Figure 7 Proportion of insured in-hospital medical services provided with no or known gap



Source: Australian Department of Health and Ageing

6.2 Informed financial consent

The ACCC is of the view that medical practitioners have a duty to inform their patient about the cost of the services they provide, while consumers have a right to obtain information regarding these costs and, where possible, in advance of the services being provided.

6.2.1 Recent initiatives

In 2003 the Australian Government established the Informed Financial Consent Taskforce, an independent body whose members represent medical practitioners, health funds, private hospitals and consumers. The taskforce has submitted a strategic plan to the minister for approval that seeks to improve the incidence of informed financial consent for private-in-hospital medial services.

In addition, the Health Insurance Commission has developed an electronic system known as Eclipse, designed to facilitate the provision of informed financial consent. This system is currently in the process of being implemented with the support of health funds.

6.2.2 Booking/administration fees

A significant issue raised by stakeholders last year was the imposition of so called booking or administration fees by medical practitioners. It was submitted by some health funds that doctors who participate in no gap schemes but charge booking or administration fees undermine the integrity of no gap schemes.

This year, health funds raised similar concerns. HCF submitted that:

> [c]onsideration needs to be given to the introduction of specific reference in legislation and specific penalties for this practice as it is inflationary and subverts the efforts by governments and funds to reduce the gaps for medical services.

The Ombudsman submitted that a small number of complaints had been received about booking fees during the reporting period. The Ombudsman also submitted that:

> [t]he level of complaint [to the Ombudsman] does not assist in determining whether or not this practice is widespread. In most cases there is a significant disincentive for patients to complain about these arrangements. The Ombudsman will continue to monitor these complaints because of their potential to undermine gap scheme arrangements.

The Department of Health and Ageing submitted that in 2004 it intends to conduct a survey of health fund members who have recently received in-hospital treatment to determine the level of information about out-of-pocket expenses provided to those members. The survey will include a question on whether a booking fee has been charged.

6.3 Specialist medical colleges

In June 2003 the ACCC granted authorisation to the Royal Australasian College of Surgeons (RACS) for its processes in selecting, training and examining surgeons, accrediting hospitals to conduct training and assessing overseas-trained surgeons.

The authorisation was subject to conditions that required reforms to be made to existing college processes. The reforms were aimed at providing a greater role for governments in standard setting and implementation of the college's training and assessment processes, and improving the transparency of college processes.

At that time it also indicated it was considering its approach to the remaining specialist medical colleges. In late 2003 ACCC staff commenced developing this approach in collaboration with the Australian Health Workforce Officials Committee (AHWOC).

AHWOC and the ACCC have developed a set of principles drawn from the RACS decision to be applied to the other colleges and are now consulting each college on the extent to which its operations are in accordance with these principles.

6.4 Medical indemnity insurance

On 23 October 2002 the Prime Minister announced a package of reforms designed to address the issue of rising medical indemnity insurance premiums. As part of this package, the Prime Minister announced that the ACCC would monitor medical indemnity insurance premiums to determine whether they are actuarially and commercially justified.

The ACCC released the first of these monitoring reports on 29 December 2003. The report examined quantitative and qualitative information about premium setting arrangements, cost structures and the impact of government reforms provided by the five current providers of medical indemnity insurance.

Broadly, the ACCC found that premiums were actuarially justified for four of the five current indemnity providers, but was unable to determine whether the fifth provider's premiums were actuarially justified due to a lack of information supplied by the provider. The ACCC also found that in the current market environment, premiums sent by the five providers were considered to be commercially justified.

Copies of the report are available from the ACCC website at www.accc.gov.au.

The ACCC will produce a further two annual monitoring reports.

6.5 Health Services Advisory Committee (HSAC)

The *Review of the Impact of Part IV of the Trade Practices Act 1974 on the recruitment and retention of medical practitioners in rural and regional Australia*, released in November 2002, highlighted the importance of communication between the ACCC and the medical profession regarding the requirements of the Act as it relates to the profession, and recommended the formation of an advisory committee to facilitate this communication.

Consequently, the Health Services Advisory Committee (HSAC) was established in September 2003 to act as a medium of consultation between the ACCC, doctors, relevant health professionals and health consumers to achieve a better understanding of and compliance with the Act.

