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 2007 to 30 June 2008
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Glossary

second tier  A government initiative that sets the level of benefit payable to a default benefit hospital that does not have a contract with a health insurer at 85 per cent of the average benefits currently paid by that health insurer for the episode of care in comparable private hospital facilities with which the health insurer has contracts.

AHIA  Australian Health Insurance Association

ancillary cover  A form of private health insurance that covers the cost of some non-hospital services such as physiotherapy or dental treatment.

CHF  Consumers’ Health Forum of Australia

code  Private Health Insurance Code of Conduct

DHA  Australian Department of Health and Ageing.

gap  The difference between the benefit payable by a health insurer and the cost of treatment.

HIRMAA  Health Insurance Restricted Membership Association of Australia

hospital cover  A form of health insurance that covers the costs of hospital treatment such as accommodation or medical fees for in-hospital services.

IFC  Informed financial consent

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 insurer.

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 insurer.

no gap/known gap  Arrangements by which a health insurer covers the entire gap, or requires members to contribute towards the gap, but informs members in advance of the amount that they will need to pay.

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).

PHI Act  Private Health Insurance Act 2007

PHIAC  Private Health Insurance Administration Council

PHIIA  Private Health Insurance Intermediaries Association

PHIO  Private Health Insurance Ombudsman

RDAA  Rural Doctors Association of Australia

SIS  standard information statement

the Act  Trade Practices Act 1974
Summary and overview

This is the tenth report prepared by the Australian Competition and Consumer Commission 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 insurers or providers, which reduce the extent of health cover for consumers and increase their out-of-pocket medical and other expenses’.

2007–08 report

This report covers the period 1 July 2007 to 30 June 2008. In writing this report the ACCC sought contributions from 108 stakeholders and received 13 submissions. The key issues raised are discussed briefly below.

Portability

As with the previous report, portability of health insurer membership was a relatively minor issue in this year’s submissions compared with earlier years. The ACCC considers that this is due at least in part to the clearance certificate process for transferring policyholders and the requirement that insurers not impose benefit limitation periods on transferring members or their dependants.

Contracting between hospitals and health insurers

Contracts and contract negotiation were not raised as major issues for this report to the same extent as they were in previous years. However, the second tier benefits scheme and preferred provider schemes continued to be concerns for some stakeholders.

Overview of reporting period

A number of issues have been identified over the period covered by the 10 reports, but the nature of the issues has changed with the development of the industry and the maturation of the market and the regulatory regime. Two areas have remained key concerns:

- the availability of useful consumer information about private health insurance products and health services and their related costs
- contract negotiations between health insurers and health service providers.

Consumer information

Concerns have historically focused on the amount of information health insurer members receive either from their insurer or from health service providers about:

- benefit entitlements
- gap payment liabilities for different medical services or forms of cover
- informed financial consent (IFC) regarding the net costs of medical services after benefit payments, particularly those involving more than one provider
- exclusions and limitations on benefits
- portability of cover between insurers.
Overall complaints/inquiries received by the ACCC and the Private Health Insurance Ombudsman (PHIO) regarding consumer information decreased again in the reporting period. Both agencies consider that this may suggest a general improvement in providing information to consumers, and thereby likely improved compliance with the consumer protection provisions of the *Trade Practices Act 1974* (the Act) and other regulatory requirements.

Factors likely to have contributed to this include:

- ACCC and PHIO compliance action and communications strategies by the Australian Department of Health and Aging (DHA) and industry bodies in the health sector to improve disclosure
- the continuing development of IFC as a standard practice with health service providers and major efforts by government and industry bodies to promote its adoption
- increasing use of systems that provide information on service provider prices
- the ongoing implementation of a quality of advice code of practice by DHA.

The ACCC believes these factors should assist the health sector to continue to improve the level of information disclosure in the future.

**Contracting environment**

The contracting environment between health insurers and health service providers is still a primary concern for health service providers. As noted in the previous report, an increasingly transparent and competitive commercial environment has led to an increasingly intense negotiating process between insurers and service providers. Even though 31 out of 38 registered and operating health insurers do not operate ‘for profit’, insurers appear to be functioning on an increasingly commercial footing. While the transition has been challenging for a number of health service providers, the views in some submissions appear to indicate a developing maturation of the market and recognition of its structure and dynamics.

In the past, this transition experience has led to complaints to the ACCC of anti-competitive conduct. However, as for the previous report, investigations by the ACCC have not found evidence that the anti-competitive provisions of the Act were breached. That said, the ACCC still encourages parties who consider that a potential breach of the Act has occurred to contact us. Any such complaints will be considered seriously under the provisions in the Act that prohibit the misuse of market power, unconscionable conduct and some forms of exclusive dealing in commercial transactions.
1. Introduction

1.1 Senate order

Section 29(3) of the Trade Practices 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 insurers 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:

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

The full text of the Senate Procedural Order can be found at appendix A.

This report has been prepared in compliance with that order. It updates the ACCC’s nine previous reports and focuses on conduct from 1 July 2007 to 30 June 2008. 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 Trade Practices Act

Broadly, the objective of the Act is to enhance the welfare of Australians by promoting competition and fair trading and providing for consumer protection. The Act prohibits certain anti-competitive conduct (including anti-competitive mergers) and unconscionable, misleading, deceptive or otherwise false trading practices.

The ACCC is also able to ‘authorise’ parties to engage in conduct that might otherwise breach some of the competition provisions of the Act when 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 state and territory equivalent of the anti-competitive conduct provisions of the Act—the competition codes.

State and territory fair trading Acts that substantially mirror the consumer protection provisions of the Trade Practices Act apply to unincorporated medical and health professionals’ businesses.

1.3 Consultation process

The ACCC consulted relevant stakeholders in the preparation of this report. A list of the parties contacted by the ACCC is at appendix B.

In total, the ACCC contacted 108 interested parties, including:

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

The ACCC received 13 written submissions: four from private health insurance insurers or related associations; two from medical associations; two from consumer/advocacy organisations; three from government agencies; and two from organisations representing parties that supply goods or services to the health insurance or health services industries. In 2007 the ACCC received 22 written submissions and, in 2006, 18 submissions.

This report has been prepared using information contained in the submissions received by the ACCC, or otherwise obtained by the ACCC during the normal course of its work.
2. Private health insurance in Australia

2.1 Numbers of Australians with private health insurance

As at 30 June 2008, 9,533,979 Australians held private health insurance hospital treatment cover. This is an increase of 389,334 from 30 June 2007. This equates to an increase of 1.1 per cent of the Australian population. Chart 1 demonstrates the change in percentage over time.

Chart 1 Australians with private health insurance cover

Source: Australian Government Private Health Insurance Administration Council.

As at 30 June 2008, 10,646,897 Australians held private health insurance general treatment (ancillary) cover. This is an increase of 909,703 people from 30 June 2007. This equates to an increase of 3.5 per cent of the Australian population. Chart 2 demonstrates the change in percentage over time. The introduction of the Private Health Insurance Act 2007 (the PHI Act) caused an artificial increase in the numbers of general treatment policies. This was a ‘technical’ result caused by changes in definitions and reclassification of policies.
2.2 Health insurer market

Private health insurance is provided by health insurers registered under the National Health Act 1953. As at 30 June 2008 there were 38 registered health insurers. Seven of the registered health insurers operated on a ‘for profit’ basis.

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

A specific exception to the community rating of private health insurance is the Lifetime Health Cover initiative, which began in July 2000. Under Lifetime Health Cover, health insurers may charge different premiums based on the age of each member when they first take out hospital cover with a registered health insurer. People who take out hospital cover early in life will be charged lower premiums throughout their life, relative to people who take out cover later.

