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 ending 30 June 2000

ISBN 0 642 40272 8

Produced by the ACCC Publishing Unit 10/00.

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1. Summary

This report is the second report prepared by the Australian Competition and Consumer Commission in compliance with an order agreed to by the Australian Senate on 25 March 1999. The Senate order required the Commission to provide a report at the end of every six-month period '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 covers the period 1 January to 30 June 2000.

The reporting period has been marked by the lead up to the introduction of the Government's Lifetime Health Cover. This has resulted in an unprecedented influx of new members to health funds in the June 2000 quarter.

A number of matters have come to the Private Health Insurance Ombudsman's and the Commission's attention, suggesting some new fund members may not have been adequately informed about certain aspects of the products they were encouraged to purchase during the Lifetime Health Cover campaign. Issues were raised in relation to advice provided by call centre staff, as well as some funds' advertising and promotional activities. The Commission is still investigating a number of matters. The Commission would expect the funds to honour any representation made to consumers.

Transferability of cover, the application of the pre-existing ailment rules and the verification of entitlements still create problems for fund members. These issues need urgent resolution if the sector is to avoid a large increase in the number of complaints and many fund members, particularly new members, becoming disenchanted with private health insurance.

Contracting between health funds and private hospitals via Hospital Purchaser Provider Agreements (HPPAs) is effectively ensuring that fund members have no or known gaps for hospital accommodation services.

Many of the concerns of private hospitals in fact reflect the competitive process. However, funds still have to be mindful, in their dealing with private hospitals, not to act unconscionably. The Commission considers this a serious issue and is currently investigating allegations of unconscionable conduct by a health fund towards a small private hospital. In addition, the Commission considers that a code of practice may be able to address some of the hospitals' concerns with the contracting process. The Commission is disappointed at the delays in the development of the code.

Health funds have continued to develop and expand contract-based no/known gap arrangements on the model of AXA Australia Health Insurance's Ezyclaim. This transaction-by-transaction Medical Purchaser Provider Agreement (MPPA) process provides practitioners with the freedom to participate in no-gap arrangements on behalf of patients or visits selected by the practitioner. For example, AXA reported that it had 3000 doctors registered to use Ezyclaim and the Australian Health Service Alliance said

its member funds currently have agreements with 2700 practitioners around Australia. HCF reported that for the months of May and June 2000, 70 per cent of medical services to HCF members were provided with no-gap payment for the members.

The *Health Legislation Amendment (Gap Cover Schemes) Act 2000*, which became effective in August 2000, allows health funds to set up no/known gap arrangements without the need for a negotiated agreement between funds and doctors. Although this new legislation was not in place during the reporting period, some funds have reported on their progress in developing gap cover schemes.

Health funds have indicated differences of view with the Australian Medical Association (AMA) on the capping of fees, direct billing to the fund, the principal doctor obtaining the informed financial consent and the provision of information to members about participating doctors. The Commission finds the AMA's stance on these issues more focused on the interests of practitioners than on effectively addressing community concerns regarding the medical gap.

The Commission acknowledges that gap cover schemes may provide a useful alternative to contract-based arrangements for some practitioners. It also acknowledges the instrumental role of the AMA in developing this further alternative option for creating no gap/known gap arrangements. However, aspects of the AMA's preferred model for these schemes appear at odds with the community objectives in these schemes. The Commission has always had some difficulty with the AMA being involved in negotiations with health funds on these issues, and in particular on pricing and capping issues. Any threat of a boycott or attempt to induce a boycott by the AMA, or any other craft group, of schemes that do not meet its preferred model would be thoroughly investigated by the Commission.

The Commission is of the view that all doctors should provide financial information to patients and obtain informed financial consent. The patient surely has a right to know his/her financial obligation before committing to the service. The Commission believes that for informed financial consent to be meaningful, the lead practitioner should have the responsibility for obtaining informed financial consent from patients for all doctors involved.

Meaningful informed financial consent requires patients to have quality information and to know about the likely costs of various specialists before making an appointment. In this way they can make a truly informed choice about the best specialist for their needs.

A number of funds are developing a list of medical practitioners who participate in the fund's no/known gap arrangements for their members to access. The Commission welcomes these initiatives. In the Commission's view, such lists will provide valuable information for members in terms of the price of medical services and the benefits provided by their health insurance products.

The Commission is of the view that all medical practitioners should disclose to patients any financial interest they may have in products or services they recommend or provide.

This issue will become increasingly important with the amalgamation and vertical integration currently taking place in the medical sector.

Effective competition in the allied health sectors will only exist when consumers are able to shop around for the best provider for their particular needs, including price, service and quality considerations. In particular, there is a need for price information to be more readily available to consumers. The Commission once again urges health funds, practitioners and their associations to take initiatives to address this issue.

2. Introduction

2.1 Senate order

On 25 March 1999 the Australian Senate agreed to the following order during consideration of the Health Legislation Amendment Bill (No. 2) 1999:

> That there be laid on the table as soon as possible after the end of each period of 6 months, commencing with the 6 months ending on 31 December 1999, 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.

Section 29(3) of the *Trade Practices Act 1974* (the Act) requires the Commission to comply with a requirement from either House of the Parliament or a Committee of either House or both Houses of the Parliament to furnish to that House or Committee any information concerning the performance of the function of the Commission under the Act.

The Commission's first *Report to the Australian Senate on anti-competitive and other practices by health funds and providers in relation to private health insurance* (first Senate report) prepared in compliance with the order, was tabled in the Senate on 12 April 2000.

This report is the second report prepared by the Commission in compliance with the Senate order, covering the period 1 January to 30 June 2000. The report provides an update to the Commission's first Senate report, focusing on practices that have occurred over the reporting period.

2.2 The Commission

The Commission is the independent statutory authority responsible for, among other functions, ensuring compliance with and enforcement of the Act.

The statutory 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 proscribes certain anti-competitive conduct and unconscionable, misleading, deceptive or false trading practices.

Since 1974 the Act has covered incorporated medical and other health professionals' businesses, as well as unincorporated medical/health professionals' businesses in the Territories. Under legislation introduced as part of the national competition policy, unincorporated businesses, including health professionals and their associations, are now subject to the competition provisions of the Act and the State equivalent, the Competition Codes. With regard to consumer protection, unincorporated medical and health

professional businesses are covered by the State and Territory Fair Trading Acts, which apply to corporations and natural persons, and substantially mirror the consumer protection provisions of the Act.

The Commission's stated objectives are to:

- secure compliance with the Act by responding to complaints and inquiries and by observing market conduct and initiating legal action when required;
- foster competition, fair trading and protection of consumers by taking initiatives to overcome market problems; and
- inform the community at large about the Act and its specific implications for business and consumers.

Although the major policy underpinning the Act is the promotion of competition, the Act also contains checks and balances. The Act allows the Commission to authorise some form of anti-competitive conduct, which would otherwise be at risk of breaching the competition provisions (part IV) of the Act. Authorisation enables anti-competitive conduct to operate in the market when the total public benefits of the conduct outweigh the detriment caused by the anti-competitive nature of the conduct. Conduct authorised by the Commission receives immunity from court action, either by the Commission or by private parties.

People affected by a Commission decision on authorisation may seek independent review of that determination by the Australian Competition Tribunal. In this way, the Commission is not the final arbiter of net public benefit in the authorisation process.

For the purposes of the matters in this report, the Commission is primarily a law enforcement agency. However, enforcement ultimately takes place in the Australian court system. The Commission does not have powers to impose fines or other penalties for contravention of the law. It also does not make the law. Finally, the Commission shares its right to take legal action under the Act with private parties. In the health sector, for example, professional associations, professionals, health funds, hospitals, patients and others could also take legal action under the Act.

2.3 Consultation process

The Commission consulted relevant stakeholders to prepare this report. A list of the parties contacted by the Commission is in attachment A.

The Commission received 28 submissions from the health fund, hospitals and medical and allied health practitioners sectors, the Australian Consumers' Association, the Department of Health and Aged Care and other State and Commonwealth agencies. A list of the parties that provided a submission is in attachment B.

The report has been prepared based on information contained in the submissions or obtained by the Commission in the normal course of its work.

3. Health funds

This chapter examines competition issues involving health funds, as well as consumer issues about private health insurance. Issues between health funds, hospitals and providers are discussed in subsequent chapters.

3.1 Health fund market

The six months to 30 June 2000 were marked by the lead up to the introduction of the Government's Lifetime Health Cover on 1 July 2000, with the deadline to join a fund extended to 15 July 2000. Lifetime Health Cover recognises the length of time a person has had private hospital cover and rewards that loyalty by offering a lower premium.[1]

A large number of people took private hospital cover in the lead up to the introduction to Lifetime Health Cover. As at 30 June 2000, 41.2 per cent of the Australian population were covered by hospital insurance compared with 32.2 per cent at the end of March 2000 and 30.5 per cent at the end of June 1999. The increase in coverage from the quarter ending 31 March 2000 equates 1 747 426 persons, to reach a total of 7.9 million persons covered. The largest increase was in the 30–49 age group.

Ancillary coverage also increased in the June 2000 quarter from 32.8 per cent to 38.3 per cent. The Private Health Insurance Administration Council (PHIAC) notes that ancillary-only coverage decreased in all categories, which suggests that members with ancillary-only coverage probably changed their policy to include hospital cover.[2]

At 30 June 2000 there were 44 registered health benefit organisations.

3.2 Prostheses

New arrangements for prostheses were introduced in 1999–2000. These arrangements came out of a round-table meeting held by the Minister for Health and Aged Care on 23 June 1999 and attended by a wide representation of the health industry. The Department of Health and Aged Care expects the new arrangements to be fully implemented by 2001.

Under these new arrangements, the benefit payable for prostheses items is no longer set by the Commonwealth but is negotiated by the health fund, either directly with the supplier or through the hospital or agent. The arrangements require that there is no gap payable by the patient.

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1 The system operates with a 'threshold age' of 30. That is, all members who join at or before the age of 30 pay the 'base rate' premium for the hospital cover of their choice. Members who join later in life will pay a loading of 2 per cent on top of the base rate for each year over 30 when they first take out hospital cover to a maximum of 70 per cent.

2 Private Health Insurance Administration Council, *Quarterly Statistics*, June 2000.

According to the Department of Health and Aged Care:

> This deregulation will ensure that market forces determine the benefit payable and introduce competition in the market.

For the first time these new arrangements are introducing time-effective price competition in the market for the supply of prostheses. In this new environment the various players have to ensure that their conduct complies with the requirements of the Act.

One important aspect is that suppliers of prostheses cannot get together to jointly negotiate with health funds as this conduct would be caught by the price fixing provisions of the Act (s. 45A) and would constitute a per se contravention (i.e. the conduct would be deemed to substantially lessen competition).

In relation to prostheses, health funds can be described as the acquirers, from prostheses suppliers, of a service, namely the contractual right that members of the health funds will be charged at specific rates for prostheses item(s). As such, if they jointly negotiate, their conduct falls within the 'collective acquisition' exception to s. 45A provided in s. 45A(4)(a). However, the conduct would still come under consideration in the general s. 45 anti-competitive agreement section. That is, health funds are able to jointly negotiate with suppliers of prostheses provided such conduct does not substantially lessen competition.

Concerns were raised with the Commission that a National Prostheses Purchasing Group (NPPG) had been set up to negotiate for the procurement of surgically implanted prostheses on behalf of all of the group's participants. The participants in this group are Medibank Private, five NSW area health services, two Victorian health care networks and the Commonwealth Department of Veterans' Affairs. The NPPG is using a tender process to negotiate pricing directly with prostheses suppliers.