HSAC meets quarterly and has been an effective forum for constructive dialogue and the exchange of information on issues relating to the effective administration of the Act that arise in the area of health service delivery.

The ACCC has worked closely with HSAC in the development of the *ACCC Info kit for the medical profession*—a package of information designed to provide doctors with guidance on doctors' rights and obligations under the Act, including in respect of medical rosters, fee setting and collective bargaining arrangements. Copies of the Info kit are available from the ACCC Infocentre on 1300 302 502 or from www.accc.gov.au.

7 Suppliers

This chapter focuses on the conduct of, and ACCC activities relating to, the suppliers of health products such as prosthetic devices.

7.1 Prostheses

7.1.1 Background

In February 2001 the Commonwealth deregulated the area of prostheses funding, allowing health funds to negotiate prices directly with suppliers.

In the past health funds have been required by regulation to meet the full cost of those prosthetic items listed by the Minister for Health and Ageing (known as Schedule 5 devices). This means that health fund members have not had to pay a gap for these prosthetic items. The cost of the items has been agreed through negotiation between the fund and the supplier of the relevant device.

However, for some time health funds have expressed concerns about the escalating costs of prostheses. Following a review of the regulatory framework for private health insurance, including the arrangements for the supply of prostheses, the Minister for Health and Ageing announced on 3 April 2003 a series of principles that were to be adopted in relation to new arrangements for prostheses.

7.1.2 Proposed new arrangements

Under the proposed new arrangements, health funds will be required to offer a range of prostheses at no gap to members, but will also be able to offer some prostheses with a gap payment to be made by the member. The listing of prostheses, benefit amount to be paid by funds for no gap prostheses and the maximum and minimum benefit payable by funds for gap permitted prostheses will be determined by the Minister for Health and Ageing.

A Prostheses and Devices Committee whose members represent clinicians, health funds, private hospitals, consumers, suppliers and the Department of Veterans' Affairs will make recommendations to the minister about listings and benefit levels. This committee will be supported by Clinical Advisory Groups comprised of clinicians who will provide advice on the clinical effectiveness of prostheses and a Benefits Negotiating Group which will advise on appropriate levels of benefits.

Broadly, under the new arrangements there will be at least one no gap prostheses available for any procedure. However, if a consumer and his/her doctor wish to use a more expensive prostheses, the consumer may need to pay a gap. The Department of Health and Ageing submitted that:

> [t]he new prostheses arrangements are expected to alleviate pressure on private health insurance premiums and are aimed at making health funds more efficient and to offer consumers better value private health insurance products.

The Bill that would have provided for the implementation of the new arrangements lapsed when parliament was prorogued. Legislation will need to be passed before the arrangements can be implemented.

The proposed new arrangements were cautiously welcomed by most stakeholders who provided submissions to this report. The Australian Health Services Alliance submitted that:

> [h]opefully the reform process will ensure a true negotiation process and will provide administrative savings for suppliers, hospitals and health funds. There should also be an opportunity to work with clinicians to introduce guidelines on the best use of very expensive technology such as defibrillator devices.

However, some stakeholders expressed concern at the slow implementation of the proposed arrangements. Others considered that there were some outstanding issues that still needed to be resolved.

Various industry participants have expressed concern about the way in which the proposed arrangements will be implemented. For instance, the MIAA was concerned that manufacturers are to be required to negotiate with health funds as a group. Hospitals were also concerned about their involvement with health funds in negotiating with manufacturers. Any competition issues such arrangements would normally raise will be resolved if the arrangements are implemented as intended under legislation.

7.2 Commission enforcement action

Baxter Healthcare Pty Ltd

On 1 November 2002 the ACCC instituted proceedings against Baxter Healthcare Pty Ltd alleging that it had misused its market power and engaged in exclusive dealing in the supply of medical products to certain Australian state and territory health purchasing authorities.

The ACCC alleged that Baxter had entered into long term, exclusive bundled contracts of between three and five years to be the sole or primary supplier of certain medical products associated with peritoneal dialysis, with each of the purchasing authorities in New South Wales, the Australian Capital Territory, Western Australia, South Australia and Queensland.

It is alleged that Baxter took advantage of its market power by structuring contractual terms for the supply of these products so that the purchasing authorities were required to acquire the products as a tied bundle of products if they wished to have the benefit of significantly lower prices.

