Australian Competition and Consumer Commission

Report to the Australian Senate

on

anti-competitive and other practices by health funds and providers in relation to private health insurance

for the period ending 31 December 1999

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1 Executive summary

This report has been prepared by the Australian Competition and Consumer Commission (the Commission) in compliance with an order agreed to by the Australian Senate on 25 March 1999. The Commission was required to provide a report 'containing an assessment of any anti-competitive or other practices by health funds or providers which reduce the extent of health cover for consumers and increase their out-of-pocket medical and other expenses'.

The Commission is the independent statutory authority which, among other functions, is responsible for compliance with, and enforcement of, the *Trade Practices Act 1974* (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.

Incorporated medical and other health professionals' businesses have been covered by the Act since 1974, as well as unincorporated medical/health professionals' businesses in the Territories. Since July 1996, through legislation introduced as part of the National Competition Policy, unincorporated businesses including unincorporated medical/health professionals, have been subject to the competition provisions of the Act through the State and Territory equivalents, the Competition codes.

Over the last few years, the health sector has been a priority area for the Commission. It has devoted considerable resources to education and guidance programs and increasingly to investigations in this sector.

An out-of-pocket expense incurred by a health fund member, which cannot be covered by private health insurance and/or is not due to the member's choice of insurance cover, is generally regarded as the 'gap'. That is, the member will incur these out-of-pocket expenses, no matter how comprehensive his/her insurance policy is. The existence or extent of such a gap is often unknown or not expected by members of the health funds. To the extent that the existence of such gaps is known by the public at large — the gaps act as a disincentive to take out private health insurance or maintain existing cover.

The hospital gap is the difference between the fee charged by a hospital for hospital accommodation, and the health fund benefit received by the patient. However, some out-of-pocket expenses incurred by fund members for hospital accommodation would not generally be considered as a gap, as these are due to the member's choice of a particular insurance cover.

The medical gap is the difference between fees charged by doctors for in-hospital medical services and the combined health insurance benefit and Medicare benefit received by the patient.

The ancillary gap is the difference between the price of a particular allied health service or product and the health fund benefit received by the patient for that product or service.

Generally speaking, health fund members are benefiting from a regime of no/known gaps for hospital accommodation services provided they use a hospital that has a contract with their health fund. This result flows from the contracts (hospital purchaser provider agreements or HPPAs) that funds have negotiated with private hospitals.

The contracting process between hospitals and health funds has not been without its problems. Hospitals have levelled criticisms at the conduct of health funds in relation to contracting for hospital services. The Commission has monitored the health funds-hospitals contracting environment. It has also conducted several investigations into allegations by hospitals that funds had contravened the Act. The results have been either that the conduct changed following the initial investigation or that the Commission did not find evidence of a contravention. In some instances parties have been unwilling to speak out to the Commission in specific terms about particular health funds and alleged conduct because of an apparent fear of future commercial retribution by health funds towards the hospital for speaking out. The contracting process, to the extent that it may raise issues under the Act, is of importance to the Commission. It will continue to examine any allegation of breaches of the Act raised in relation to the contracting process and will further investigate, and if necessary, litigate any such matters that raise trade practices issues.

The Commission notes that several initiatives supported by both the hospital and the health fund sectors, including the development of a voluntary industry code of conduct, are underway which may help in addressing some of the hospitals' concerns.

Member surveys conducted by health funds have clearly indicated that the medical gap is a major consumer concern and a key reason for public dissatisfaction with private health insurance.

Many medical practitioners and their professional associations have expressed firm philosophical opposition to doctors entering into contractual arrangements with health funds in relation to services they provide to patients, (medical purchaser provider agreements — MPPA). They argue such contracts would lead to health funds interfering with doctors' clinical independence. Legislative endeavours have been made in the *National Health Act 1953* (ss 75BDA and 73BDAA) to protect the medical practitioners' clinical independence. In addition, in November 1997 AXA Australia Health Insurance (formerly National Mutual Health Insurance) introduced its Ezyclaim system which is a transaction-by-transaction process providing medical practitioners with the freedom to participate in no-gap arrangements on behalf of patients and episodes of treatment selected by the medical practitioner. Other health funds have recently followed the AXA Ezyclaim system by introducing such transaction-by-transaction no gap or known gap insurance products providing medical practitioners with the freedom and control to participate in no gap arrangements for patients selected by the medical practitioner.