The Commission has formed the view that as the participants in the NPPG are jointly negotiating the acquisition of services, their conduct falls within the exception to s. 45A. As the participants compete in different consumer markets, there does not appear to be a substantial lessening of competition in these various markets. However, the conduct could still substantially lessen competition in the buying market. At this stage, the Commission does not consider that the joint negotiations by the NPPG on behalf of its participants with suppliers of prostheses items, is likely to breach the Act.

However, if a number of health funds were to form a buying group or appoint a single negotiator for the purpose of negotiating with suppliers of prostheses, it might lead to a substantial lessening of competition, depending on the funds' combined share of the private health market.

On the supply side, suppliers of prostheses cannot agree not to supply to particular acquirers or acquirer groups. This would constitute a primary boycott in breach of ss. 45/4D of the Act, which is a per se breach. However, individual suppliers of prostheses can take the unilateral decision not to deal with particular acquirers.

Health funds and/or suppliers of prostheses, in their dealings with each other, also need to ensure that they do not breach the unconscionable conduct provisions of the Act.[3]

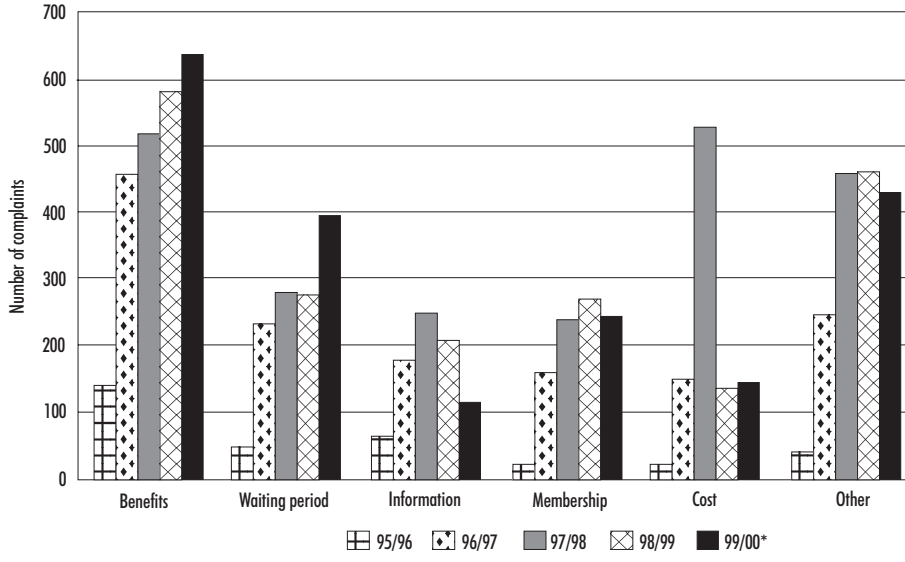
The Commission will be monitoring the conduct of the various participants in the prostheses sector.

3.3 Consumer protection

3.3.1 Consumer complaints

The Private Health Insurance Ombudsman's office felt the impact of the Lifetime Health Cover campaign. It experienced a significant increase in workload in the June 2000 quarter across the whole spectrum of its activities. Overall, the Ombudsman received 1875 complaints for the year 1999/2000, of which 1739 were about health funds.

Figure 1. Private Health Insurance Ombudsman complaints by issues



Source: Private Health Insurance Ombudsman
*Preliminary data

Figure 1 provides comparative information about the issues raised in complaints received by the Ombudsman in 1999/2000 and previous years. While benefits remain the largest area of complaints, complaints about waiting periods have increased to become another main area of complaint in 1999/2000.

3 An outline of these provisions is provided in section 3.2 in the Commission's first Senate report.

The Commission received 34 complaints raising consumer issues about private health insurance during the first half of 2000. These complaints raise allegations of misleading or deceptive conduct and or false representations in relation to funds' advertising and other promotional material.

3.3.2 Consumer information

The period from 1 January 2000 to 30 June 2000 has been marked by the lead up to the introduction of the Government's Lifetime Health Cover. This has resulted in an unprecedented influx of new members to health funds in the June 2000 quarter.

A number of submissions suggest that new fund members do not always properly understand the products they have purchased.

In that regard, the Australian Private Hospitals Association (APHA) commented that:

> With the recent influx of new health fund members, private hospitals are concerned that an additional group of members do not understand the type of insurance product that they hold, its restrictions, exclusions and co-payments.

A national survey of about 70 private health care facilities, undertaken by the Network of State Private Hospitals' Associations and APHA in July 2000, indicated that consumer confusion is still a significant issue.

The Network of State Private Hospitals' Associations notes that:

> All too often, patients are unaware of the implications of the health insurance product they have purchased, particularly in respect of Front End Deductibles (FEDs), exclusionary products and pre-existing ailment rules until their pre-admission interview.

The Network further notes that the success of the Lifetime Health Cover campaign has magnified this problem, as it is apparent that many new members do not know the conditions of their insurance cover and do not understand waiting periods or the pre-existing ailment rules.

New members would have joined a particular health fund based on information provided by that fund. A number of matters have come to the Ombudsman and/or the Commission's attention, suggesting some new fund members may not have been adequately informed about some aspects of the products they were encouraged to purchase during the Lifetime Health Cover campaign.

Call centres

The Ombudsman reported that during the Lifetime Health Cover campaign, a significant number of complaints were associated with inaccurate information provided by third-party call centres.

The Ombudsman noted that:

> The campaign showed up those call centres where insufficient quality audit is carried out by fund staff. Complaints were generally associated with those funds, which previously had poor quality control within their call centre. It is vital that third party call centre staff are as well trained and audited in fund products as the fund's own front office staff. [4]

In June 2000 the Australian Consumers' Association (ACA) conducted an anonymous survey of several funds' call centres (AXA, HBF, HCF, MBF and Medibank Private). The aim of the survey was to determine whether call centre staff provided consumers with accurate information.

The ACA timed that research to coincide with the introduction of the Government's Lifetime Health Cover. In that regard, the ACA noted that:

> At the time there was an extensive advertising campaign informing consumers of the implementation of the [Lifetime Health Cover] scheme and urging them to take out private health insurance. It was recognised that this would be an unusually busy time for the health funds, however it was also a time when consumers would be reliant on health fund call centres for accurate advice on lifetime cover, the benefits of private health insurance more generally and advice regarding specific product features.

Call centre staff were asked about one of six scenarios covering issues, such as:

- participating hospitals for each fund;
- suitable policies for older people;
- appropriate advice on the benefits of private health insurance as opposed to Medicare;
- waiting periods;
- excesses;
- out-of-pocket expenses; and
- pre-existing ailments.

Some of the more significant findings of the survey that reflected positively on health funds' call centres generally were:

> Most of the operators — 34 out of 48 (or 71 per cent) — were able to give accurate details of the hospitals with which their fund had an agreement in particular in regional areas. Also most operators gave accurate advice on waiting periods for pregnancy and pre-existing ailments. (However, in many cases they had difficulty explaining what a pre-existing ailment was.)

However, the ACA also found that:

> Our survey looked at whether the operators would inform our callers of the benefit limitations that apply, particularly for older people. Of the 37 responses, 17 operators recommended policies that has benefit limitations on one or more of these: major joint replacements, cataract surgery or coronary treatment. In one sense this is not surprising because we asked for a cheap policy. But what was

4 Private Health Insurance Ombudsman, *Quarterly Bulletin*, No. 15, April to June 2000.

> disappointing is that of the 17 who recommended these policies 10 gave no explanation of benefit limitations whatsoever.
>
> The call centre operators we surveyed seemed very confused about what private health insurance actually covered ... Close to a third of the 41 operators said or strongly implied that private hospital cover would meet all expenses.
>
> Only four operators out of 47 were able to give a full definition of a pre-existing ailment. Seventeen operators gave misleading information to consumers which could have led to significant disadvantage if they had used this information to make decisions.

The Commission appreciates that health funds' resources were stretched during this period. However, it was nevertheless essential for funds and their call centre staff to provide accurate advice as consumers rely on that advice to make their purchasing decision about private health insurance. The Commission would expect the funds to honour the representations made to consumers by call centre staff.

This issue also highlights the importance of staff training. It is not an acceptable excuse for providing misleading or inaccurate information that staff lack training. The Commission recommends that all health funds focus on improving staff training.

Advertising and promotion

The introduction of Lifetime Health Cover, in addition to the availability of government rebates and taxation considerations, put pressure on many consumers to take up private health insurance. In this environment, the Commission has been watching health insurance advertising and promotion closely to ensure that consumers are not at risk of being misinformed. The Ombudsman's office also handled many complaints about inaccurate advertising and promotion and was able to have corrective action taken. The Ombudsman also referred some matters to the Commission.

In May 2000, following discussions with the Commission, HBA (part of AXA Australia Health Insurance) revised a television commercial shown in April and early May in Victoria.

The commercial showed a cyclist colliding with a stationary bus after veering to avoid an opening door of a kerbside parked vehicle. The Commission was concerned the use of a traffic scenario was likely to mislead Victorian consumers about the need for private health cover because of comprehensive hospital, medical and other benefits provided through Victoria's Transport Accident Commission's (TAC) scheme. The scheme covers most traffic accidents. The benefits under the TAC scheme are available to members of the public involved in a transport accident as defined under section 3 of the Victorian *Transport Accident Act 1996.* The TAC scheme is a no-fault compensation scheme and benefits are provided at little or no cost to an eligible claimant. In addition to providing for payment of reasonable hospital, medical and rehabilitation expenses, claimants may be eligible under the TAC scheme to income and disability payments.

The cyclist in the advertisement would not be covered by the TAC scheme, as he was not struck by a car and did not collide with the opening car door. The Commission believed,

however, that the advertisement could have misled consumers about the situation applying to most traffic accidents by omitting to mention the TAC scheme.

The Commission acknowledged that upon being approached, AXA acted both responsibly and quickly to remove the commercials from broadcast and to address the Commission's concerns.

The court enforceable undertaking provided by AXA included to:

- broadcast a revised version of the commercial, which alerts consumers to the operation of the TAC scheme;
- provide further details on the operation of the TAC scheme through its July members' newsletter and a leaflet to be made available to the public at HBA branches and issued to new members; and
- put in place a refund procedure for members who joined HBA after viewing the earlier commercials and who wished to cancel their cover on the basis that they were misled.

As indicated earlier, waiting periods have become one of the main areas of complaints received by the Ombudsman in 1999/2000. The Ombudsman expressed concerns that some funds' advertising of waiver of waiting periods failed to adequately disclose that some waiting periods still apply.

Concerns about fund advertisements of 'waiver of waiting periods' was a major issue which gave rise to the need for the joint publication by the Commission and the Ombudsman of the *Guide to the Trade Practices Act for the promotion of private health insurance* in April 1998. The guide clearly indicates that funds should clarify which type of waiting period is being waived and draw attention to the existence of other waiting periods. The Commission is very concerned that these problems are still occurring two years after the publication of the guide. The Commission is investigating several allegations of misleading and deceptive advertising in relation to the issue of waiting periods.

The Commission is also investigating allegations of misleading or deceptive conduct regarding representations made about the price of particular insurance policies.

Many funds are in the process of establishing networks of participating providers in the medical and allied health sectors, where members incur less or no gap payment by going to these providers. These initiatives are of great benefit to consumers. However, a number of issues have been raised in relation to their advertisement and promotion.