The ACCC alleged that this conduct was engaged in for the purpose of damaging the company's competitors, in contravention of s. 46 of the Act. It is further alleged that the bundling of these products in long term exclusive contracts contravened the exclusive dealing provisions of the Act.

The ACCC is seeking penalties against the company, findings of facts, declarations, injunctions and orders for Baxter to review its trade practices compliance program. The Federal Court's hearing of this matter began in May 2004 and a judgment is expected shortly.

Advanced Medical Institute Pty Ltd

On 22 April 2002 the ACCC instituted legal proceedings against Advanced Medical Institute Pty Ltd (AMI) and its Managing Director, Mr Jacov Vaisman, alleging false, misleading and deceptive conduct in relation to the advertising and promotion of treatments for erectile dysfunction (impotence) and premature ejaculation.

AMI operates a number of clinics in capital cities and regional centres around Australia. The ACCC alleged that from February 2001 until April 2002, AMI made misleading representations about the suitability and effectiveness of its treatments and the nature of its services.

On 2 December 2003 the Federal Court declared that AMI breached the Act by making misleading or deceptive representations.

For example, AMI claimed that:

- its treatments would provide guaranteed results when no such results could be guaranteed
- no needles would be involved, when in fact self-injection treatments were regularly prescribed by AMI to some patients
- its treatments were suitable for men of all ages with almost any medical condition when in fact erectile dysfunction is less responsive to treatment when it appears in older men and men with certain conditions such as diabetes.

The court enjoined AMI from engaging in misleading and deceptive conduct in relation to the impotency treatments it formerly or presently supplies. The court also ordered that AMI publish corrective notices once a week in various newspapers circulating throughout Australia for six weeks, and implement a trade practices compliance program.

AMI also agreed to provide full refunds to more than 160 patients.

On 3 November 2004 the ACCC applied to the Federal Court for further orders against AMI and Mr Vaisman, alleging that they did not comply with one of the court orders. Under that order AMI and/or Mr Vaisman were to use their best endeavours to have published a corrective statement on the ninemsn internet site.

Advanced Medical Institute Pty Ltd, Philip Somerset and Ian Turpie

On 19 July 2004 the ACCC instituted proceedings against AMI, Philip Somerset of ColbyCo Media and Ian Turpie, alleging that they had engaged in misleading or deceptive conduct in relation to the advertising and promotion of a nasal spray for treating erectile dysfunction.

The ACCC allegations relate to advertisements that appeared in newspapers in various Australian cities bearing the headline ‘TV Star’s amazing confession’ which featured Mr Turpie.

AMI’s advertisements represented that its nasal spray had cured Mr Turpie of the effects of impotence or erectile dysfunction and improved his sexual potency. The ACCC alleges that these representations were not true.

The ACCC has also alleged that Mr Somerset and Mr Turpie were knowingly concerned in the misleading and deceptive representations.

On 1 September 2004 the ACCC action against Mr Turpie was resolved by consent. However, the action against AMI and Mr Somerset will be heard shortly.

David Zero Population Growth Hughes (Crowded Planet)

On 22 March 2002, following legal action taken by theACCC, the Federal Court found that David Zero Population Growth Hughes (trading as Crowded Planet) had engaged in misleading or deceptive conduct and made false representations about the supply of oral contraceptives through his Crowded Planet internet site.

The Crowded Planet site sold oral contraceptives over the internet without a prescription. The site did not disclose that the use of oral contraceptives could pose a significant health risk to some people, nor did it disclose that in both Australia and the United States—where the site's server was based—it is illegal to buy or sell oral contraceptives without a prescription.

Justice Allsop ordered that Mr Hughes be restrained from supplying oral contraceptives in Australia without disclosing relevant information, including that the supply of such products without prescription was illegal and that using oral contraceptives without obtaining medical advice can raise significant health risks. Mr Hughes is also restrained from supplying oral contraceptives to people in the United States.

In September 2003 the ACCC again took action against Mr Hughes alleging that he had not complied with Justice Allsop's orders by setting up a new website and offering contraceptives to persons in Australia and the United States.

On 30 April 2004 Justice Conti ordered that Mr Hughes be imprisoned for contempt for a total period of six months, two of those months to be served immediately and the remaining four to be suspended. Justice Conti also ordered that Mr Hughes was to transfer his website to the ACCC and the ACCC was to then publish a notice on the site advising consumers of the unlawful conduct.