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

The government is also able to regulate health insurers through conditions imposed on registration relating to matters such as waiting periods, portability between insurers, categories of membership and the types and levels of benefits. If the requirements are not met, an insurer can be deregistered.
2.3 Number of insured hospital acute episodes

Chart 3 shows privately insured episodes in both public and private hospitals. In private hospitals, privately insured episodes rose slightly over the reporting period. During the 2007–08 financial year there were 2,035,205 privately insured episodes in private hospitals. This is an increase of 108,143 or 5.12 per cent from the previous financial year.

In public hospitals, privately insured episodes also rose in the current reporting period. During the 2007–08 financial year there were 404,047 privately insured episodes in public hospitals. This is an increase of 37,484, or 9.28 per cent, from the previous financial year.

During the 2007–08 financial year there were 397,215 acute episodes in private day facilities. This is an increase of 37,403, or 9.42 per cent, from the previous financial year.

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

Source: Australian Government Private Health Insurance Administration Council.
2.4 Total hospital benefits

There was a net increase in the total hospital benefits paid by health insurers (including public, private, acute hospital-substitute, medical, prostheses and nursing home-type patients) during the 2007–08 financial year. The total amount of hospital benefits paid in the 2007–08 financial year was $7 419 562 574. This is an increase of $732 358 562, or 9.87 per cent, from the 2006–07 financial year. Chart 4 shows the total hospital benefits paid.

Chart 4 Total hospital benefits paid quarterly
2.5 Benefits paid for prostheses

Chart 5 shows that the cost of the benefits paid for prosthetic devices continued to escalate over the reporting period.

During the 2007–08 financial year the total amount of benefits paid for prostheses was $1 039 220 344. This is an increase of $111 075 025 (12 per cent) from the previous financial year.

Chart 5 Benefits paid for prostheses

Source: Australian Government Private Health Insurance Administration Council.
2.6 Benefits paid for in-hospital medical services

Chart 6 shows that the cost of the benefits paid for in-hospital medical services continues to escalate. During the 2007–08 financial year the total amount of benefits paid for in-hospital medical services was $1 183 233 120. This is an increase of $135 988 045, or 13 per cent, from the previous financial year.

2.7 Private Health Insurance Ombudsman the third health funds report

In March 2008 the PHIO published the State of the Health Funds Report 2007 for the 2006–07 financial year. The report provides comparative information on service delivery, complaints figures and health insurer finances and general information about health insurance policies. The PHIO noted in its submission that:

- The range of issues and performance information in the report was the same as in previous years and was chosen after taking account of the availability of reliable data and whether the data was reasonably comparable across insurers. Most of the information included in the report is based on data collected by the Private Health Insurance Administration Council (PHIAC).
- The report was generally well received by consumers and health insurers and was cited in a number of media articles during the year. The report provides consumers with more detailed information about private health insurance and the performance of individual insurers.
3. Complaints

Consumers may complain to several organisations if they have complaints or inquiries about health-related issues. The ACCC is one of these organisations. Consumers who have complaints or inquiries about private health insurance (or health insurers, medical practitioners or hospitals) may also approach the PHIO. Consumers who have complaints or inquiries about health may also approach health complaints offices in each state or territory.

3.1 Complaints to the Private Health Insurance Ombudsman

During the reporting period, the PHIO received 2385 complaints. This is an increase of 2 per cent from the previous reporting period. This is the first time in six years that the number of complaints received by the PHIO has increased.

The PHIO considers that the small increase in complaint levels occurred in the early part of 2008 and related to several issues that arose at that time, including insurer rule changes, complaints relating to demutualisation and associated share and cash allocations.

As a result of the introduction of the PHI Act, insurers were required to ensure that their policies and rules were compliant with the PHI Act by 1 July 2008. The PHIO noted in its submission:

In some instances, this meant that insurers had to remove benefits from some of their policies to ensure compliance with the PHI Act [e.g. funeral benefits that had been retained for historical reasons but were no longer eligible benefits under the current regime]. This led to a number of complaints from consumers about the removal of benefits from their policies. In some cases, insurers wrote to members advising that a number of benefits had been removed as a result of legislative changes.

While overall complaint numbers increased in 2007–08, there was a decline in the number of higher level complaints investigated by the PHIO during this period. This was a reversal of the trend over recent years of the PHIO receiving higher numbers of more difficult complaints.

Correction: the ACCC’s 2006–07 report to the Senate stated that the PHIO received 2374 complaints in 2006–07 and 2571 in 2005–06. This was incorrect and should have been 2340 complaints in 2006–07 and 2374 in 2005–06.

3.2 Complaints to the ACCC

The ACCC generally relies on contacts from members of the public and industry to identify possible breaches of the Act. During the reporting period, the ACCC received 627 contacts relating to the health sector as a whole. Table 1 shows the breakdown of contacts by industry. This data was extracted from the ACCC’s national database using the ANZSIC industry classification codes developed by the Australian Bureau of Statistics.
Table 1  Health-related complaints and inquiries received by the ACCC

<table>
<thead>
<tr>
<th>1 July 2007 to 30 June 2008</th>
<th>Part IV</th>
<th>Part IVA/B</th>
<th>Part V</th>
<th>Other</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other health care services (not elsewhere classified)</td>
<td>11</td>
<td>2</td>
<td>66</td>
<td>22</td>
<td>101</td>
</tr>
<tr>
<td>Specialist medical services</td>
<td>25</td>
<td>1</td>
<td>133</td>
<td>26</td>
<td>185</td>
</tr>
<tr>
<td>Health insurance</td>
<td>14</td>
<td>2</td>
<td>56</td>
<td>24</td>
<td>96</td>
</tr>
<tr>
<td>Optometry and optical dispensing</td>
<td>5</td>
<td>0</td>
<td>51</td>
<td>10</td>
<td>66</td>
</tr>
<tr>
<td>Hospitals</td>
<td>8</td>
<td>0</td>
<td>19</td>
<td>9</td>
<td>36</td>
</tr>
<tr>
<td>General practice medical services</td>
<td>7</td>
<td>4</td>
<td>28</td>
<td>17</td>
<td>56</td>
</tr>
<tr>
<td>Dental services</td>
<td>6</td>
<td>0</td>
<td>29</td>
<td>11</td>
<td>46</td>
</tr>
<tr>
<td>Nursing homes</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Pathology and diagnostic imaging services</td>
<td>2</td>
<td>0</td>
<td>7</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Chiropractic and osteopathic services</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Physiotherapy services</td>
<td>4</td>
<td>0</td>
<td>6</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Ambulance services</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>85</strong></td>
<td><strong>9</strong></td>
<td><strong>403</strong></td>
<td><strong>130</strong></td>
<td><strong>627</strong></td>
</tr>
</tbody>
</table>

The most common complaints made to the ACCC are complaints regarding:

- representations made to consumers about specific medical services and the effectiveness of certain treatments
- representations made to consumers by specialist medical providers about the full cost, likely rebates and/or cancellation policies associated with particular services or treatments
- disputes between consumers and their private health insurance insurer
- increases in health insurance premiums
- difficulties experienced by consumers in obtaining refunds or remedies from healthcare providers.

**Consumer protection**

During the reporting period, 96 of the contacts received by the ACCC related to private health insurance insurers. This is an increase of 3 per cent from the previous reporting period, where contacts for private health insurance insurers accounted for 12.3 per cent of the contacts and received about the healthcare industry overall.

Complaints about health insurers primarily related to disputes regarding the terms, conditions and cost of health insurance and consumers’ subsequent inability to obtain a satisfactory remedy.
Outcome of concerns

Of the 627 contacts recorded by the ACCC during the reporting period, 553 did not progress beyond an initial telephone call or email to the ACCC’s Infocentre. This is because these matters were:

- requests for information or for specific publications
- inquiries regarding the legitimacy of a trader, offer or product
- outside the ACCC’s jurisdiction, and more appropriately dealt with by another agency such as the PHIO, a state or territory office of fair trading or health complaints office
- within the jurisdiction of the ACCC but not a breach of the Act.