It is important that funds' brochures and other promotional material adequately inform consumers about any limitation to the coverage of their participating provider network, so that consumers can make informed purchasing decisions. Silence about coverage of the network is likely to be interpreted by consumers as meaning there is no limitation in the coverage and therefore they can access network providers anywhere, particularly in their own area. However, if access to providers is limited or not available in that particular

area, then silence in relation to the extent of coverage may be misleading or deceptive. Oral representation made to consumers about network providers must also be truthful about access and availability. Failure to do so may, in some circumstances, constitute misleading or deceptive conduct.

Before joining a particular fund, some consumers may also want to know whether their medical or allied practitioners of choice or those located in a particular area participate in the fund's network. This constitutes important information for consumers on which to base their decision to join a particular fund. It is the Commission's view that consumers are entitled to this information. In addition, the list of practitioners participating in these networks may change over time. Therefore members need easy access to up-to-date information on participating practitioners at any point in time. To that effect, the Commission is of the view that health funds should maintain lists of participating medical and/or allied health providers for consumers to access and provide that information on request. A number of funds have taken such initiatives, which the Commission welcomes. This is discussed in more detail in section 5.2.2.

Both the Commission and the Ombudsman have investigated a number of complaints about participating provider networks in the medical and allied health sector and have raised issues with a number of funds. These issues have been resolved by the funds, amending or withdrawing particular advertising or promotional material when required. The Commission will continue to monitor this area.

Comparative information

The Commission indicated in its first Senate report that the Department of Health and Aged Care was involved in developing a Private Health Insurance Consumer Hotline to address the needs of consumers for comprehensive information on private health insurance funds and products. The first stage of the project was the implementation of a six-week hotline trial in the ACT.

Consumers' feedback on the hotline indicated that there was a need for unbiased and easy to understand information on private health insurance, but consumers were dissatisfied that the hotline did not recommend a specific fund and product. However, the Department indicated that consumers were satisfied with the information that was contained in the information packs and after the trial this pack was integrated into the departmental information line for distribution to callers.

As a result of the hotline trial, the Steering Committee did not feel that a national hotline was the most effective and cost-efficient way to provide private health insurance information. They recommended the development of a national information service in the form of an Internet site rather than a hotline. The Department of Health and Aged Care is considering this option.

In the Commission's view, consumers' feedback from the hotline trial clearly indicates that there is a role for brokerage services in the private health insurance sector; consumers are keen to get assistance to choose the best cover for their needs.

The Commission reported in its first Senate report that the Department of Health and Aged Care had been involved in the development of a Key Feature Statement for private health insurance. The Key Feature Statement would enable consumers to better compare the relative benefit of different private health insurance policies, select a product that meets their needs and understand the complex conditions of the policy they are purchasing.

It is disappointing that the Key Features Statement was not finalised before the introduction of the Lifetime Health Cover. The statement would have proved particularly useful to the large number of consumers purchasing private health insurance for the first time in assisting them to compare the various products on offer by the different funds, and to better understand the complex conditions of these products.

The Commission would urge all parties involved in the development of the Key Features Statement to finalise it quickly, and then for the funds to adopt it as a matter of priority, as this is an essential tool for the provision of better consumer information about private health insurance.

Provision of information by health funds

It is important for health funds to recognise that the rush preceding the introduction of Lifetime Health Cover has, at the least, resulted in some new members not receiving adequate information about the product they purchased or not being able to carefully examine the features or exclusions of that product.

The Commission believes that health funds can play a positive role in making sure these new members understand their product better and are satisfied with it. In that regard, AXA Australia Health Insurance has informed the Commission that it had written to its new members to explain what their newly purchased health insurance policy covers and does not cover. The Commission understands other funds have similar initiatives in place. The Commission welcomes such initiative and urges other health funds to do the same. The Commission considers that this would contribute to alleviating some consumer confusion.

The Commission notes that health funds are now required to explain to their members, in plain English, any changes in their rules before the changes take effect. This requirement results from revised provisions in the *Health Legislation Amendment Act (No. 3) 1999* that cover rule changes about new products, existing products and any other changes affecting members.

3.3.3 Transferability of cover

The seamless transfer of membership between health funds is an essential component of competition in the private health insurance market. To ensure effective competition, consumers must be able to switch to another fund at no cost[5] especially if, for example,

5 Costs in this context particularly include waiting periods to be served by switching members.

that other fund proposes better packages in terms of price or coverage, or consumers are not happy with the products or services provided by their current fund.

This is even more relevant now with the introduction of Lifetime Health Cover and the large increase in fund membership associated with it.

The Ombudsman noted that:

> It is quite evident from our exposure that some of these [new members] are reluctant members … It is obvious they do not have fund loyalties which others may have maintained and will be far more willing to change funds than their more established counterparts.[6]

Medibank Private also notes that:

> One of the after-effects of LHC may be that funds' recruitment strategies will concentrate on:
>
> - People under the age of 31; and
> - Members of other funds.
>
> There may also be a greater degree of movement of members between funds as people exercise their rights of portability.

In this environment, it is essential that fund members are able to transfer from one fund to another easily and without costs or penalties.

Consumers' right to transfer to another fund's policy offering comparable benefits is recognised by the portability provisions in the National Health Act. However, as indicated by the Ombudsman, and reported in the Commission's first Senate report, these provisions no longer provide for seamless transfer of membership across funds in all situations. Although the reasons are complex, in essence, this is because there is a dispute on what constitutes a broadly comparable benefit and the effect of different components within products to establish beyond doubt the relevant part of the relevant benefit.[7]

The Ombudsman is of the view that the portability provisions will be a significant industry problem over the next year if the issues are not resolved. With this in mind, the Ombudsman has recently undertaken to review the current practices to produce clearer guidelines on which consumers can confidently act. To that effect, the Ombudsman released a discussion paper in June 2000, seeking comments from all interested parties.

The Commission would urge all parties involved to work towards resolving this issue in the interest of consumers.

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6 Private Health Insurance Ombudsman, *Quarterly Bulletin*, No. 15, April to June 2000.

7 Private Health Insurance Ombudsman, *Portability*, Industry Discussion Paper, June 2000.

3.3.4 Pre-existing ailment

As indicated in the Commission's first Senate report, the pre-existing ailment rules constitute another major area causing problems for consumers. In that regard, the Australian Medical Association (South Australia) indicated in its submission that:

> The most important problem that needs to be addressed relates to the issue of pre-existing illness … Many of our members, and also members of the general public, find this a complicated issue and we believe that action needs to be taken to resolve the existing problems.

With the recent large increase in funds' membership, it is uncertain whether all the new members clearly understand how the pre-existing ailment rules operate.

A review of the current pre-existing ailment provisions commenced in September 1999 with the appointment of an independent committee by the Minister for Health and Aged Care. The committee is examining the interpretation and implementation of the current pre-existing ailment rules applying to private health insurance, and is expecting to submit a report to the Minister in the second half of 2000.

This issue needs urgent resolution if the sector is to avoid a large increase in the number of complaints and possibly many consumers, in particular new members, becoming disenchanted with private health insurance.

4. Hospitals

This chapter examines competition and other issues between health funds and hospitals.

4.1 Background

Hospital Purchaser Provider Agreements (HPPA) contracting has been in effect some five years following Parliament's revision of the National Health Act in 1995. The Commission understands that the Government's intention in opening the way for the contracting process was to ensure that efficiencies flowing from a competitive market would allow the funds to offer their members 'no gap' policies for hospital accommodation at little or no increase in premiums. In this way they would be adding to the attractiveness of private health insurance. This has certainly been the result of the process.

For example, HCF indicated that:

> HCF believes its health fund members have benefited directly from a regime of no/known gaps for hospitals' accommodation, and indirectly as a result of lower premiums than would have otherwise been achieved. This result flows from the efficiency initiatives introduced into the private hospitals as a consequence of the contracting process.

HCF further reports that:

> Our members' utilisation of our participating private hospital network is very high and growing, with the following coverage as at 30 June 2000.

	% of total HCF private hospital Admissions in participating hospitals	
	Overnight stay	**Day only**
NSW/ACT	98%	96%
Victoria	88%	76%
Queensland	86%	78%

The contracting process between hospitals and health funds has not been without problems. A detailed outline of these problems and concerns, which emanate mainly from the hospital sector, was included in the Commission's first Senate report.[8]

8 See pp. 133–7 of the Commission's first Senate report.

The Commission notes the comments made by the Australian Private Hospitals Association (APHA) in relation to its first Senate report.

> The Commission made no recommendations in the report, or comments on matters which it assessed as being outside the scope of the *Trade Practices Act*.

This appears to reflect a misunderstanding about the role and functions of the Commission. The Commission is an enforcement agency, not a policy department. It is important to note that s. 29 of the Act requires the Commission to comply with, for example, an order from the Senate to provide information **concerning the performance of the functions of the Commission under this Act**. The Commission is not required, nor would it consider appropriate, to step outside its role to become involved in health policy.

In that regard, the Commission is of the view that it did adequately assess the concerns raised by APHA, but found that they did not belong to the category of anti-competitive practices. The Commission has been closely monitoring the activities of the health funds since the contracting of Hospital Purchaser Provider Agreements (HPPAs) became a reality. It has not found evidence of collusion among funds, nor has it found evidence of misuse of market power by any fund. Any complaint of unconscionable conduct or misleading and deceptive conduct has been thoroughly investigated.

4.2 Hospitals' concerns

A detailed submission to this report was made by the Private Hospital Association of Queensland on behalf of the Network of State Private Hospitals' Associations. The major issues were summarised in the submission as follows:

- One of the most significant benefits of private health care is consumer choice of medical and hospital provider. Competitive and selective tendering practices clearly have the potential to restrict consumer choice. To avoid out of pocket expenses, consumers will be required to be treated by a clinician, credentialled to practice at a contracted facility, which may not be the providers of first choice. As the practice of selective contracting becomes more widespread it will become a problem of greater magnitude and could diminish the value of private health care.
- Increasingly, private health care providers are required to devote considerable resources to ensuring that patients are appropriately informed regarding their level of cover and likely out of pocket expenses. All too often, patients are unaware of the implications of the health insurance product they have purchased, particularly in respect of Front End Deductibles (FEDs), Exclusionary Products and pre-existing ailment rules until their pre-admission interview. In many cases hospitals have had to employ additional staff specifically to handle patient benefit queries, for which they receive no added remuneration from the funds for undertaking tasks which rightly should be the responsibility of the insurer who sold the product.
- The current difficulties in (a) obtaining authorisation and (b) the increasingly high percentage of rejected claims on the basis of pre-existing ailments, has placed a significant additional burden on hospitals. In the case of rejected claims, the hospital must try and recoup the cost from the health fund member, which

often at best results in a disruption to cash flow, and at worst increases hospital exposure to bad debts.