7.3 Authorisations

Australian Self-Medication Industry

During the reporting period the ACCC considered an application for authorisation in relation to a code of conduct developed by the Australian Self-Medication Industry (ASMI) to prevent common cold and cough medicines containing pseudoephedrine from being used in the illegal manufacture of amphetamines.

ASMI members supply 98 per cent of all non-prescription medicines containing pseudoephedrine sold in Australia. The code requires suppliers of these products to monitor and report to law enforcement agencies all sales of stocks to pharmacies for the purposes of monitoring trends in the sale of these products. The code also requires suppliers to limit packaging size and promotional activities, and to support pharmacies in holding minimal stock of products containing pseudoephedrine.

The ACCC issued a final decision granting authorisation to the code on 22 October 2003.

Medicines Australia

During the reporting period the ACCC also considered an application for authorisation in relation to the Medicines Australia code of conduct for pharmaceutical manufacturers. The code seeks to regulate the provision information about prescription medicines to healthcare professionals and the public, and the provision of hospitality to healthcare professionals by pharmaceutical companies.

On 14 November 2003 the ACCC issued a final decision granting authorisation to the code, subject to conditions, for a period of three years.

7.4 Mergers

During the reporting period the ACCC considered three mergers in the medical supply industry.

Smith & Nephew/Midland Medical Technologies

On 19 March 2004 the ACCC decided not to oppose the proposed acquisition of Midland Medical Technologies Ltd, a manufacturer of metal-on-metal hip resurfacing products, by Smith & Nephew plc, an advanced medical devices company. The ACCC considered that the principal area of overlap between the two parties was in the supply of orthopaedic hip implants.

While the ACCC had some concern over the continuing aggregation of the orthopaedic hip implant market in Australia, the existence of a number of alternative suppliers led the ACCC to conclude that the proposed acquisition was unlikely to result in a substantial lessening of competition in the market for surgical orthopaedic hip implants.

Luxottica Group/OPSM Group

On 4 July 2003 the ACCC decided not to oppose the proposed acquisition of OPSM Group Ltd by Luxottica Group SpA. The proposed acquisition involved both a horizontal merger in the area of sunglass retailing and a vertical merger in the area of wholesale and retail supply of prescription frames and sunglasses.

The ACCC considered that the merged entity would still face competition at both the wholesale and retail levels and that it may achieve some efficiencies. Ultimately, the ACCC considered that the proposed acquisition was unlikely to substantially lessen competition in the relevant markets.

MIA Group Ltd/Hobart Radiology

On 3 July 2003 the ACCC decided to oppose the proposed acquisition of the radiology business and assets of Hobart Private Hospital by MIA Group Ltd, Australia's largest radiology company. Hobart Private Hospital is the last private radiology practice other than MIA in the Hobart region and was owned and operated by Mayne Health until it was sold to Healthscope in April 2003. Healthscope intends to withdraw from the provision of radiology services.

The ACCC concluded that the proposed acquisition would be likely to result in a substantial lessening of competition for the provision of radiology services for private patients in southern Tasmania. The proposal was withdrawn following the ACCC decision to oppose it.

7.5 Other activities

In February 2004 the ACCC again led a sweep of internet sites by national and international consumer law enforcement agencies. This year the sweep focussed on claims that are 'too good to be true'.

A number of websites providing misleading information about health products uncovered during the sweep were amended or taken down by traders after the ACCC raised its concerns.

Misleading claims identified by the ACCC included claims that sufferers of serious illnesses could be 'guaranteed' remission and claims that a weight-loss product was suitable for all ages, had no side effects and was effective in causing weight-loss without diet or exercise.

In total, more than 30 Australian traders removed or amended their websites in light of the ACCC's concerns. In addition, the supplier of one 'weight-loss' product provided a court enforceable undertaking to the ACCC that will prevent it from making misleading claims about the product in the future and requiring it to place corrective advertising on its websites and offer a full refund to any consumer that purchased the product.