The remaining 74 matters progressed to an initial investigation\(^1\); of these matters, 55 required no formal action by the ACCC, four led to an ‘in-depth investigation’, two were resolved administratively and five were referred to a more appropriate agency. The remaining eight matters are still at the initial investigation stage.

After initial investigations have been undertaken, staff then determine whether a matter should be progressed to in-depth investigation status, which generally requires the deployment of significant resources.

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1 An initial investigation is the first stage of a detailed assessment to determine whether a complaint is a breach of the Act. The key decision to be made during the initial investigation is whether the matter should be escalated to an in-depth investigation. This involves determining what material is needed to make that decision and then collecting the necessary material.
4. **Private health insurance and consumer information**

This chapter discusses the provision of information to consumers about their health insurance policy or prospective health insurance policy.

### 4.1 Exclusions and restrictions

In recent years, only a small number of submissions have expressed concerns about exclusions and restrictions in health insurance policies. Only one submission to the 2007–08 report expressed concerns about exclusions and restrictions.

In its submission, the Australian Society of Plastic Surgeons raised concerns about health insurers placing restrictions on plastic and reconstructive surgery. The ASPS noted:

Health funds sell products which restrict access to certain item numbers from the MBS schedule. Restrictive policies which relate to obstetric services or cardiac services are readily understood, but those that relate to restrictions on Plastic and Reconstructive Surgery are less clear. This is largely due to confusion in the terms, plastic surgery and cosmetic surgery. In fact Cosmetic Surgery is part of the practice of Plastic Surgery. The result is that patients unwittingly restrict themselves from services relating to cancer, burns, trauma, to name but a few … For example a patient who has a skin cancer removed cannot have the defect reconstructed, or a patient who has had breast cancer cannot have the breast reconstructed.

The ASPS also raised concerns about health insurers only reimbursing private hospitals for one procedure when multiple procedures are performed at the same time. For example, a hospital treating a patient having a double breast reconstruction would only receive compensation for a single reconstruction.

The ASPS noted that these policies have the effect of penalising or discouraging hospitals from completing multiple procedures and may benefit the health insurer as they limit the amount that they are required to reimburse. As a result of these policies, some hospitals find that it is not economically viable to admit patients whose condition requires multiple procedures and are restricting the admitting rights of surgeons with such patients.

The ASPS noted:

This has already happened in Victoria and is currently happening in Western Australia where some surgeons have been asked to leave certain private hospitals so as the hospital can concentrate on procedures which allow the hospital to run more economically.

This severely limits patient choice of doctor and hospital, and disadvantages any patient that has a condition that a hospital would not consider economic. While one cannot blame the hospitals trying to run a business, the health funds are effectively skewing the delivery of health care by their inequitable funding arrangements.

The ASPS’s concerns were noted by the PHIO in its *State of the Health Funds Report* for the 2005–06 and 2006–07 financial years.
4.2 Informed financial consent

Informed financial consent (IFC) refers specifically to information on costs a health insurer member obtains before undergoing a particular procedure, treatment or series of treatments. It does not refer to broader information regarding the member’s decisions about which policy to purchase, their treatment or choice of health service provider.

The ACCC considers that consumers have a right to seek and obtain information about these costs—where possible—in advance of the services being provided. The ACCC also considers that healthcare providers and health insurers have a duty to provide consumers with information about the total cost of health services and the amount that they will be able to claim back from their insurer. All submissions supported the provision of comprehensive information to health insurer members and potential members.

Health insurers should provide clear, straightforward information about health insurance products, particularly where restrictions and exclusions apply. This information can help consumers’ understanding of their coverage and reduce disputes between members and insurers.

In its submission the Department of Health and Aging (DHA) noted that it worked with a range of stakeholders throughout the reporting period to promote IFC before the treatment of private patients.

In July-August 2007 the department undertook a consumer survey to measure the rate of IFC. The survey was sent to recent private hospital insurance claimants across all private health insurers. Similar surveys were conducted in 2004 and 2006. The Surveys show that in 2004 there was a gap (out-of-pocket cost) and lack of IFC in 21% of hospital episodes. This improved to 16% in 2006, and was 17% in 2007. While there has been some improvement since 2004, some people are still experiencing large, unexpected gaps.

The department continued to work with the Australian Medical Association to increase the incidence of IFC obtained by medical specialists with limited patient contact. The outcomes of this work included an online IFC training package for anaesthetists, workshops for practice managers around Australia, and the establishment of an Australian Diagnostic Imaging Association IFC website.

The department also worked with the Consumers Health Forum who facilitated a National Consumers and Stakeholder Forum 22-23 May 2008, which included a session for consumer representative groups on IFC.

The PHIO noted that there has been a decline in complaints regarding out-of-pocket costs over the past three financial years:

76 complaints were received about [out-of-pocket costs] in 2007/08, compared with 115 in 2006/07 and 125 in the previous Financial Year. There have been a number of initiatives at government and industry level to improve rates of IFC by medical practitioners. The reduction in complaints about medical gap issues to the PHIO in the last two years indicates that practitioners are improving their advice to consumers and seeking informed financial consent from patients.

The PHIO also noted that a recent Ipsos survey on IFC indicated that consumers still report a lack of IFC at higher levels. This indicates that there is room for improvement in relation to the provision of IFC by medical practitioners.
The PHIO also investigates cases where hospitals have not provided IFC to their charges. The PHIO noted that most hospitals now have procedures in place for checking the eligibility of health insurers and providing IFC to patients about any out-of-pocket costs they may incur.

The Australian Health Insurance Association (AHIA) supports the full and timely provision of cost information to patients, adding:

> The AHIA is concerned that almost one in five private patients still experience unexpected out-of-payment associated with their treatment, and that this number has remained relatively constant since 2004. Without IFC on the part of the treating medical practitioner, the health fund is unable to provide the patient with information related to what benefits they are eligible for and what out-of-pocket expenses, if any, they may experience.

In its submission, the Health Insurance Restricted Membership Association of Australia (HIRMAA) noted that it:

> has been and remains a strong advocate of rigorous Informed Financial Consent … HIRMAA contends that a rigorous IFC regime will only benefit consumers when insurers, hospitals and the medical profession share the same level of commitment.

HIRMAA stated that it will cooperate fully with any current and future government efforts to entrench IFC as a standard practice.

The Australian Dental Association (ADA) stated that:

> Health professionals have a responsibility to provide patients with appropriate information about costs but such health professionals should not have any responsibility to provide details as to the financial impact of “third party” arrangements between patients and others – such as health funds. Such responsibility must rest between those two parties only.

The ADA also noted that ‘business rules’ of health insurers could lead to unexpected denial of benefit payments. The ADA proposes that details of these business rules be openly disclosed to members. The ADA noted that the PHIO could assist by requiring insurers to provide this information and setting out insurers’ key business rules in its *State of the Health Funds* report.

The ADA noted that, generally, health insurers had not matched benefit levels for dental services to either the consumer price index or to premium increases for many years. Benefit payments to consumers have fallen in real terms and as a result out-of-pocket costs have increased. The ADA understands that premiums have increased by approximately 35 per cent since 2002 and considers that some of this increase should be passed on to members in the form of increased payments.