- The private hospital sector considers that verification of member entitlements is wholly the responsibility of the insurer and not the hospital operator, and furthermore, that insurers have an obligation to ensure that this process is completed expeditiously to minimise risk to the provider. Failure to do so imposes a significant additional financial burden on hospital operators at a time when margins are minimal.
- The continual margin squeeze in recent years has resulted in an increasing number of operators being unable to allocate funding to refurbishment and equipment upgrades from annual trading — instead having to utilise such funds to support normal business operations. In the longer term this will have a detrimental impact on the provision of private health care services.
- Private health insurers, hospitals and clinicians are mutually dependent on each other. The private hospital sector would argue therefore that the cost of providing no gap treatment for patients should be equitably distributed and not solely borne by one group of providers.
- Refusal to pay medical day stays where a Type C certificate has been signed by a doctor, effectively contradicts the clinical judgement of the doctor that the patient required hospitalisation. Hospital operators consider that this practice is totally unacceptable.
- Standardisation of contracts, billing and reporting requirements was perceived as being a major priority for hospital operators to reduce this spiralling cost centre. Health funds need to urgently address this issue, or if agreement cannot be reached on standardised procedures, funds must acknowledge the significant additional burden placed on hospitals in negotiating and administering multiple contracts and remunerate hospitals accordingly.
- Whilst hospitals said quality of patient care had not yet been affected by current contracting practices, some providers expressed concern that unless benefit levels were increased, quality may suffer and patient care be compromised.
- Private health insurance is merely a vehicle to access the real product which is private health care. Consumers join health funds to enable access to services and treatment in private hospitals. If such unrealistic benefit levels and significant disruptions to cash flow force hospitals to reduce levels of service or withdraw services altogether, the private health care product, and therefore private health insurance, will rapidly become unattractive to the discerning public.

4.3 Health funds' position

The funds have also commented on their side of the contracting situation. They pointed out that their relationships with private hospitals were generally good. For example, HCF stated that:

> HCF strives to conduct its business in a professional and ethical manner. Generally we believe our relationship with private hospitals is good and we endeavour to enhance this by:
>
> - Setting and achieving timely service standards in relation to the various aspects of our relationship with private hospitals including hospital negotiations, membership eligibility checking, etc.

- Providing benchmarking information to hospitals to broaden their knowledge and make available to them information which can help improve their performance.
- Conducting patient satisfaction surveys and presenting the information to the respective hospitals as part of our quality reporting.

AXA made the following comments:

> AXA believes it maintains good professional relationships with the majority of private hospitals. Negotiations on price remain difficult due to the reduced profitability of the private hospital industry and the funds determination to keep contribution rate increases at or below CPI.

However, Australian Unity indicated its concerns at the lack of financial information from some hospitals and concluded that:

> In a negotiation situation, this often puts us at a disadvantage, leading to contracts that could have the result of curtailing access to certain hospitals for our members or affecting the rates that we charge our members for their health insurance.

HCF also made the following points:

> While there has been a turnaround in the fortunes of Health Funds' profitability with the success of Lifetime Health Cover, HCF believes that efficient hospitals are also experiencing a turnaround in their profitability concurrently. An example of this is the recently reported result of Ramsay Health Care. We believe overall hospital margins will continue to improve over the next few years as they improve their efficiency, increase their occupancy levels and increase their contracted rates.
>
> We should not lose sight of the fact that there remains significant excess capacity in the private hospital industry with the average occupancy levels remaining at 70% for all patients and 62% for overnight patients (refer Productivity Commission Report on Private Hospitals). While many hospitals operate efficiently there are others where efficiency leaves a lot to be desired. While the overall profitability of the industry will improve there is still likely to be some rationalisation that occurs over the next 12 months. This should not be seen as anything other than the effective operation of the market, rationalising poorer performers.
>
> In markets where HCF has a small market share, some hospitals have advised us that they do not want to renegotiate with us at a particular point in time due to other work commitments.
>
> A growing concern is the aggressive nature of some hospitals to the negotiating process requesting rates significantly in excess of inflation and comparable hospital rates. Some use their dominance in a geographic market to achieve their demanded increase. If the contract rate increases are excessive it may force health funds to increase premiums. This in turn may result in the health insurance product being devalued and the overall market being reduced. At the end of the day, the private health care industry should use this marvellous opportunity of increased private insurance coverage, to develop strategies for the long term improvement in the value and delivery of services to consumers. If the hospital rate increases are reasonable it will facilitate the private healthcare market to continue to grow and for the funds to hold or possibly reduce premiums.

4.4 Commission's assessment

4.4.1 Selective contracting

As indicated above, hospitals are concerned that selective contracting reduces consumer choice. It should be noted that where a health fund has contracts with only certain hospitals, the fund's members are still covered by their private hospital insurance to attend any hospital. However, it is the level of cover that differs, with members usually incurring a gap if they attend a non-contracted hospital.

Funds that practice selective tendering deny that this reduces consumer choice. For example, MBF stated that:

> MBF has embarked on open competitive tenders in Queensland and NSW to establish a network of private hospitals & day surgeries for the purchasing of health services on behalf of our members. MBF's initiative is designed to offer members continued access to quality health services combined with the financial certainty of sustainable and affordable gap cover.

Funds need to retain their members and attract new members, and therefore need to have products that are attractive to consumers. Whether selective tendering reduces consumer choice is for consumers to determine. That is, if a fund does not have a contract with a particular hospital that its members want to attend without incurring out-of-pocket expenses, then the fund's members can transfer to another fund. Anecdotal evidence suggests that this is actually happening.

This issue, however, highlights the fact that it is essential to have mechanisms in place to ensure the seamless transfer of membership from fund to fund. This issue was discussed in detail in section 3.3.3. The Commission would again urge all parties involved to take the necessary steps to resolve this issue quickly.

As indicated in the Commission's first Senate report, the practice of selective contracting raises consumer information issues. Consumers need to be informed by health funds that not all hospitals are contracted and what this means for their health cover. Consumers need to be informed about which hospitals are contracted and of any changes to contracted hospitals before the changes come into effect. This is to ensure consumers can make a fully informed decision about which fund to choose, and later on whether to stay with their fund or transfer to another fund.

4.4.2 Unconscionable conduct

The Network of State Private Hospitals' Association made the comment that:

> With the introduction of unconscionable conduct in the TPA in 1998, the manner in which health funds dealt with private hospitals in contracting, both before and after the HPPA had been entered into, became particularly relevant.

The Commission certainly agrees with this statement. In that regard, the Commission has been investigating allegations of unconscionable conduct, in breach of s. 51AC of the

Act, by a health fund towards a small hospital. The matter relates to the attempt by the fund to impose a unilateral contract variation clause in a proposed HPPA with the hospital. The Commission used its powers under s. 155 of the Act to demand information and documents and to take testimony under oath. The Commission is currently assessing its position in this matter given the evidence that has been collected to date.

The clause, while not being included in current contracts, is of concern particularly as endorsement of its inclusion in the proposed Code of Practice for Hospital Purchaser Provider Agreement Negotiations between Private Hospitals and Private Health Insurers has caused the development of the code to stall (see section 4.5).

4.4.3 Verification of entitlements

Considering fund members' confusion about their entitlements, and in particular the application of waiting periods and pre-existing ailment rules, it is essential that member entitlements are verified before or at the time of admission to hospital, so that members are fully informed of the costs to them. Problems surrounding the verification of entitlements were outlined in the Commission's first Senate report.[9]

The Commission strongly disagrees with the views of the Network of State Private Hospitals' Associations that verification of member entitlements is wholly the responsibility of the funds. For any episode of care in a hospital, the hospital is ultimately the only certain point of contact with the fund member. When going to hospital, members are entitled to know how much the services they are going to receive from the hospital will cost. As this depends on the patient's health cover, the hospital must check the patient's membership details with the relevant fund to inform the patient before admission or as soon as possible after admission.

The Commission understands that funds recommend that members check their entitlements with the fund before undergoing any hospital treatment. The Commission considers that funds should take every opportunity to remind members of doing so. However, in the Commission's view, this does not in any way reduce the hospitals' responsibility for checking member entitlements.

The National Health Act requires Hospital Purchaser Provider Agreements (HPPAs) to include a clause obliging the hospital to inform the member of any amount he/she will have to pay to the hospital for hospital accommodation/theatre services. However, if a hospital does not carry out appropriate checks, consumers can be facing significant out-of-pocket expenses.

While the Commission strongly believes that hospitals have a responsibility to check member entitlements with health funds, the Commission also agrees with the hospitals' views that health funds also have a responsibility to provide information on members' cover to hospitals in a timely manner.

9 See pp. 125 and 126.

The Network of State Private Hospitals' Associations noted that:

> The current practice regarding verification of member entitlements give rise to an undue element of financial risk to private health care providers, particularly for out of hours and emergency admissions. Most national call centres operate business hours Monday to Friday.
>
> Whilst the majority of health funds undertake to provide advice within 24 hours of a request received on a normal business day, hospitals have advised that it is not uncommon to wait 2–3 days for confirmation of entitlement — including patients admitted via Accident & Emergency Departments.
>
> This problem is particularly difficult in two areas — cardiac patients admitted through Accident & Emergency Departments and gastroenterology patients where there is often as little as 24 hours between advice of admission and a procedure being performed … That is, doctor and patient require immediate treatment to be delivered.

The Network of State Private Hospitals' Associations concluded that hospitals should be able to access advice and a decision about eligibility and pre-existing ailments on a 24-hour basis.

The Ombudsman also made the point that:

> Given that a high level of ancillary providers currently use point of service electronic checking methods for health fund related accounts, surely in this day and age, a 24 hour a day electronic eligibility checking system for hospitals is not only possible but essential.

The Commission is of the view that to ensure informed financial consent in relation to services provided by hospitals, hospitals must be able to provide patients with advice about any out-of-pocket expense. To do so, hospitals must be able to contact the funds on a 24-hour basis, and must receive advice from the funds in a timely manner.

The Commission is of the view that there is an urgent need for appropriate mechanisms to be put in place to ensure funds can be contacted by hospitals 24-hours a day and provide advice on members' cover in a timely manner. The Commission recognises, however, that funds' decisions about pre-existing ailments may take more time.

In that regard, HCF indicated to the Commission that it is committed to provide timely advice to hospitals on membership eligibility. HCF stated that:

> Currently this is predominantly done on a fax system with a service standard requiring HCF to respond to hospitals on a 24 hour turnaround basis. HCF is moving to improve this situation by allowing hospitals to electronically check on membership eligibility and we now have a number of pilots in progress.

MBF has also indicated to the Commission that to assist with the process of verification of entitlement, the fund has developed an Internet member verification method to speed up information to the hospital. The Commission welcomes these developments.

The Commission understands that the private hospital and health fund sectors have recently agreed on protocols regarding verification of membership as a short-term solution. Both sides, however, recognise that there is a need for a longer term solution to this issue to ensure the private health industry continues to prosper. The Commission has been informed that the private hospital and health fund sectors have undertaken a Billing and Payment Systems Project to identify and implement improved contract management practices that address the significant problems in the payment/billing systems by:

- facilitating exchange of payment/billing models between stakeholders;
- promoting the exchange of billing, payment and membership information economically and electronically;
- enhancing efficiency in contract management for the mutual benefit of all stakeholders; and
- improving the value of private health to consumers by reducing errors, avoiding unnecessary paperwork, and reducing transactional costs for all stakeholders.

With regard to membership eligibility inquiries and checking, the aim of the project is to develop standard data elements to enable:

- accurate membership eligibility inquiries by hospitals and responses by funds; and
- membership inquiries between funds to assist with assessing the entitlements of members who have transferred from another fund (portability message).

The Commission is very supportive of this initiative and would urge all parties involved to commit themselves to progress these matters.

4.4.4 Negotiation process

Although health funds stress their good professional relationships with a majority of private hospitals, the negotiation process continues to raise issues for hospitals.[10] The Network of State Private Hospitals' Associations reported that:

> In the survey [of private hospitals] ... most respondents stated that there was little opportunity for genuine negotiation, with most health funds adopting a 'take it or leave it' attitude. [11]

The Commission is of the view that many of these issues could be addressed by the implementation of the Code of Practice for Hospital Purchaser Provider Agreement Negotiations between Private Hospitals and Private Health Insurers currently being developed by hospitals and health funds (see section 4.5).