Attachment A. List of stakeholders consulted

*denotes written and/or oral submission received

Private health insurance funds/association

ACA Health Benefits Fund

AMA Health Fund Limited

Australian Health Insurance Association Ltd

Australian Health Management Group

Australian Health Service Alliance Ltd*

Australian Unity Health Limited

BUPA Australia Health Pty Ltd*

CBHS Friendly Society

CDH Benefits Fund

Credicare Health Fund

Defence Health Ltd

Federation Health

Geelong Medical and Hospital Benefits Association Ltd*

Goldfields Medical Fund (Inc)

Grand United Health Fund

HCF*

Health Care Insurance Ltd

Health Insurance Fund of Western Australia

Health Insurance Restricted Membership Association of Australia*

Health Partners

Health Practice Committee

Healthguard Health Benefits Fund Ltd

Hospital Benefit Fund of WA (Inc)

Hospital Contribution Fund of Australia Ltd

IOR Australia Pty Ltd

Latrobe Health Services Inc

Lysaght Hospital and Medical Club

Manchester Unity

MBF

Medibank Private

Medical Benefits Fund of Australia Ltd

Mildura District Hospital Fund

Navy Health Limited

NIB Health Funds Limited

NRMA Health Pty Ltd

NSW Health Funds Association

NSW Teachers' Federation Health Society

Phoenix Welfare Association Ltd

Queensland Country Health Limited

Queensland Teachers' Union Health Society

Railway and Transport Employees' Friendly Society Health Fund

Reserve Bank Health Fund Friendly Society

SA Police Employees' Health Fund Inc

SGIC Health Ltd

St Luke's Medical & Hospital Benefits Association*

Transition Benefits Fund Pty Ltd

Transport Friendly Society

United Ancient Order of Druids

Western District Health Fund Ltd

Private hospitals sector

Australian Private Hospitals Association Limited*

Catholic Health Australia

John James Memorial Hospital*

Mayne Nickless Ltd

Montserrat Day Hospitals

Private Hospitals Association of Queensland*

Private Hospitals Association of WA Inc

Ramsay Health Care Ltd

Consumer Organisations

Australian Consumers' Association

Consumers' Federation of Australia

Consumers' Health Forum

Medical Associations

Australasian Day Surgery Association

Australian Association of Surgeons

Australian Doctors' Fund

Australian Medical Association Limited

Australian Medical Association (ACT) Limited

Australian Medical Association (NSW) Limited

Australian Medical Association (NT) Limited

Australian Medical Association (QLD) Limited

Australian Medical Association (SA) Limited

Australian Medical Association (Tasmania) Limited

Australian Medical Association (VIC) Limited

Australian Medical Association (WA) Limited

Australian Orthopaedic Association

Australian Society of Anaesthetists Ltd*

Australian Society of Otolaryngology

Australian Society of Plastic Surgeons Inc

Cardiac Society of Australia and New Zealand*

Committee of Presidents of Medical Colleges

Doctors Reform Society

National Association of Specialist Obstetricians and Gynaecologists

Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Royal Australian College of General Practitioners

Suppliers

Medical Industry Association of Australia*

Allied Health Organisations

Association of Massage Therapists Australia Inc

Australian Association of Occupational Therapists

Australian Association of Pathology Practices Inc

Australian Dental Association*

Australian Natural Therapists Association Ltd

Australian Osteopathic Association

Australian Physiotherapy Association

Australian Podiatry Council

Australian Psychological Society Ltd*

Chiropractors' Association of Australia (National) Limited

Dieticians Association of Australia

Federation of Natural & Traditional Therapists Ltd

Optometrists Association Australia*

Pharmaceutical Society of Australia

Pharmacy Guild of Australia

Speech Pathology Association of Australia

Government agencies

Community and Health Services Complaints Commission (ACT)

Consumer Policy Unit, Department of the Treasury (Commonwealth)

Department of Health (NSW)*

Department of Health (Western Australia)*

Department of Health and Ageing (Commonwealth)*

Department of Health and Human Services (Tasmania)*

Department of Health, Housing and Community Care (ACT)

Department of Human Services (South Australia)

Department of Human Services (Victoria)

Health Care Complaints Commission NSW

Health Complaints Commission

Health Rights Commission

Health Services Commission

National Competition Council

Private Health Insurance Administrative Council

Private Health Insurance Ombudsman*

Queensland Health*

State Ombudsman South Australia

Territory Health Services

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June 2002 (ACCC's fourth report).

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