The Commission notes that with 1600 medical practitioners in South Australia and Victoria now using AXA's Ezyclaim, this system is successfully delivering no-gap cover to over 9000 patients a month. The Commission is not aware of any concern by medical practitioners participating in this system about actual or potential interference with their clinical independence.

The Commission also sees merit in a proposal of the Private Health Insurance Ombudsman that the medical fraternity agree on a set of words which enshrine safeguards into any contract between health funds and medical practitioners which provides for the absolute medical discretion within college or profession acceptable standards. The Commission sees a role for professional associations to provide guidance on the negotiation process to their members to ensure they consider all the relevant issues pertaining to contracts, including clinical independence. The Government's *Health Legislation Amendment (Gap Cover Scheme) Bill 2000* will provide another option for the development of no gap or known gap health insurance products.

Competition for the provision of specialist medical services is limited by high barriers to entry into specialists markets and lack of consumer information. The Commission is currently investigating some of these issues to see if there is any breach of the Act.

In order for consumers to make informed choices about medical specialists, they need comparative information on quality and price of a range of practitioners. The importance of price and price information to consumers is highlighted by the community demand for 'no gap or known gap' health insurance products.

The Commission is of the view that advertising can be a way of providing some service quality and pricing information needed by consumers, provided that the advertising is honest, accurate and complete. Health funds may also be able to provide information on the charges of individual specialists, by setting up their database of specialists' fees, including no or known gap arrangements, for their members to access.

Professional associations could take a leadership role in helping the community to better understand the services their members provide and how to select appropriate professionals to provide these services. This could include advertising or other information to general practitioners and/or consumers on which factors to consider when selecting a specialist and regularly publishing directories of their members and including, where individual specialists choose to do so, the fees they charge.

A number of health funds have introduced preferred provider arrangements with allied health practitioners, to ensure that members have no gap or known gap for ancillary services. Many allied health practitioners and their associations have expressed concerns that these schemes may place restrictions on the treatment offered to a patient and may therefore lead to the fund interfering in the clinical decision making of the practitioner. They have also raised concerns that the schemes may breach the Act.

The Commission has found no evidence of a breach of the Act in the preferred provider schemes it has examined to date. It is of the view that 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, who compete to provide the most attractive package to consumers. The Commission is not aware of any reduction in service quality as a result of the introduction of preferred provider schemes.

However, there can only be effective competition between allied health practitioners if consumers can shop around for the best practitioners (including quality and price

considerations). Among other things, consumers need to have access to comparative information about charges of allied health practitioners to make an informed choice.

As outlined above with respect to medical specialists, allied health professionals could make more use of advertising to make their quality of services and fees known to consumers. Health funds may also be able to set up their own database of practitioners' fees for their members to access. Finally, allied health professional associations could take a leadership role in helping the community to better understand the services their members provide and how to select appropriate professionals to provide these services. This could include advertising or other information about the factors to consider when selecting a practitioner and regularly publishing directories of their members including, where individual practitioners choose to do so, the fees they charge.

Complaints received by the Private Health Insurance Ombudsman and the Commission from consumers raise some issues of concern, including confusion about benefit entitlement, verification of entitlements, pre-existing ailments, transferability of cover, changes to benefit entitlements. A clear message is that funds must provide adequate information to consumers about their health insurance policies and any changes affecting these policies. Failure to do so may, in certain circumstances, amount to a breach of the Act. The Commission will continue to examine allegations in this area. There are also a number of initiatives by the Government, the Ombudsman and/or the industry to address some of these issues.