10 These issues were outlined in a submission by the Australian Private Hospitals Association to the Commission's first Senate report and were reproduced on pp. 133–5.

11 This national survey was conducted by the Australian Private Hospitals Association and the Network of State Private Hospitals' Associations and covered a representative sample of approximately 70 private health care facilities.

4.4.5 Level of benefits

Many of the concerns raised by hospitals relate to the level of benefits paid by health funds. The Commission does not see this as resulting from anti-competitive behaviour by the health funds, in breach of the Act.

The Network of State Private Hospitals' Associations itself noted in its submission that:

> The difficulty under the existing wording of Section 46 of the Trade Practices Act is actually establishing that by reducing funded beds by approximately 30 percent (as per MBF's stated objective in Queensland), this is being done by a fund for one of the anti-competitive purposes set out in the Section.

Thus, in the Commission's assessment, the concerns expressed by hospitals reflect the cut and thrust of the competitive process. In addition, the Commission does not see these concerns as resulting from other practices by health funds 'which reduce the extent of health cover for consumers and increase their out-of-pocket medical and other expenses', the requirement of the Senate order.

There is no doubt that profitability in the private hospital sector has been reduced as a result of the contracting environment. However, this has had the effect of funds being able to offer no-gap policies for hospital accommodation services without the need for massive premium increases. Despite the protestations of the hospital sector, it would appear that health fund members are benefiting from the contracting of HPPAs.

The Commission acknowledges that the contracting process may lead to rationalisation in the sector. Whether the transition to a more competitive market should be assisted in some way is a matter for the Department of Health and Aged Care, not the Commission.

4.5 Code of practice

As indicated above, in an attempt to address many of the concerns of the private hospital sector, a Code of Practice for Hospital Purchaser Provider Agreement Negotiations between Private Hospitals and Private Health Insurers is being developed by health funds and private hospitals. The code is to deal with processes and not the level of benefits or prices to apply in contracts.

The Commission's view is that the implementation of the code and its dispute resolution mechanism can contribute to improve the relationship between health funds and private hospitals and have a positive effect on the level of disputes in contract negotiation. Of course, the Commission recognises that whether the code delivers on its promises would depend on the goodwill of the parties in implementing it.

The Commission is very disappointed with the delays in the code formulation. The Commission understands that the code negotiation process is currently stalled due to the insistence of some health funds to include a clause in the code indirectly endorsing a 'unilateral contract variation clause' in HPPAs. The Commission is surprised at the insistence by some funds to include such a clause in the code considering that a

'unilateral contract variation clause' is currently the subject of a Commission investigation, as detailed above.

The Commission would be concerned if any other funds were to try to include such unilateral contract variation clauses in their HPPAs until the outcome of the Commission's investigation. Health funds should be well aware that endorsement of such clauses in the proposed code would not exempt the funds from s. 51AC of the Act.

The Commission is of the view that finalisation of the code should not be held back by the unresolved issue of a 'unilateral contract variation clause'. After the conclusion of the Commission's investigation, the issue could be revisited and the code amended if need be.

Considering the difficulties the parties seem to experience in negotiating directly with one another, the Commission would recommend that the Department of Health and Aged Care or an independent third party, acceptable to both hospitals and health funds, intervene in the process and mediate between the parties to ensure the code is quickly finalised.

Given the level of animosity between the two sectors, it may be that stronger measures are required to make the sector function if the code cannot be agreed to or fails to remedy the problems. Again this is an area for the Department of Health and Aged Care to assess.

4.6 Hospital alliances — authorisation applications for joint negotiations

Since the Commission's first Senate report, no new applications for authorisation has been received from hospitals wishing to jointly negotiate with health funds. The application from three Sydney hospitals was not authorised by the Commission. The Commission's preliminary thinking on this application outlined in its first Senate report became the basis of the determination rejecting the application. [12]

A further application from eight smaller hospitals located in both rural and urban areas in NSW remains under consideration.[13] Delays in this matter were due to the time required to obtain submissions from interested parties and for the applicants to respond to them. The Commission has recently received a submission in reply from the applicants. It is expected that a Commission determination will be made in the next few months.

12 See p. 141 of the first Senate report.

13 Initially there were 12 applicant hospitals; however, on 17 July 2000 the Commission was advised that two hospitals had withdrawn from further involvement in the application. On 8 September 2000 the Commission was advised that a further two hospitals had withdrawn from the application.

5. Medical practitioners

5.1 Contracting with health funds

As indicated in the Commission's first Senate report, the medical gap is a major consumer concern and has been a key reason for public dissatisfaction with private health insurance.

As at 30 June 2000, health funds were only permitted to cover the medical gap where a negotiated agreement between the doctor and fund (Medical Purchaser Provider Agreement or MPPA) or doctor and hospital (Practitioner Agreement or PA) exists and specifies the price of the medical procedure.[14] Funds have continued to develop such arrangements. The *Health Legislation Amendment (Gap Cover Schemes) Act 2000*, which was passed by Parliament on 8 June 2000 and became effective from August 2000, now enables funds to offer gap cover through non-contract arrangements.

5.1.1 Contract-based arrangements

As indicated in the Commission's first Senate report, health funds have developed no/known gap products based on the model of AXA Australia Health Insurance's Ezyclaim. Ezyclaim is a transaction-by-transaction MPPA process providing practitioners with the freedom to participate in no-gap arrangements on behalf of patients, and even visits, selected by the practitioner.

Participation in these arrangements by individual medical practitioners is increasing despite the opposition of the Australian Medical Association (AMA).[15] In that regard, HCF indicated that:

> At the end of June 2000, there were over 1390 providers operating under HCF no gap initiatives with all specialties covered. This number has risen to 1880 as at 15 September 2000.
>
> For the months of May and June 2000, 70% of medical services provided to HCF members were at no gaps to our members, ie. covered under a gap arrangement or charged at the Commonwealth Medicare Benefit Schedule (CMBS).

HCF further indicated that the arrangements it has put in place to date have all been no-gap initiatives, i.e. HCF does not have a known gap component to its medical gap initiatives.

14 The legislation allowing funds to cover the gaps in these circumstances was described in section 6.3 on pp. 76 and 77 of the Commission's first Senate report.

15 This issue is discussed at length in the Commission's first Senate report in section 11.1.4.

Similarly, AXA stated that:

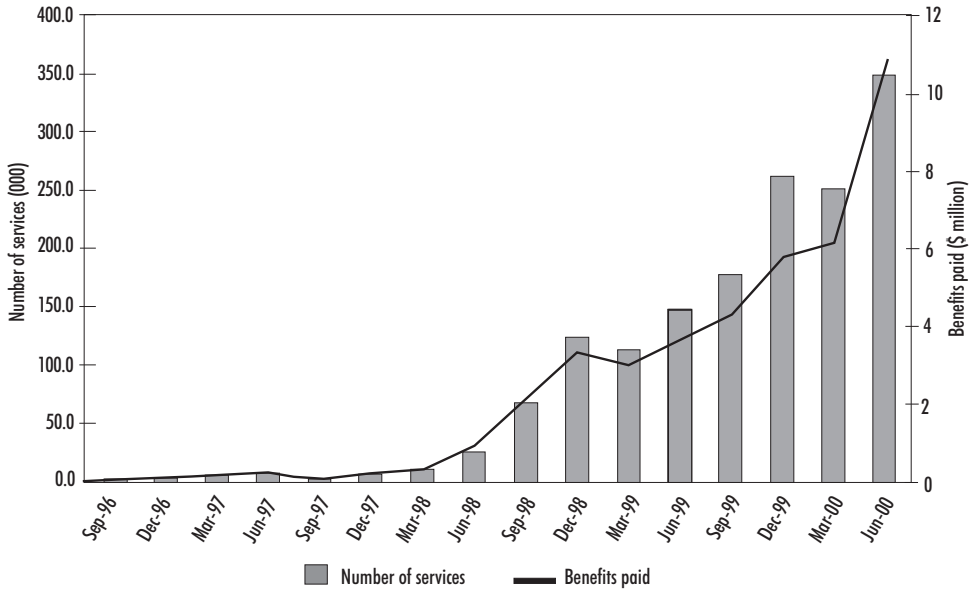
> AXA's Ezyclaim system continues to expand at a rapid rate …
>
> March 2000 — Two dozen specialties in SA where over 50% of services are Ezyclaims, and a dozen in Victoria. Over half of AXA's medical claims are Ezyclaims. 3000 doctors registered to use AXA Ezyclaim.

The Australian Health Service Alliance (AHSA) indicated that:

> AHSA member funds currently have agreements with approximately 2700 medical practitioners around Australia.
>
> Based on HCP data for the 12 months, we estimate that the number of No Gap Scheme arrangements, MPPAs and HPPA/PAs which were held by AHSA member funds constituted 18.9 per cent of the total number of services provided by medical practitioners to the AHSA funds nationally.

Figure 2, reproducing data from the Private Health Insurance Administration Council (PHIAC), shows there has been a dramatic increase in services and benefits paid by health funds above the MBS fee. However, PHIAC has warned that the particular reports from which the data is extracted were never developed to show the extent of no/known gap arrangements and therefore the data should not be interpreted in that way. PHIAC indicated in particular that some funds have agreements with doctors at the MBS fee level, but such no-gap arrangements are not captured by the data reproduced below.

Figure 2. Health fund services and benefits above the MBS fee



Source: PHIAC *Annual Report 1998/99* and *Quarterly Statistics* from September 1999 to June 2000.

HCF also stated in its submission that:

> The information published by PHIAC grossly understates the coverage of medical services and misleads the various users of the information e.g. parliamentarians, the general public, doctors and other stakeholders. This is best illustrated by the following example for HCF for the June Quarter.
>
> | | Services | % of total Services |
> |---|---|---|
> | Services charged at the CMBS level (ie no gap) | 81,628 | 42% |
> | Services covered under a specific no gap arrangement: | | |
> | – at above CMBS rate | 40,904 | 21% |
> | – at CMBS | 10,988 | 6% |
> | | 51,892 | 27% |
> | Total services at no gap to our members | 133,520 | *69% |
> | Services charged above CMBS | 61,360 | 31% |
> | Total Services | 194,880 | 100% |
>
> **Note:* 69% for the quarter however 70% for May and June.
>
> The above demonstrates that our specific gap arrangements cover 27% of medical gap services and when added to those services charged at CMBS result in 69% of services to our members being at no gap to our members. It follows that only 31% of our services now involve a gap to our members.
>
> This is quite different to the '21%' being reported by PHIAC — only one of the components of medical gap. In regard to the 10,988 services covered under gap arrangements but paid at CMBS, HCF has specific contracts covering these arrangements. However, PHIAC does not require the industry to report these services. HCF intends to extend these no gap at CMBS arrangements further in the future.
>
> Surely the public and the Government would feel greater comfort in knowing that 69% of medical services are at no gaps to our members rather than interpreting from the published data that only 21% of services are covered as per the PHIAC reports.

PHIAC is well aware of the potential misuse of the current medical statistics. It has indicated to the Commission that together with the Department of Health and Aged Care, it has been liaising with health funds to organise a new format to capture the extent of medical gap coverage. PHIAC further indicated that data intended to capture the coverage of medical gap would be collected and reported from the March 2001 quarter.