During the 2007–08 financial year, the Consumer Health Forum of Australia worked with a number of healthcare providers that are committed to providing IFC. Despite this, the CHF considered:

> The current compliance to IFC arrangements by health providers falls well short of what consumers require to ensure that consumers are able to make informed decisions about their health care … The challenge moving forward is to reach those providers who are less committed, to educate health professionals just entering their fields on the importance of IFC and to continue to promote awareness of IFC amongst consumers.
The CHF noted that a number of resources available to consumers are related to IFC, including brochures from the Australian Medical Association (AMA) and the PHIO. The CHF provided these resources to consumers during its private health reform projects. Consumers reported that the resources were useful but the majority of consumers had not previously had access to them.

The CHF recommends that health professionals be more accountable for ensuring that consumers are provided adequate and timely information, so that health care is provided with IFC. The CHF provided a number of options to ensure that health professionals are more accountable:

- incorporating IFC into professional registration
- directing the tertiary sector, colleges and other peak organisations for health professionals to promote better IFC practices among health professions through targeted promotion, awareness and education programs and active engagement with consumers to help shift attitudinal barriers
- implementing effective monitoring and reporting requirements for health professionals’ IFC processes and compliance
- involving private health funds in the promotion of consumer resources for IFC, including advice to check cover with health funds.

Health insurer the Hospital Benefit Fund of Western Australia stated that it strongly supports every patient receiving all necessary information before medical treatment to enable them to give IFC, with the exception of emergency cases where it is not possible. The HBF noted that ‘unexpected out of pocket costs, caused by lack of informed financial consent, are currently one of the major causes of discontent with private health insurance’.

The HBF noted that the provision of information on the costs of medical procedures is often out of the control of health insurers, as some members do not contact their insurer before treatment or admission:

[HBF believes] it is in the interests of members for the lead clinician involved in a medical procedure to inform each patient of an approximation of all the costs they will face during the procedure. Hence the lead clinician (often the surgeon) would provide information about not only his/her costs but also those of the anaesthetist, pathologist, and any other practitioners involved in a procedure. Where this is not possible, they should as a minimum provide the names of the other providers to enable the member to confirm directly with them any out of pocket expenses they can expect. Although Informed Financial Consent is now obtained in most cases, instances where it is not can place a serious financial impost on members. For this reason, HBF supports Informed Financial Consent by service providers being a legislated requirement.

The HBF also noted that in a recent member survey, a number of its members had been treated as private patients in public hospitals despite not having elected as private patients or not being aware that they had done so:

This indicates that even though signed election forms may have been obtained, the member’s choices are not being explained or the member may simply believe it is just another form required for admission.

The results of this survey so far clearly indicate that members are not being informed of all relevant information and the consequence of their election choice. HBF believes this issue needs to be addressed with strengthened requirements for provision of information during the election process being included in the new Australian Health Care Agreements being negotiated.
The Western Australian Office of Health Review receives a number of complaints each year that relate to IFC, noting that consumers generally tend not to ask their health insurer about their coverage, nor their medical practitioner about procedure costs or possible gap cover. The WAOHR also said its experience is that not many practitioners provide this information voluntarily. Lower benefits paid or larger gap payments than expected were common issues with anaesthesia, dental and prosthetics.

4.3 Quality of advice code

The Private Health Insurance Code of Conduct is a voluntary agreement among insurers, and is overseen by the health insurance industry with the support of the PHIO. The code aims to improve the performance of health insurers in the areas of staff training, consumer documentation, complaint management and privacy in their dealings with consumers. The code seeks to achieve this by setting out minimum standards for health insurers who are signatories to the code. At present, responsibility for implementing and administering the code lies with the health insurance industry associations, the AHIA and HIRMAA.

The ACCC supports the principles of the code. In the ACCC’s experience, the most successful codes enjoy support from all major stakeholders—not just those directly regulated or affected by the code. The ACCC continues to encourage the PHIO, health insurers and healthcare providers to engage in discussion and coordination of the code, particularly regarding the potential involvement of all parties affected by the operation of the code.

The PHIO noted that the overall number of complaints has gradually decreased in recent years. The PHIO believes this indicates that insurers’ internal complaint-handling procedures have improved and that the introduction of the code has been a factor in this improvement.

The AHIA noted that after three years of operation, 32 health insurers are now accredited for compliance with the code. The AHIA also stated that these insurers’ membership covers 98.8 per cent of private health insurance hospital treatment policies.

The PHIO noted in its submission that:

- The Code of Conduct introduced standards for health insurers as well as agents, brokers and other intermediaries acting on their behalf, in relation to the provision of advice about private health insurance to consumers.
- A majority of the 38 health insurers [are now accredited], with more insurers expected to be admitted to the Code in future.
- There has been a gradual reduction in overall complaints to the Ombudsman in recent years. This suggests that insurers’ internal complaint handling processes have improved and it is likely that the introduction of the Code will lead to further improvement over time.

HIRMAA noted that it is a strong advocate for the code and that its representative on the code implementation committee is the current chair. As at January 2008 a small number of insurers had not become signatories to the code and HIRMAA stated that it would support a campaign to have 100 per cent membership across the industry.
BUPA Australia noted its concern:

that there is no direct regulation of private health insurance brokers, unlike other financial service brokers. As a result, BUPA Australia’s view is that some brokers engage in sharp practice, misleading consumers about their objectivity in making recommendations and failing to disclose the existence of commercial arrangements that they have in place with particular insurers. In particular, BUPA Australia considers the propensity of online brokers to describe themselves as “comparators” to be inappropriate.

The CHF’s submission supported the broad principles of the code but had concerns relating to the consultative process by which the code was developed and the monitoring of compliance of health insurers with this self-regulatory system.

The CHF also called for the addition of a consumer representative, nominated by consumer networks, on the code compliance committee as a minimum initial step to achieve transparency:

The membership of this Committee is not transparent and CHF is concerned that such an appointment has not been made in the last twelve months. CHF would be pleased to nominate a consumer representative to work in this capacity to improve the Code as has been done, for example, with the Medicines Australia Code of Conduct Committee.

4.4 Other consumer information developments

4.4.1 Private Health Insurance Act and consumer information website

After the introduction of the PHI Act, the PHIO developed a website for consumers. This website (www.privatehealth.com.au) contains information about health insurance. The website was recently awarded Best Comparison Site in the annual NetGuide Australian Web Awards for 2007, recognising the site as being the best comparison service and giving visitors enough information to make informed choices. The DHA noted in its submission:

The Private Health Insurance Act 2007 and the Private Health Insurance (Complying Product) Rules require insurers to produce a Standard Information Statement for each of their policies. These statements contain key information in a standard format to allow consumers to compare products and make informed choices about their private health insurance cover.

The legislation requires insurers to provide newly insured persons with an up-to-date standard information statement for the policy they are insured under, and to provide each policyholder with an up-to-date standard information statement relating to their policy at least once every 12 months.

The PHIO considers the development and launch of the consumer website in April 2007 the most significant initiative that affected consumers’ understanding of health insurance products:

The website enables consumers to access independent and reliable information about private health insurance, as well as download and view Standard Information Statements (SISs) showing the main features of their own and other health insurance policies.

A significant challenge for the website was the upload of 16,000 revised health insurance policies following the approval of 2008 premium rates, which proceeded smoothly. The website currently receives an average of 650 unique visits a day and feedback from consumers continues to be positive.
The PHIO is able to organise targeted internet advertising to ensure consumers looking for private health insurance on the internet are aware of the website. This has become more important in the last twelve months, with the launch of several commercial health insurance comparison websites, as PrivateHealth.gov is the only independent comparison website for private health insurance.

Some modifications have been made to the appearance of the site to make it more consumer friendly. In March 2008, the website received an unsolicited award for the “Best Comparison Website”, voted for by the readers of “Netguide Magazine”.

The PHIO noted that the website will be reviewed in 2009 and it will continue to promote the website. The HBF stated that to comply with the required issue of standard information statements annually (and for detrimental changes), it issued SISs to members with their rate review notification early in 2008. The HBF noted that this resulted in more calls and complaints about the SIS than about the premium increase:

HBF estimates that the administrative costs of implementing SIS and managing ongoing member queries at over $350,000 to date.