The Commission considers it essential that health funds report data on medical services covered by any no/known gap arrangements, including arrangements at the MBS fee level, as well as services charged at the MBS fee level for which there are no specific arrangements. This data would enable a true analysis of the extent to which medical

services are provided at no gap to fund members, including whether they are provided through a specific arrangement and the nature of that arrangement.

The Australian Health Service Alliance recently surveyed practitioners who had declined to be involved in AHSA members' gap arrangements. The results of this survey indicated that the main reasons for practitioners refusing to be involved were:

- benefits too low
- disagree with health fund contracts
- waiting for approved scheme
- don't trust health funds

The Association for the Advancement of Private Health made the following comments with respect to the reluctance for practitioners to enter contracts:

> A feature of contracting is that there is a net pressure on fees.
>
> Professional Associations are more concerned about the long-term effects.
>
> - That once the majority in the profession are contracted, then the profession is now competing for a share of a smaller 'cake'.
> - That fee updating mechanisms are usually tied to CPI type indicators, and do not allow practitioners to seek a return for investment in more expensive technology or materials.
> - That historically, professions, which become bound to third party funding fee levels, have eventually lost independence and have been controlled by the third party.
> - That poor funding levels lead to a lower quality of service. The evidence for this is dentistry in the under-funded National Health Service dental treatment in the United Kingdom, which is renowned for its poor quality.

HCF in its submission reported the following:

> We are generally finding that the initial apprehension that some doctors had to participate in such arrangements is disappearing, although in some specialities there appears to be some trepidation of their peers knowing that they are participating. The best example of this is anaesthetics where we have over 330 participating providers. However, only 35% of participating practitioners wish to be made known to our members compared to 72% for all other specialties, excluding pathology.

The reluctance of some doctors to enter contract-based gap arrangements also stems from the opposition to these arrangements by the AMA and other specialist associations.

HCF stated in its submission:

> The misinformation promulgated by various medical bodies about medical gap arrangements and the specialties participating is at best ill informed, possibly mischievous and at worst deceptive. This certainly causes confusion amongst

> practitioners and importantly, we believe results in delays in practitioners experimenting with the new arrangements.

As indicated in the Commission's first Senate report, the law allows associations to make policy statements and give advice to members provided no enforcement or disciplinary action is imposed to force members to comply. Doctors are able to make unilateral decisions not to enter contracts. The Commission has seen no evidence to date to indicate that doctors have colluded in their refusal to sign contracts.

5.1.2 Health Legislation Amendment (Gap Cover Schemes) Act 2000

As indicated above, the *Health Legislation Amendment (Gap Cover schemes) Act 2000*, which became effective in August 2000, allows health funds to cover the gap without the need for a negotiated agreement between funds and doctors. It therefore should address some doctors' ideological concerns with contracts.

The Department of Health and Aged Care stated:

> This legislation should result in more doctors providing services on a no or known gap basis, offering obvious benefits to consumers in the form of reduced out-of-pocket costs and greater choice of doctor.

Gap cover schemes have to be approved by the Minister for Health and Aged Care before the schemes become operative. Health funds have to demonstrate that the schemes satisfy a number of criteria in order to be approved by the Minister including:

- offer genuine no gap or known gap policies which cover the full cost, or a specified amount or percentage of the cost, for all in-hospital medical services and which eliminate or reduce the gap;
- be a voluntary arrangement with the providers (no contractual arrangement in place);
- not interfere in any way with the clinical discretion of the doctor–patient relationship;
- provide for the doctor to obtain informed financial consent from the eligible member regarding the gap available before the treatment, or as soon as practicable afterwards;
- provide for patients to acknowledge receipt of the information;
- provide for the disclosure of any financial interests that a medical practitioner may have in the products or services they may recommend or provide;
- contain anti-inflation measures;
- ensure that contributors will not be disadvantaged if the scheme is revoked by the Minister; and
- provide a simplified billing arrangement where appropriate.

In particular, schemes cannot allow for open-ended reimbursement of medical fees or increase the total cost borne by contributors, which would have an inflationary impact.

The schemes will also be reviewed at regular intervals and will be independently monitored by PHIAC to determine the extent to which they genuinely reduce or eliminate gap payments by consumers. PHIAC will also publish details of all gap cover schemes on the Internet and have it available at its offices.

HCF expressed concerns regarding the proposed publication of details of gap cover schemes.

If PHIAC only publishes Gap Cover Scheme arrangements it would be grossly misleading to the public as the great bulk of medical gap arrangements are likely to continue to be under Medical Purchaser Provider Agreements (MPPA) and HPPA arrangements.

As indicated above, the Commission's view is that there is a need to publish data on all types of gap arrangements and on gap coverage (i.e. the extent to which medical services are provided at no gap to fund members). This will ensure that the debate about medical gap issues is based on actual facts.

5.1.3 Gap cover schemes

The AMA, whose lobbying was largely responsible for the introduction of the 'no contract' gap cover legislation, has indicated that it has been actively discussing with the major health funds the various models of 'no contract' gap cover schemes. The Commission understands the AMA preferred scheme includes the following:[16]

- protect patients' rights to receive full fund rebates if they are appropriately insured, when the treating doctor has given informed financial information, regardless of the quantum of the doctor's fees;
- protect the rights of all doctors involved in the patient's care to individually set their own fees;
- promote a known-gap product allowing doctors the discretion to charge a no-gap fee;
- be benchmarked upon a percentage of the AMA Schedule of Fees and adjusted annually in line with the AMA indexation rate; and
- prohibit explicit or implicit fee capping, fee fixing and incentives encouraging inappropriate clinical practice.

Although the new legislation was not in place during the reporting period, some funds have reported their progress in developing gap cover schemes.

Medibank Private indicated that the preparation for the introduction of no/known gap schemes has raised certain issues with providers. The fund stated that:

> Medibank Private has been having detailed discussions with groups of providers, principally with representatives of the AMA, in an effort to resolve any issues.

16 Australian Medical Association (Queensland branch), *AMAQ News*, July 2000.

> The main areas of difference between funds and the AMA relate to:
>
> - The capping of benefits to be paid. The AMA does not wish to have any restrictions imposed on what its members can charge patients under the scheme;
> - Simplified billing. The AMA is very firm that the doctor should give the bill to the patient, rather than sending it directly to the fund.
>
> The direct billing system is central to the effective operation of the new GapCover scheme and the delivery of a simplified billing arrangement to our members. We have recently modified our position to allow for the customers to choose whether they wish to be billed directly to the fund. The AMA's position will hinder the development of an appropriate billing mechanism.
>
> In our view, no-capped fees will tend to be inflationary and will defeat the purpose of the legislation, and we need to protect our members from potential premium increases.

Since then, Medibank Private's 'GapCover' scheme has been approved by the Minister.[17] The scheme guarantees that members will not incur more than a maximum known gap payment per episode of care of $800. Medibank Private stated that it was aware the AMA may still have concerns about the new scheme and it would continue its discussions with the profession to reach common ground. The Commission understands that the AMA has welcomed the introduction of Medibank Private's GapCover scheme.[18]

The Australian Health Service Alliance (AHSA) indicated that AHSA funds are also keen to register a scheme or schemes under the new legislation and reported on its negotiations with the AMA to develop a scheme that has some consensus. The AHSA stated:

> It is also clear, however, that there are still some basic philosophical differences which may impede development of a scheme that has a true consensus. These differences mainly surround:
>
> - Patient Billing – the Doctors wish to retain the right to bill the patient direct.
> - No Gap vs Known Gap – AHSA funds believe that a no gap approach has greater consumer acceptance than a known gap. This is at odds with some members of the medical profession who prefer to retain the right to charge a patient moiety at their discretion.
> - Advising members/patients of participating doctors. Consumers are asking their funds to advise them of the details of participating doctors to assist them in their choice of specialist. The AMA does not endorse this dissemination of information.

HCF indicated that it has not entered into any gap cover scheme arrangements and provided the following comments:

> We believe the AMA will promote these arrangements as a means of developing known gap arrangements. In many cases the known gap may not be limited to a

17 See Medibank Private press release, 'Medibank Private's 'GapCover' scheme first approved under new law', 8 September 2000.

18 See AMA media release, 'AMA backed legislation delivers first no contract private health scheme', 8 September 2000.

> certain defined upper limit. We believe that the arrangements are highly likely to be inflationary.

HCF provided pertinent comments on known gap generally:

> We believe that a known gap outcome can be achieved in any situation involving a proper informed financial consent process. There seems to be little point in a fund paying extra for a known gap if it is not addressing the principle concern of our members, ie. that having paid a health insurance premium they would be provided the financial security of having no gaps for medical services. We also believe that known gap medical gap schemes will tend to be inflationary resulting in premium increases to fund members and delivering little value. By participating in such arrangements funds may run the risk of devaluing their product in the eyes of their members.

The Commission finds the AMA's stance on these issues disturbing. The AMA position on these issues seems to be more focused on the interests of practitioners than on effectively addressing community and patients' concerns regarding the medical gap.

As indicated in the Commission's first Senate report, the whole debate about community dissatisfaction with unexpected medical gaps and the need for no/known gap private health insurance products highlights the importance that members of the public place on price information in the medical sector **and** the actual amount they pay for particular medical services. This was reinforced in recent submissions received from health funds. For example, HCF stated:

> While more and more doctors are participating in no gap arrangements, one of the biggest complaints we still receive from members relates to where they receive unexpected charges for medical services for which they are not fully covered by their health insurance.

The Commission is of the view that gap arrangements with no cap on the gap would not provide much more than informed financial consent. The Commission has difficulty seeing how such arrangements could address community concerns about the medical gap.

The Commission also strongly disagrees with the AMA position regarding the provision of information to members about participating doctors. This issue is examined in detail in section 5.2.

In its submission to the Commission, the AMA has asked for an acknowledgment in this report of its work in discussing the various models of 'no contract' gap schemes with the major funds in an endeavour to put suitable models to the Minister for approval.

The Commission acknowledges that gap cover schemes may be a useful alternative to MPPAs and HPPA/PAs for some practitioners who have an ideological aversion to direct contracts with funds. The Commission acknowledges that the AMA has been instrumental in such an alternative option being made available. However, some of the characteristics of the AMA's preferred model for such schemes seem to be quite contrary to the community objectives for the schemes. It is also important to note, as discussed in section 5.1.1, that other options for delivering no-gap outcomes for patients have also become popular with practitioners.

In addition, the Commission has always had some difficulty with the AMA being involved in negotiations with health funds on these issues, and in particular on pricing and capping issues, and has raised them with the Federal and State AMAs. In particular, the Commission made the following points in relation to the application of the Act to gap cover schemes.

- When putting these schemes in place, health funds, competing hospitals, competing providers and their professional associations need to make sure that their conduct is in compliance with the requirements of the Act.
- Negotiations with health funds by the AMA or other craft groups would be at serious risk of breaching s. 45 and/or s. 45A of the Act.
- A health fund can of course consult or hold discussions with the AMA, or any other group of providers, and then choose to make its own independent decisions about the terms and conditions of its gap cover schemes. However, the persons with whom the health fund consults or holds discussions with must ensure they do not reach a collective agreement with each other on matters which may be anti-competitive, including, but not restricted to, the fees for the services they provide to fund members.
- With regard to negotiations on other matters, the only example of such matters provided so far to the Commission by the AMA has been the issue of informed financial consent and the form this consent may take. On this particular issue, it is not likely there will be concerns regarding the requirements of the Act, provided the negotiations do not result in contracts, arrangements or understandings which have the purpose, effect or likely effect of substantially lessening competition or which can be characterised as an exclusionary provision (primary boycott) under the Act.

Any threat of boycott or attempt to induce a boycott by the AMA of schemes that do not meet its preferred model will be thoroughly investigated by the Commission.

The Commission has also had discussions with the major funds reminding them of their obligations and duties under the Act, particularly with respect to the negotiating process.

As gap cover schemes are still being developed or have just been introduced, it is of course too early to judge whether these new schemes will be effective in providing gap cover and thus reducing consumers out-of-pocket expenses. This will be the subject of the Commission's future reports. In addition, the Commission will continue to examine the issues raised in this section.

5.2 Consumer information

Consumer information in relation to medical practitioners and their services, or rather the lack of it, was identified as a major issue in the Commission's first Senate report.

5.2.1 Informed financial consent

The *Health Legislation Amendment (Gap Cover Schemes) Act 2000* requires medical practitioners providing services under a gap cover scheme to inform the patient in writing of any amount the patient may have to pay for the treatment. The patient must in writing acknowledge receipt of this pricing information.

The Commission is of the view that all doctors should provide financial information to patients and obtain informed financial consent regardless of whether or not the service is provided under a gap cover scheme. Currently, many doctors are quite willing to provide this information. Patients surely have a right to know their financial obligations before committing to the service. This is the norm in all other areas of business.

The Australian Health Service Alliance in its submission stated that:

> The main informed financial consent problems appear to be in the area of anaesthesia and pathology where there is little or no contact with the provider.

This clearly causes a problem to the process and underlines the desire of the health funds to have the lead practitioner obtaining informed financial consent for all doctors involved in the episode of care. AXA in its submission stated that:

> The AMA recently seems to have backed away from full support for informed financial consent, now taking the view that this only applies to individual doctors, not for the episode-of-care. *Australian Medicine* (3 July 2000) quotes Dr Phelps as saying 'Surgeons won't want to be saying, for example, what physicians downstream in the episode will charge'.

Similarly, HCF indicated that:

> While the AMA's position is to promote the individual doctor to be responsible for the informed financial consent process, this abrogates what the industry is trying to achieve as far as properly informing the consumer in as simple a manner as possible. Therefore, HCF strongly recommends that the principal practitioner should have the responsibility for facilitating informed financial consent for all medical services.

The Commission believes that for informed financial consent to be meaningful, the lead practitioner, who after all is usually responsible for selecting other doctors to work with him/her on the episode of care, should have the responsibility for obtaining informed financial consent from patients for all doctors involved.

Alternatively, it may be appropriate to legislate that in cases where individual doctors do not obtain informed financial consent in writing, that the patient's liability be limited to the MBS level of fee for the procedure.

Another area of concern to the Commission is the situation whereby doctors do not declare their 'interests' in other medical practices that they refer patients to, or inducements they receive from medical suppliers whose product they recommend and use.

HCF in its submission stated that:

> One area of concern in relation to medical services is that many doctors do not appear to appreciate the need and responsibility to disclose to their patient their financial or other interest in one of the other service providers or the suppliers of services for the patients procedure. Two common occurring examples that warrant mention are when the surgeon has an interest in a pathology or radiology provider that may be utilised or where the doctor is receiving some indirect benefit from a supplier such as a prosthesis supplier and the member is not aware of this interest.

The Commission notes that the *Health Legislation Amendment (Gap Cover Schemes) Act 2000* requires that medical practitioners providing services under a gap cover scheme must disclose any financial interest they may have in products or services they recommend or provide.

The Commission again is of the view that medical practitioners should disclose their commercial or financial interest to patients regardless of whether the service is provided under a gap cover scheme or not. The issue is important from a proper and fully informed consent point of view.

The Commission's view is that this issue will become increasingly important with the amalgamation and vertical integration currently taking place in the medical sector. The Commission therefore recommends that the Department of Health and Aged Care, following consultation with relevant stakeholders, develop a set of guidelines regarding the disclosure of financial interests by medical practitioners. If such disclosure does not happen voluntarily, it may then be appropriate to consider other legislative or regulatory measures to ensure medical practitioners' commercial or financial interests in recommending particular services or products are adequately disclosed to patients.

5.2.2 Provision of price information

As indicated in the Commission's first Senate report, for consumers to make informed choices about purchasing specialist medical services, consumers need reliable information about the fees charged by various practitioners and the quality, experience and training of these practitioners. Naturally, price is not the only element for selecting a practitioner but it is an important one.

The Commission is of the view that meaningful informed financial consent requires patients to know about the likely costs before making an appointment to visit a particular specialist. This gives the patient the option of rejecting the services of the specialist if the price is not suitable. In addition, consumers need to be able to compare the price and quality of various specialists to truly make an informed choice about the best specialist for their needs.

With regard to price information, the Commission suggested in its first Senate report that funds could provide that information by setting up a database of specialists' fees for their members to access.

As indicated in chapter 3, a number of funds are looking at setting up a list of medical practitioners who participate in the fund's no/known gap arrangements.

HCF indicated that:

> We are currently developing a data set for doctors and hospitals that members can access.
>
> For those doctors that wish to be known we will consider making this available to our members via the web, by access through a personal computer at some HCF branches and through customer Direct Information Service.

Medibank Private also indicated that:

> We maintain lists of providers with whom we have contracts, or who are known to have used GapCover. We provide this advice on request as a service to members. Our advice does not endorse any particular practitioner.

The Commission welcomes these initiatives. It is the Commission's view that such lists provide valuable information to members in terms of the price of medical services but also the benefits provided by their health insurance products.

HCF also indicated to the Commission that it is considering ways of providing information to its members on doctors that are not participating in HCF agreements. The Commission strongly supports this initiative.

The Commission understands that the AMA is opposed to health funds making available to their members a list of practitioners who participate in their no/known gap arrangements. The Commission does not see any basis for the AMA's opposition. Such lists do not recommend any particular practitioners. They do not suggest that the practitioners on the list are better than other practitioners, nor do they encourage members to choose the practitioners on the list. They simply provide members with some information about what they can expect to pay, or not pay in the case of practitioners in no-gap arrangements. Members are free to make their final decision on any other consideration.

In addition, the community has clearly indicated that it expects no or known gap medical cover as well as information on the gap. Funds are clearly responding to community expectations when providing details of practitioners that members can go to without having to pay a gap.

5.2.3 Advertising

The Commission indicated in its first Senate report that advertising can also be used to provide some quality and price information about medical services and practitioners. However, advertising must be honest, accurate and complete. Advertising that is false, misleading or deceptive does not assist consumers in making informed decisions.

Recent changes to the laws have relaxed many of the previous restrictions on advertising in the medical sector with the Act becoming one of the main regulatory instruments in relation to promotional activities in this sector. This has given medical practitioners much wider opportunities to communicate directly with consumers.

The transition to this new environment appears to have created some problems and members of the community, regulators and medical and health practitioners have raised concerns.

To address these concerns, the Commission, in conjunction with the NSW Health Care Complaints Commission, published in July 2000 a guide to the Trade Practices Act for the advertising or promotion of medical and health services, titled *Fair Treatment?* The guide seeks to help health and medical sector associations, individual practitioners and others assisting in the provision of medical and health services develop strategies that will improve compliance with the Act.

With the guide, the Commission has also developed a consumer checklist with tips to help consumers of medical and health services interpret advertising and assist them in deciding on services and procedures. It encourages consumers to be vigilant whenever they are choosing medical and health services or practitioners. In particular, it recommends that consumers ensure the practitioner has disclosed the full costs of services of treatment before they commit themselves. It also raises consumer awareness of the practitioner's possible conflict of financial interest.

While the Commission hopes the guide will assist practitioners, the Commission will continue taking enforcement actions in this area when serious breaches of the Act occur.

6. Allied health practitioners

6.1 Preferred provider arrangements

Preferred provider arrangements with allied health practitioners is growing in popularity, as health funds seek to ensure that members have no or known out-of-pocket expenses for ancillary services.

It is apparent, however, that allied health practitioners and their associations still have concerns in respect of 'preferred providers' or 'participating providers' schemes. Concerns have been raised again about health funds placing restrictions on the treatment to be offered to a patient which may, according to practitioners, lead to the fund interfering in the clinical decision-making of the practitioner. Paramount to these concerns are the suggestions that health funds misrepresent the type of providers that members can access under their policies.

Speech Pathology Australia suggested that:

> Very few speech pathologists are participating providers, yet anecdotally health funds are putting forward to consumers that they can access a variety of speech pathologists with known gaps.

In respect of the nature of preferred provider arrangements, the Dietitians Association of Australia stated that:

> Members feel that preferred provider arrangements are unfair to those practitioners who do not participate.
>
> In promoting these schemes the funds suggest that fund members will be advantaged by attending a preferred provider. Our members believe that there is potential for a negative impact on service quality as practitioners attempt to make services to these clients viable.

Similarly, the Australian Physiotherapy Association indicated that:

> Members are concerned about instances where the funds give their members the impression that physiotherapists who have not signed up as preferred providers are overcharging and/or provide a lesser quality service.

Concerns have also been raised in respect of the fees offered. Speech Pathology Australia notes:

> Anecdotal evidence suggests that few speech pathologists have been offered provider agreements and for those that have very few, if any, have shown interest.
>
> Various reasons account for this:
>
> 1. The capped fees offered were so low as to not even cover business expenses.

2. A number of patients need to be treated out of speech pathology rooms … When discussing this issue with health funds they have refused to consider rebating a travel fee or an extra Item Number …

The Australian Physiotherapy Association mentioned that:

> Some allied health professionals and their associations are also concerned that the fees paid by health funds under these preferred provider schemes are not adequate.

The Optometrists Association of Australia was also critical of preferred provider arrangements claiming that the arrangements established by private health funds should be closely monitored by consumer affairs authorities and the Commission to ensure that consumer interests are adequately represented.

The Optometrists Association of Australia suggested that preferred provider arrangements might contravene the third line forcing provisions of the Act and also raised concerns about the market power of funds.

As indicated in the Commission's first Senate report, the Commission has formed the view that the preferred provider schemes it has examined so far had not breached the Act. Many aspects of preferred provider schemes appear pro-competitive in that they foster competition among providers with regard to the fee they charge, and also among the funds themselves, who compete to provide the most attractive package to consumers. These schemes have benefited consumers by reducing their out-of-pocket expenses.

However, as indicated in chapter 3, funds have to take care when advertising these schemes to ensure they do not breach the consumer protection provisions of the Act.

A number of funds also raised concerns that those opposed to preferred provider arrangements have made a number of statements and representations which are inaccurate and potentially misleading.

In particular, AXA claims that:

> ADA [Australian Dental Association] has fiercely opposed preferred provider arrangements between health funds and dentists, to the extent that they have used inaccurate and possibly libellous statements to support their case.

Medibank Private indicated its concerns at possible misleading representations also made by the Australian Dental Association (ADA):

> For over a year the ADA has been making public comment via the media, its website and periodicals regarding Medibank Private's Members' Choice regime. These comments have included the misrepresentation of products offered by funds, and unjust and inaccurate aspersions against dental providers who participate in the schemes, many of whom are ADA members.

As stated in the Commission's first Senate report, it is a requirement of s. 52 that conduct be engaged 'in trade or commerce' for a breach of the Act to occur. Whether an association, when making policy statements or giving advice to its members, engages in conduct 'in trade or commerce' will depend on the particular circumstances of the matter.