Some of the common issues raised by members were that their own personal circumstances were not considered. For example, the maximum entitlements listed on the SIS are those for new members whereas members who have held cover for some years often receive higher maximum entitlements. Also, the SIS does not address every service covered under a member’s product. Many members called to confirm that they still had the additional benefits they believed they had and were unhappy that these were not accurately represented on the SIS.

While SIS may be a useful comparison tool for consumers new to private health insurance looking to compare products, they have created confusion for many existing members who are already well informed by funds’ normal product information.

In its submission, BUPA Australia noted:

Whilst there has been some progress in relation to SISs, [they] could be improved to achieve greater clarity for consumers. In particular, the format and content of an SIS is prescribed in great detail in the PHI Act. In some instances, it is necessary to provide consumers with additional information in relation to a product that is not set out in an SIS, or to clarify an aspect of the product, not covered by the SIS. This has increased importance as there are a number of web comparison tools available to consumers (such as CANNEX and Choice) that use SIS as a basis for product comparison between health Insurers.”

In its submission, HIRMAA noted its support for the development of the consumer website and its continuing close working relationship with the PHIO, praising the PHIO’s commitment to ‘continually improve and refine the content and format of the report over time taking account of feedback and following appropriate consultation.’ HIRMAA also noted that:

HIRMAA believes that the PHIO has honoured the commitment to improve and refine the content and format and that the 2006-07 State of the Health Funds report is further evidence of this commitment. HIRMAA notes the comments of the Acting Ombudsman in the Foreword to the report that “I have made a number of changes to this year’s report, in order to produce a more streamlined document for consumers and in response to feedback from stakeholders”. Our members have valued the willingness of the PHIO to attend our organisation’s quarterly meetings to discuss relevant issues, including the role and new powers of the Ombudsman and the development of the consumer website:
HIRMAA is very pleased that the report records the fourth consecutive decline (a reduction of 1.4% against the previous year) in complaints and believes that this trend is a tribute to the work of individual insurers and their working relationship with the PHIO.

The CHF stated that the website ‘is a positive advancement to ensuring that consumers have access to comparable and independently monitored information on private health funds and the packages they offer’, but noted that consumers still needed:

... accurate, timely and appropriate resources, tools and information pathways to assist them in navigating the health system and making informed decisions about their health care … any proposal [should be] based on achieving better health outcomes for consumers rather than marking objectives …

The CHF also noted that:

consumers would like the ability to search for funds offering illness specific cover and cover for broader health options. Consumers also require more in depth information to understand whether funds are offering genuinely new options, or merely marketing as broader health coverage those products which were previously described as “ancillary”.

4.4.2 Other consumer information issues

The DHA stated that during the reporting period it continued its private health insurance communication campaign, which began in late 2006, to increase consumer awareness of private health insurance reforms. The campaign included television, radio and internet advertising:

Post-campaign evaluation indicated that community awareness of private health insurance reforms was significantly enhanced as a result of the campaign (14 per cent awareness prior to the campaign, 53 per cent following).

The first LHC [Lifetime Health Cover] mailout, which was conducted by Medicare, occurred on 14 June 2007. Approximately 254,000 uninsured people approaching 31 and 99,000 new migrants were sent a letter signed by a departmental official, notifying them that they were approaching their LHC deadline, and a brochure outlining private health insurance reforms. The first mail out coincided with a mass media campaign about private health insurance, including LHC.

On 2 June 2008, the department informed 181,899 uninsured people approaching 31 and 107,317 new migrants about private health insurance Lifetime Health Cover. A further mail-out was conducted on 15 September 2008 to 20,636 new migrants. The department also had the Lifetime Health Cover brochure translated into 19 community languages. This was subsequently distributed to Migrant Resource Centres around Australia and made available online at www.health.gov.au, www.medicareaustralia.gov.au, and at www.privatehealth.gov.au.

The DHA translated the Private Patients’ Hospital Charter into 19 languages to aid consumers in understanding their rights and responsibilities as a private patient and what they can expect from their doctor(s), hospital and health insurer.
The CHF was concerned that some health insurers may be restricting access to research data:

Currently, ‘commercial in confidence’ arguments may be unnecessarily used, or overused, to prevent access to product research. These business arguments need to be weighed against the benefits of having information available about products that will enable health funds and providers to know what health care consumers need and help consumers to make informed choices about their health care options …

The CHF also noted that there is a need for health insurers to provide members with information to allow assessment of insurers’ performance and its competitiveness with packages offered by other insurers:

The inadequacy of current information provision and communication between health funds and their members has been highlighted by consumers. Some consumers have compared this level of information and communication with other areas of fund membership, such as superannuation where regular update reports to members are considered a vital component to ensure the accountability, transparency and competitiveness of superannuation funds. CHF recommends that the Government require funds to provide better information and communication avenues with their members, including regular reports and options, to increase transparency, accountability and competitiveness.
5. **Health insurer and health service provider contracting**

This chapter examines the potential issues that are relevant to the relationship between health insurers and hospitals (both private and public). In particular, this chapter examines conduct that may raise concerns under the competition provisions of the Act.

5.1 **Background**

When a hospital enters into a hospital purchaser provider agreement with a health insurer, this allows the insurer to guarantee their members that there will be no out-of-pocket costs incurred from a procedure. These insurance policies are referred to as ‘no gap’ or ‘known gap’ policies.

5.2 **Health insurer and health service provider contracting**

In recent years, only a small number of submissions commented on contracting, and this was again the case in 2008. In the submissions that did comment, the comments primarily related to:

- preferred provider schemes (including ‘no gap’ or ‘known gap’ arrangements)
- ‘take it or leave it’ offers in lieu of genuine negotiation.

The submissions differed in their views of the contracting environment. Private hospitals and their associations were concerned about restrictions and requirements that may be placed on them by health insurers in contracting for ‘no gap’ arrangements; they generally acknowledged and supported the second-tier benefits system as a valuable safety net. The second-tier system is a government initiative that sets the level of benefit payable to a default benefit hospital that does not have a contract with a health insurer at 85 per cent of the average benefits currently paid by that health insurer for the episode of care in comparable private hospital facilities with which the health insurer has contracts.

Health insurers and their associations generally considered that their bargaining position was undermined by the second-tier system and that it generally keeps service costs higher than they would have otherwise been, which affects health insurers’ costs and the cost of insurance premiums.

The AHIA noted that while the contractual environment is very competitive as each health insurer contracts individually with each service provider, the second-tier default benefit scheme for some hospitals tended to disadvantage insurers. The AHIA stated that:

> … the continuation of 2nd tier default benefits for some hospitals that do not have contractual arrangements with health funds is a concern to purchasers of hospital services.

The criteria for obtaining 2nd tier default benefits may be lower than which a hospital must undergo to receive contractual benefits from a health fund. The AHIA believes that the 2nd tier default benefits should be removed, and funds be allowed to contract with safe and quality driven organisations which will continue to improve treatment outcomes for consumers. Under the current arrangements health funds must continue to pay benefits to hospitals for services which may not be in the best interests of health fund members.
The 2nd tier arrangements are not in the interest of industry competition, nor in the interests of achieving the best health outcome for the consumer. At minimum the benchmarks to achieve 2nd tier benefits should be lifted to improve safety and quality of hospital services.

In its submission BUPA Australia noted that:

… 2nd tier default benefits play an important role in the contractual environment between health insurers and service providers by guaranteeing a minimum payment to accredited private hospitals …

This minimum payment acts as a floor in price negotiations with those private hospitals. Hospitals which are accredited for second tier defaults are not, however, prevented from charging any amount of out of pocket expense. This strengthens the bargaining power of those private hospitals in contract negotiations with health insurers, as policy holders who experience an out of pocket expense are more likely to switch health insurers and exercise their portability rights under the Private Health Insurance Act 2007 …

BUPA Australia does not consider that it is equitable for a floor price to be set in the form of second tier default benefits, without a corresponding ceiling price that serves to limit the fee charged by a hospital. BUPA Australia maintains that out of pocket expenses experienced by patients in hospitals accepting second tier default benefits would be limited if those hospitals set a maximum fee.

The CHF considers that contractual arrangements between health insurers and service providers should be transparent, allow competition and be flexible to ensure best outcomes for consumers. In the CHF’s view, ongoing review of these arrangements and their possible impact on consumers is necessary as they directly affect consumers’ access to services.

The HBF noted that the second-tier benefit scheme was attractive to some hospitals. However, the HBF considers that the second-tier benefit scheme could distort pricing in the sector as hospitals use the scheme as a useful fallback. The HBF believes the second-tier benefit scheme should be removed:

Effectively, hospitals are provided with an underwriting mechanism from default benefits, without any consideration of supply or demand within the health sector. This in itself can create more admissions than are actually necessary in the private health sector. The current system of default benefits restricts competition and encourages inefficiencies.

In addition, the second tier default system restricts funds from rewarding better outcomes from providers. Although some facilities demonstrate substantially improved outcomes, any facility accredited for second tier is guaranteed to receive 85% of the benefit income of comparable facilities. To increase agreed fees and benefits in recognition of improved outcomes would likewise result in the calculation of a higher second tier benefit. In effect, all hospitals receive increased benefits from the improved outcomes of one.

The ADA raised concerns that some of the practices of health insurers could potentially interfere with the delivery of quality dental care. In particular, the ADA stated that some members received correspondence from their health insurer which suggested that a dentist’s provision of dental services to a patient would give rise to a contractual obligation on the dentist’s part with the insurer. The ADA stated that this is not the case. The insurer ceased sending the correspondence after the ADA contacted them but the ADA is under the impression that the insurer did not retract the letter or clarify the issue with its members.
The Private Health Insurance Intermediaries Association noted that its members have observed a growing dissatisfaction with the ‘preferred-provider’ schemes. The PHIIA noted that:

Many dentists are unhappy about the rebate levels, but more importantly consumers are becoming very disillusioned. They question why there is such a discrepancy between benefits supposedly paid in respect of preferred-providers and others. The question being asked more and more frequently is, if one Fund can pay those sorts of benefit levels, how come other Funds who charge similar premiums can’t do the same. Also what sort of incentives are the preferred providers getting. Consumers are getting more savvy, and are inclined to suspicion about the whole industry.

The PHIIA members also identified medical gap payments as a major source of complaints:

Medical gap payments are one of the most rapidly-increasing causes of dissatisfaction with private hospital cover. The actual gap, and the coverage or non-coverage of gap costs in hospitalisation, is one of the most widely misunderstood areas in the industry. Intermediaries receive calls daily from people committed to a hospital visit who have had no idea of what the gap is or even of its existence, and most often they have been in their fund for a long time, and have believed they have had “full” hospital cover.

Under the PHI Act the PHIO is able to compel an insurer and a health care provider to attend mediation to resolve disputes about contractual arrangements that have the ability to adversely affect consumers’ entitlements. The PHIO noted that during the reporting period, it was involved in informally mediating a number of contractual disputes, but was not required to formally mediate any disputes.

The PHIO commented on parties to mediation making public statements:

The Ombudsman’s view is that, where there is dispute over contractual issues, funds and hospitals should ensure that any public statements made by them, or on their behalf, do not include any information or comment that could create negative perceptions of the other party to the dispute.

In dealing with several contractual disputes during 2007/08, it became clear that the Ombudsman’s Transition and Communication Protocols need to include more detail about the types of communication that are considered acceptable. These will be amended over the coming months and circulated to industry for comment.

On the second-tier default benefit scheme, the PHIO noted:

The office received a small number of complaints from hospitals regarding the payment of second tier benefits. These complaints were either from hospitals considering contract cessation with a particular fund, or hospitals that did not have a contract with a fund and were concerned about the level of 2nd tier benefits they were receiving for their services.

In the case of hospitals considering going out of contract with an insurer, complaints about 2nd tier benefits were mainly related to the insurer’s perceived unwillingness to provide the hospital with information about their 2nd tier rates, to assist the hospital in deciding whether to discontinue the contract or not. In these cases, the Ombudsman was able to assist the hospital in obtaining the necessary information.
5.3 Portability

Division 78 of the PHI Act was amended in 2005 to set out portability requirements for complying health insurance policies; this is known as the portability scheme. In its submission the PHIO described Division 78 as follows:

It provides for consumers to transfer between insurers without the imposition of benefit limitation periods. This change was made in late 2005 and included in the new legislation. The introduction of this requirement has seen a decline in complaints to the PHIO about portability issues. Current complaints about this issue tend to be related to administrative problems such as members having difficulty in obtaining clearance (transfer) certificates.

The AHIA noted that the industry supported the portability scheme and the work done in developing it:

Portability is a policy which the private funds support, and the industry developed a Common Clearance Certificate to facilitate movement by policy holders between the funds. The AHIA is unaware of any issues related to the 2nd tier benefits arrangement system given that the eligibility requirements for hospitals to obtain the benefit are quite well established, and are therefore easily accessed by most hospitals.

The AHIA does not support a situation where a policy holder transferring between funds is able to access the identical hospital contracting arrangements for which they were eligible with their previous fund, unless the fund holds the same contracting arrangements. The industry considers that this transfer arrangement would be unfair on the membership base of the fund to which the person has transferred, and potentially not in the interests of the transferring member.

The CHF raised concerns that there is confusion among consumers regarding the applicable waiting period when they transfer from one health insurer to another. In some cases, consumers are not aware that their new insurer can only impose waiting periods for new or higher benefits or that the new insurer must give consumers credit for the waiting periods already served in their old policy.

To that end:

CHF is pleased to see that this information is provided on the new PHIO comparative website but recommends that it be more widely communicated by health funds and other stakeholders. In addition, it is imperative that health funds comply with the nominal timeframe of 14 days in which to provide inter-fund clearance certificates to ensure that consumers are not adversely affected when transferring between funds.

The HBF believes the efficiency and effectiveness of the common clearance certificate scheme could be improved if the system were changed to use electronic transfer of information between insurers and not require the member’s signature. In the HBF’s view the current paper trail has a number of costs and shortfalls that could be avoided, not least the requirement for consumers to obtain certificates, sign them and provide them to their new insurer. To ensure that insurers only gained members appropriately, the HBF suggests:

The gaining fund would assume the responsibility to request and obtain the transfer certificate and funds would also issue certificates on request to any consumer leaving the fund.

The PHIO noted that it received 115 complaints relating to portability issues during the 2007–08 financial year, compared with 106 in the previous financial year.
6. ACCC activities

This chapter summarises the public statements made by the ACCC in the 2007–08 financial year that related to health insurers and suppliers of health services and products.

6.1 Enforcement action

Baxter Healthcare Pty Ltd

On 1 November 2002 the ACCC instituted proceedings in the Federal Court of Australia 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 for the supply 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. The state governments of New South Wales, Queensland, South Australia and Western Australia took the position that companies contracting with them should be exempted from the Trade Practices Act. (The governments of Victoria, Tasmania and the Australian Capital Territory were not involved in the proceedings.)

The court held that Baxter had not contravened the Act because it was dealing with various state government departments which were not carrying on business. The ACCC appealed this decision to the Full Federal Court and this appeal was dismissed.