The Commission will continue to examine these issues as they arise on a case-by-case basis.

6.2 Registration of practitioners

Providers of ancillary services need to be registered with the health funds for the payment of benefit to their patients. Many funds require practitioners to be in private practice and meet other predetermined criteria, which differ according to the external governance of provider standards.

In its first Senate report, the Commission discussed in detail certain issues and concerns that may arise in relation to the process of registering providers. In particular, the Commission made it clear that a requirement for a practitioner to belong to a particular professional association as a criteria for registration by a fund would be likely to breach the third line forcing provisions of the Act.

The Commission has received several complaints concerning the process of recognition of allied health practitioners by some funds. All complaints indicated that these funds relied on membership of professional associations to ensure quality of service and suitability of qualifications. The Commission recognises the difficulty in assessing practitioners in a field where there is no State Registration Board. However, other funds have put in place procedures that ensure professional associations do not have control over the recognition process. Such procedures ensure that non-association members can have an independent assessment. The Commission is currently investigating these matters.

6.3 Funds' rebates

Several submissions suggested that fee schedules and rebates offered to consumers remain unclear and that providers, as well as consumers, are experiencing difficulties in obtaining health fund rebate amounts for their information. For example, Speech Pathology Australia stated:

> A major complaint by consumers is that there is a limited total amount payable.

The Dietitians Association of Australia further commented:

> The setting of health fund rebates is not transparent to providers or consumers and there is considerable variation around the country.

The Optometrists Association of Australia also raised the difficulty in consumers obtaining benefit levels:

> Patients attending optometrists frequently want to know what benefits for optical appliances are available to them when purchasing spectacles or contact lenses.

Each fund is free to set its fee schedule to be used as a reference to calculate rebates at the level it wishes. The Commission would encourage funds to provide details of rebates to consumers and providers to enable a more informed market.

6.4 Consumer information

For consumers to make an informed choice about purchasing health services from a particular provider, consumers need reliable information about the proposed services or procedures and the provider's quality and price.

As indicated in chapter 5, the Commission believes that advertising can be a way of providing some quality and price information. However, advertising that is false, misleading or deceptive does not assist consumers in making informed decisions.

The Commission, in conjunction with the Health Care Complaints Commissioner, has produced *Fair Treatment?,* a guide to the Trade Practices Act for the promotion of medical and health services to assist medical and health practitioners develop promotion strategies which comply with the Act. However, the Commission will continue to take enforcement actions when serious breaches of the Act occur.

The Commission is strongly of the view that effective competition in the allied health sector will only exist when consumers are able to shop around for the best provider for their particular needs, including price and quality considerations. There is a particular need for price information to be more readily available to consumers. This issue was highlighted in the Commission's first Senate report and still remains. The Commission once again urges health funds, practitioners and their associations to take initiatives to address this issue.

Attachment A. Consultation process

ACA Health Benefits Fund

AMA Health Fund Limited

Association of Massage Therapists Australia Inc.

Australian Association of Occupational Therapists

Australian Association of Surgeons

Australian Consumers' Association

Australian Dental Association

Australian Doctors' Fund

Australian Health Insurance Association Limited

Australian Health Management Group

Australian Health Service Alliance Ltd

Australian Institute of Radiography

Australian Institute of Radiography

Australian Medical Association (ACT)

Australian Medical Association (NSW) Limited

Australian Medical Association (QLD branch)

Australian Medical Association (SA branch)

Australian Medical Association (Tasmanian branch)

Australian Medical Association (Victoria)

Australian Medical Association (WA branch)

Australian Medical Association Limited

Australian Orthopaedic Association

Australian Osteopathic Association

Australian Physiotherapy Association

Australian Podiatry Council

Australian Private Hospitals Association Limited

Australian Psychological Society Ltd

Australian Society of Anaesthetists Inc.

Australian Society of Oto-Laryngology Head and Neck Surgery Ltd

Australian Society of Plastic Surgeons Inc.

AXA Australia Health Insurance

Catholic Health Australia

CBHS Friendly Society

CDH Benefits Fund

Chiropractors' Association of Australia (National) Ltd

Community and Health Services Complaints Commissioner (ACT)

Consumers' Health Forum

Council of Procedural Specialists

Credicare Health Fund

Defence Health

Department of Health and Aged Care

Dietitians Association of Australia

Doctors Reform Society

Federation of Natural & Traditional Therapists Ltd

Geelong Medical and Hospital Benefits Association Ltd

Goldfields Medical Fund (Inc.)

Grand United Health Fund

Health & Community Services Complaints Commission (NT)

Health Care Complaints Commission (NSW)

Health Care Insurance Ltd

Health Care of Australia

Health Complaints Commissioner (Tas.)

Health Insurance Fund of WA

Health Rights Commissioner (QLD)

Health Services Commissioner (Vic.)

Healthguard Health Benefits Fund Ltd

Health-Partners

Hospital Benefit Fund of WA (Inc.)

Hospital Contribution Fund of Australia Ltd

Independent Order of Odd Fellows of Victoria

IOR Australia Pty Ltd

Latrobe Health Services Inc.

Leonie Short

Lysaght Hospital and Medical Club

Manchester Unity Friendly Society in NSW

Medibank Private

Medical Benefits Fund of Australia Ltd

Mildura District Hospital Fund

National Association of Specialist Obstetricians and Gynaecologists

Naval Health Benefits Society

NIB Health Funds Limited

NRMA Health Pty Ltd

NSW Health Funds Association

NSW Teachers' Federation Health Society

Office of Health Review (WA)

Optometrists Association Australia

Pharmaceutical Society of Australia

Pharmacy Guild of Australia

Phoenix Welfare Association Ltd

Private Health Insurance Administration Council

Private Health Insurance Ombudsman

Private Hospitals Association of NSW

Private Hospitals Association of Queensland

Private Hospitals Association of WA Inc.

Qld Teachers' Union Health Society

Queensland Country Health Limited

Railway and Transport Employees' Friendly Society Health Fund

Reserve Bank Health Fund Friendly Society

Royal Australian College of General Practitioners

SA Police Employees' Health Fund Inc.

State Ombudsman (SA)

SGIO Health Pty Ltd

Speech Pathology Association of Australia

St Luke's Medical & Hospital Benefits Association

The Association for the Advancement of Private Health

Transition Benefits Fund Pty Ltd

Transport Friendly Society

United Ancient Order of Druids

Urological Society of Australasia

Victorian Private Hospitals Association

Western District Health Fund Ltd

Yallourn Medical and Hospital Society

Attachment B. List of submissions

Health fund sector

Australian Health Management Group

Australian Health Service Alliance Ltd

Australian Unity

AXA Australia Health Insurance

Geelong Medical & Hospital Benefits Association

HBF

HCF

MBF

Medibank Private

R & T Health Fund

St Luke's Health Insurance

Medical practitioners sector

Association for the Advancement of Private Health

Australian Institute of Radiography

Australian Medical Association (South Australia) Inc.

Australian Medical Association Limited

Australian Physiotherapy Association

Australian Society of Oto-Laryngology Head and Neck Surgery Ltd

Dietitians Association of Australia

Dr Richard J. Waldron

Optometrists Association Australia

Speech Pathology Australia

Hospital sector

Australian Private Hospitals Association Limited

Network of State Private Hospitals' Associations (prepared by the Private Hospitals Association of Queensland)

Consumer organisations

Australian Consumers' Association

Department of Health and Aged Care

Office of Health Review (WA)

Private Health Insurance Administration Council

Private Health Insurance Ombudsman

State and Commonwealth departments and agencies

Attachment C. Commission's complaints

The Commission relies mainly on complaints to find out about possible breaches of the Trade Practices Act. Complaints received by the Commission about the health sector during the reporting period are shown in table 1.

Table 1. ACCC complaints — 1 January to 30 June 2000

	Part IV	Part IVA	Part V	GST*	Other	Total
Health insurance services	11	0	34	55	11	111
Hospital services	5	1	2	11	3	22
General practice medical services	20	0	10	21	3	54
Specialist medical services	20	0	7	25	3	55
Dental services	1	0	3	8	1	13
Pathology services	3	0	3	0	2	8
Optometry and optical dispensing	2	0	8	53	1	64
Ambulance services	1	0	1	1	3	6
Physiotherapy and chiropractic services	2	0	1	21	1	25
Other health services	15	0	27	89	6	137
Total	**80**	**1**	**96**	**284**	**34**	**495**

* GST complaints and inquiries

The main areas of complaints received in the first half of 2000 were similar to those of previous years.

- Misleading and deceptive conduct in relation to advertising and other promotional activities by health funds and providers of medical and other health services.
- Allegations of agreements lessening competition, price fixing, exclusive dealings and/or misuse of market power by groups of medical specialists or other providers of health services.
- Complaints and queries about agreements lessening competition and price fixing by groups of GPs or medical centres, including allegations of agreement between GPs not to bulk bill.
- Complaints against hospitals and/or group of medical practitioners for refusing credentialling at particular hospitals.

The Commission currently has a number of part V matters under investigation. In July 2000 proceedings were instituted against Emerald Ocean Distributors which retails electronic muscle stimulation products generally referred to by the trade name 'Slendertone'. The Commission alleged that representations made in respect of the product and advertised in *Women's Health* and *Ultrafit* were false, misleading or deceptive.

The Commission has also instituted legal proceedings against Mr Paul Storer alleging that he made false and misleading representations about the benefits of using the product Probiotics — used in isolation as a cure for Chronic Fatigue Syndrome. The Commission is also alleging that Mr Storer's claims of being a 'doctor' and having a PhD in microbiology from the University of Western Australia is either false or cannot be substantiated.

The Commission has succeeded in an action against the promoters of health therapy devices, Vital Earth Company Pty Ltd and its director for a number of representations on the product's ability to treat all disease-causing bacteria, AIDS and diseases such as diabetes and leukaemia. In May 2000 the Federal Court issued declarations, and granted injunctions. Consumers misled by the claims received refunds.

The Commission hopes that its *Fair Treatment?* guide will assist providers of medical and health services in developing promotional strategies complying with the Act. However, the Commission will continue to take enforcement action in this area for serious breaches of the Act.

The Commission currently has a number of part IV matters under investigation. In July 2000 the Commission also instituted proceedings in the Federal Court in Perth against the Western Australian branch of the Australian Medical Association and Mayne Nickless Ltd, alleging they were involved in price fixing and other anti-competitive conduct at Joondalup Health Campus in breach of the Act. The Commission is seeking court orders including declarations, injunctions, pecuniary penalties, costs and orders requiring the publishing of public notices and institution of a trade practices compliance program.

The Commission is also investigating allegations of unconscionable conduct by a health fund towards a small private hospital, in breach of s. 51AC of the Act.

Attachment D. 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*, April 2000.

Australian Competition and Consumer Commission, *Application for authorisation: Inter-hospital arrangement between St Vincent's Private Hospital, Mater Misericordiae Private Hospital and Sydney Adventist Hospital*, Determination, 28 June 2000.

Australian Competition and Consumer Commission, *Fair Treatment?*, Summary of the guide to the *Trade Practices Act 1974* for the advertising or promotion of medical and health services, with tips for consumers on interpreting advertising and selection of medical and health services, July 2000.

Australian Competition and Consumer Commission and Health Care Complaints Commission (NSW), *Fair Treatment?*, guide to the Trade Practices Act for the advertising or promotion of medical and health services, July 2000.

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