In September 2006 the ACCC sought special leave to appeal to the High Court of Australia on the findings by the Full Federal Court that Baxter was protected from the operation of the Act by Crown immunity; in February 2007 the High Court granted special leave for this appeal.

In August 2007 the High Court upheld the ACCC's appeal against the findings by the Full Federal Court. The matter then returned to the Full Federal Court to consider the underlying issue of whether Baxter’s conduct constituted a misuse of market power or had the purpose, effect or likely effect of substantially lessening competition.

In August 2008 the Full Federal Court issued orders declaring that Baxter had breached ss. 46 and 47 of the Act when it entered long-term contracts with state purchasing authorities.

The court found that Baxter:

- Had taken advantage of its market power in sterile fluids to structure the terms on which it offered to enter into contracts for the supply of these products to the purchasing authorities in New South Wales, Queensland, South Australia and Western Australia. The court found that Baxter’s purpose in leveraging its market power in sterile fluids was to deter or prevent competitors from being competitive in the supply of peritoneal dialysis products in contravention of s. 46 of the Act.
- Had contravened the exclusive dealing provisions of the Act with the bundling of all sterile fluids and peritoneal dialysis products into long-term exclusive contracts with purchasing authorities in New South Wales, Queensland, South Australia and Western Australia.
- Had engaged in this conduct for the purpose and with the effect or likely effect of substantially lessening competition in the peritoneal dialysis products market in contravention of s. 47 of the Act.
The Full Federal Court remitted the matter to a single judge of the Federal Court to consider the imposition of penalties and other relief.

**Ranu Pty Ltd, P. R. & G. Crowe Pty Ltd and Hazel Ridge Pty Ltd**

In December 2007 the Federal Court found that Dr Sawindar Ranu and his company Ranu Pty Ltd, Dr Paul Crowe and his company P. R & G Crowe Pty Ltd and Dr Antanas Stankevicius and his company Hazel Ridge Pty Ltd had contravened s. 45 of the Act by engaging in price fixing and market sharing. The court found that the orthodontists, in various combinations, had entered into a series of illegal anti-competitive arrangements to:

- fix the price of the orthodontic services they each provided to consumers in northern Tasmania
- restrict their respective supply of orthodontic services to new patients when an orthodontist had more customers than the others
- restrict the ability of the orthodontists to supply their respective services from separate premises or work with other orthodontists within 20 kilometres of the existing practices in Launceston, Devonport and Burnie
- stop another orthodontist from setting up a competing practice in northern Tasmania.

The orthodontists operated from shared premises in the cities of Launceston, Devonport and Burnie, and the majority of the illegal arrangements were written into the shared premises co-location agreement.

The co-location agreement was drafted by a lawyer in 1992 and that the orthodontists relied on that lawyer’s legal advice. In light of the faulty legal advice and because the respondents cooperated with the investigation, the ACCC did not seek a monetary penalty. The court found that in all the circumstances it was sufficient to deal with the matter by way of a series of injunctions restraining the orthodontists from again engaging in the anti-competitive conduct. The court also ordered the respondent orthodontists to attend a trade practices law seminar and to make available trade practice reference material at the co-located premises.

**iSelect Health Pty Ltd**

In November 2007 the ACCC accepted s. 87B undertakings from iSelect Health Pty Ltd. The ACCC was concerned that iSelect made various representations on its website in the period between June 2002 and August 2007, which were likely to mislead consumers as to the range of insurance policies which it compared when recommending a policy. In particular, the ACCC was concerned that iSelect made representations that:

- misrepresented that it compared a significant proportion of health insurance policies available to consumers
- misrepresented the number of health insurance policies that it compared for consumers
- misrepresented that it compared for consumers all the health insurance covers available to them and could find the best suited policy for a consumer’s needs at the lowest price.

After the ACCC raised its concerns with iSelect, it ceased making the representations and took steps to implement a trade practices compliance program.
iSelect provided undertakings that it would:

- not make the representations of concern in specified circumstances where they may be misleading
- inform certain customers that it arranged to purchase a health insurance policy of the range of insurance policies it compared for them
- maintain a trade practices compliance program.

**Mr John Knight and Mr Iain Ross**

On 5 July 2007 the Federal Court imposed penalties totalling $110 000 on two Adelaide cardiothoracic surgeons over moves to prevent competition from two other cardiothoracic surgeons in the Adelaide metropolitan area.

The Federal Court made a number of declarations relating to the anti-competitive conduct of the two Adelaide cardiothoracic surgeons, including:

- they made an arrangement they would hinder or prevent a newly qualified surgeon from entering or supplying his services in the market before he had undertaken further surgical training, notwithstanding that he was legally qualified to practise as a cardiothoracic surgeon
- they each attempted to reach a non-competitive arrangement with a second surgeon whereby that surgeon would not provide surgical services at one hospital and Mr Knight and Mr Ross would each agree not to provide surgical services at another hospital.

The court ordered the surgeons to each pay a pecuniary penalty of $55 000 and make a contribution of $5000 each to the ACCC’s costs for the proceedings. They were also required to attend trade practices law compliance training.

The proceedings were finalised by consent.

### 6.2 Merger reviews

**Lake Imaging and Western Medical Imaging**

In March 2008 the ACCC announced that it would not oppose the proposed merger between Lake Imaging and Western Medical Imaging.

The ACCC identified some preliminary concerns about the proposed merger including whether the merged entity would reduce competition within the diagnostic imaging industry in the Ballarat area and the extent to which Western Medical Imaging was likely to be perceived as a viable alternative for diagnostic imaging and diagnostic imaging reporting services without the proposed merger.

Following inquiries, the ACCC found that Western Medical Imaging was unlikely to expand its operations and may only be able to provide a limited constraint to Lake Imaging’s operations. While the ACCC considers that having a single provider of radiologists in Ballarat is not ideal, Western Medical Imaging is unlikely to pose a strong competitive constraint to Lake Imaging for the provision of diagnostic imaging reporting services should the proposed merger not proceed.
BUPA Australia Pty Ltd and MBF Australia Limited

In November 2007 the ACCC announced that it would not oppose the proposed merger between BUPA Australia Pty Ltd (BUPA) and MBF Australia Limited.

The ACCC conducted a comprehensive review of the proposed merger, including extensive market inquiries with interested parties. The ACCC carefully considered the likely effects of the proposed merger on the supply of private health insurance to consumers and on the acquisition of services from private hospitals.

The ACCC paid particular attention to the potential effects in the supply of private health insurance to South Australian consumers because of BUPA’s strong position in that state. The ACCC also investigated concerns that the proposed merger may enhance BUPA’s bargaining position in negotiations with private hospitals in South Australia.

Following the inquiries, the ACCC found that competition from a number of competing private health insurance providers in South Australia was likely to continue to constrain BUPA in the foreseeable future. In addition, the inquiries indicated that it was unlikely that BUPA would have market power with respect to the acquisition of private hospital services in South Australia as a result of the proposed merger.

Healthscope Limited and Symbion Health Limited

In August 2007 the ACCC announced that it would not oppose the proposed merger between Healthscope Limited (Healthscope) and Symbion Health Limited.

Competition concerns arose in regions within Victoria where the merged entity would be the sole or dominant provider of community pathology services; however, Healthscope provided s. 87B undertakings that it would divest a number of pathology businesses in the north-eastern and Gippsland regions of Victoria.

The undertaking requires that Healthscope sells the divestiture business to a purchaser approved by the ACCC. The undertaking also requires Healthscope to preserve the divestiture business as a separate, fully operational and competitive going concern that is maintained and independently managed until it is sold.

After extensive market inquiries into the impact of the proposed acquisition on competition in the relevant market and the effectiveness of the undertaking to address the ACCC’s competition concerns, the ACCC was satisfied that the undertaking provides for the divestment by Healthscope of sufficient assets to enable a purchaser of those assets to compete effectively in the relevant market.

6.3 Authorisations and notifications

Rural Doctors Association of Australia

In May 2008 the ACCC granted authorisation to a collective bargaining arrangement put forward by the Rural Doctors Association of Australia (RDAA).

The RDAA proposes to collectively negotiate with state and territory health departments the terms of contracts for general practitioner (GP) visiting medical officers in rural areas, particularly for payments for services provided to public patients and for on-call services.
The ACCC considers that the proposed collective bargaining arrangement may generate some public benefits in the form of small transaction cost savings and enhanced representation of rural doctors in dealings with state and territory health departments.

Importantly, while authorisation removes the legal risk associated with the RDAA negotiating with state/territory health departments on behalf of its members, it does not compel state/territory health departments to negotiate with the RDAA. The state/territory health departments remain free to continue with their existing arrangements for GP visiting medical officer contracts.

Wangaratta Anaesthetist Group

In December 2007 the ACCC decided not to object to a collective bargaining notification lodged by the members of the Wangaratta Anaesthetic Group.

The ACCC considered that the proposed collective bargaining arrangement may result in some public benefits in the form of increased input into contracts and some efficiency savings.

The ACCC considered that the voluntary nature of the proposed arrangements would militate against the potential for anti-competitive impact. In particular, it was likely that the proposed collective bargaining arrangements would only lead to an agreement if it were mutually beneficial to both parties.

Australian Medical Association (Vic)

In December 2007 the ACCC issued a final objection notice in relation to the collective bargaining notification lodged by Australian Medical Association (Vic) on behalf of 39 visiting medical officers at Latrobe Regional Hospital.

The ACCC considered that the public benefit to result from the arrangement would be limited as there was no strong evidence of a disparity in bargaining positions between the group of doctors and the hospital. The ACCC’s inquiries also found that, as there were several different specialties in the group of visiting medical officers, the public interest justification for collective bargaining is reduced.

The ACCC considered that the coverage and composition of the group could lead to anti-competitive outcomes. In particular, the ACCC considered that a potential price rise as a result of the proposed arrangements could force the hospital to operate with fewer medical practitioners or to rationalise services.
Appendix A: Senate Procedural Order of Continuing Effect #12

Health—Assessment reports by the Australian Competition and Consumer Commission

There 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.

(Agreed to 25 March 1999, by means of an amendment to the motion that the report of the committee on the Health Legislation Amendment Bill (No. 2) 1999 be adopted. J.626, amended 18 September 2002 J.761)

Appendix B: List of stakeholders consulted

Private health insurance funds/associations

ACA Health Benefits Fund
AMA Health Fund
Australian Health Cover Advisors
Australian Health Insurance Association*
Australian Health Management Group Limited
Private Health Insurance Intermediaries Association*
Australian Unity Health Ltd
BUPA Australia Health Pty Ltd*
CBHS Friendly Society Ltd
Central West Health Cover
Cessnock District Health Benefits Fund Ltd
Credicare Health Fund
Defence Health Limited,
Druids Friendly Society Ltd
Federation Health
GMF Health
GMHBA Ltd
Grand United Health Fund Pty Ltd
HBA
HBF Health Funds Inc.*
HCF
Health Insurance Fund of WA
Health Insurance Restricted Membership Association of Australia*
Health-Partners Inc.
Hospitals Contribution Fund of Australia Limited
Latrobe Health Services Inc.
Lysaght Peoplecare Ltd
Manchester Unity Australia Limited
MBF Australia Ltd
MBF Health Pty Ltd (NRMA Health Insurance)
Medibank Private Limited
Mildura District Hospital Fund Ltd
Mutual Community
Navy Health Ltd
NIB Health Funds Ltd
Phoenix Health Fund Ltd
Police Health
Queensland Country Health Ltd
Queensland Teachers Union Health Fund Limited
Railway & Transport Health Fund Ltd
Reserve Bank Health Society Ltd
St Lukes Health
Westfund Ltd

**Private hospitals sector**

Australian Private Hospitals Association
Australasian Day Surgery Association
Catholic Health Australia Incorporated
Pendlebury Clinic Private Hospital

**Consumer advocacy organisations**

Australian Consumers Association
Consumers Health Forum of Australia*
National Network of Private Psychiatric Sector Consumers and Carers

**Medical associations**

Australasian College for Emergency Medicine
Australasian College of Cosmetic Surgery
Australasian Society of Clinical Immunology and Allergy
Australian and New Zealand College of Anaesthetists
Australian College of Rural and Remote Medicine
Australian Institute of Radiography
Australian Medical Association
Australian Society of Anaesthetists
Australian Society of Plastic Surgeons*
Royal Australasian College of Surgeons*
Royal Australasian College of Medical Administrators
Royal Australasian College of Physicians
Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Royal Australian and New Zealand College of Ophthalmologists
Royal Australian and New Zealand College of Psychiatrists
Royal Australian and New Zealand College of Radiologists
Royal College of General Practitioners
Royal College of Pathologists of Australasia
**Allied health organisations**

Australian Acupuncture and Chinese Medicine Association Ltd
Australian Association of Practice Managers
Australian Association of Somatic Psychotherapists
Australian College of Clinical Psychologists
Australian Dental Association Inc.*
Australian Homeopathic Association
Australian Hypnotherapists’ Association
Australian Medical Acupuncture College
Australian Osteopathic Association
Australian Physiotherapy Association
Australian Podiatry Council
Australian Psychological Society Ltd
Australian Resource Centre for Healthcare Innovations
Australian Society of Clinical Hypnotherapists
Australian Society of Hypnosis
Australian Society of Orthodontists Inc.
Australian Traditional Medicine Society Ltd
Chiropractors Association of Australia (National) Limited
Dietitians Association of Australia
International Institute of Psychosomatic Medicine
Medical Technology Association of Australia*
Mental Health Council of Australia
NSW Council for Intellectual Disability
Optometrists Association Australia

**Government agencies**

ACT Community and Health Services Complaints Commissioner
Australian Capital Territory Minister for Health
Australian Government Department of Health and Ageing*
Health Insurance Commission
Health Services Commissioner
Healthcare Complaints Commission (NSW)
New South Wales Minister for Health

NT Commissioner for Health and Community Services Complaints
Northern Territory Minister for Health
Office of Health Review (WA)
Office of the Health Complaints Commissioner Tasmania
Private Health Insurance Administration Council
Private Health Insurance Ombudsman*
Queensland Minister for Health
Queensland Health Rights Commission
South Australian Minister for Health
South Australia State Ombudsman
Tasmanian Minister for Health
Victorian Minister for Health
Western Australian Minister for Health
WA Office of Health Review*

*denotes written submission received
Appendix C: References

Australian Competition and 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 1999–31 December 1999*, April 2000 (ACCC’s first report).

—— *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 January 2000–20 June 2000*, October 2000 (ACCC’s second report).


—— *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 January 2002–30 June 2003*, October 2003 (ACCC’s fourth report).

—— *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 January 2003–30 June 2004*, November 2004 (ACCC’s fifth report).

—— *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 2004–30 June 2005*, December 2005 (ACCC’s sixth report).

—— *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 2005–30 June 2006*, December 2006 (ACCC’s seventh report).

—— *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 2006–30 June 2007*, April 2008 (ACCC’s ninth report).


ACCC Contacts

Infocentre: 1300 302 502

Website: www.accc.gov.au

Callers who are deaf or have a hearing or speech impairment can contact the ACCC through the National Relay Service www.relayservice.com.au.

TTY or modem users—phone 133 677 and ask for 1300 302 502.

Voice-only (speak and listen) users—phone 1300 555 727 and ask for 1300 302 502.