In order to make a financially informed decision about treatment options, the patient has to know about the likely costs of alternative treatment options prior to giving consent to receive treatment. Patients need this information prior to making an appointment to visit a specialist.

Information about alternative specialists and their fees may be provided to patients by their referring general practitioner. As indicated above, in the future patients may be able to obtain this information from their health funds or medical practitioners' professional associations.

All participants in the private health care industry, be they health insurance funds, private hospitals, medical or allied health practitioners and their professional associations must ensure that they do not engage in anti-competitive conduct which puts them at risk of breaching Part IV of the Act or the Competition codes of the States and Territories. Additionally, they need to ensure that they are aware of and comply with the fair trading and consumer protection provisions of the Act and the Fair Trading Acts of the States and Territories. In the Commission's view, putting in place effective compliance programs or systems is an important and essential risk management strategy.

2 Introduction

2.1 Senate order

This report has been prepared by the Australian Competition and Consumer Commission (the Commission) in response to an order agreed to by the Australian Senate on 25 March 1999, during consideration of the Health Legislation Amendment Bill (No. 2) 1999. The order is as follows:

> 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.

A copy of the Senate order is at attachment A.

On 20 October 1999 the Commission received the following clarification from Senator Harradine's office as to the intended scope of the Senate order:

The intent of the order was to require the ACCC to report to the Senate on anti-competitive conduct in the area of health insurance funds and health care providers, including medical and allied health practitioners, as well as hospitals and health care services. The issue of gap fees was a major issue in the Senate debate. Any assessment should focus particularly on those funds or providers who uniformly charge a significant gap fee and/or those that over-service and/or those who do not provide all of the information and advice required for informed consent.

It would be reasonable for the ACCC to form an assessment by drawing on:

- Information gathered by the Commission in its normal dealings with health funds, providers and consumers;
- Information gathered in investigation of complaints made to the Commission in relation to specific issues;
- More detailed reviews of practices within a sample of funds or providers;
- Reviews from time to time of the adequacy of Trade Practices compliance and awareness programs within fund and provider organisations;
- Complaints made to the Private Health Insurance Ombudsman which raise relevant issues;
- Investigations should cover services provided outside PHI to ensure consumers of non-PHI funded services receive the benefits of any investigations;
- Monitoring of developments in the health sector through the media and conferences with a view to identifying issues that are causing concerns;
- Monitoring of pricing and charging information published by the Health Insurance Commission.

2.2 The Commission

The Commission is the independent statutory authority which among other functions is responsible for compliance with, and enforcement of, the *Trade Practices Act 1974* (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 where 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. For example, in the health sector professional associations, professionals, health funds, hospitals, patients and others could also take legal action under the Act.

2.3 The consultation process

In order to prepare this report, the Commission initiated a consultation process with the relevant stakeholders. A list of the parties contacted by the Commission is at attachment B. The Commission also organised meetings with key stakeholders to canvass specific issues relevant to the order (see attachment B).

The Commission received 33 submissions from individual health funds and their associations, hospitals and their association, medical and allied health practitioners' associations, consumer organisations, the Private Health Insurance Ombudsman, some State and Territory health complaints bodies and the Department of Health and Aged Care. A list of the parties which provided a submission is at attachment C.

The report has been prepared based on information contained in the submissions or provided at meetings, as well as information obtained by the Commission in the normal course of its work.

3 The Trade Practices Act

This chapter outlines key provisions of the Act relevant to the private health industry.

The broad objective of the Act is to enhance the welfare of Australians through the promotion of competition and fair trading and by providing for consumer protection. The Act proscribes certain anti-competitive conduct and unconscionable, misleading, deceptive or false trading practices.

3.1 Restrictive trade practices

Broadly speaking, Part IV of the Act prohibits the following anti-competitive practices:

- anti-competitive agreements and exclusionary provisions, including primary or secondary boycotts and price fixing (ss 45–45EA);
- misuse of market power (s. 46);
- exclusive dealing (s. 47);
- resale price maintenance (ss 48, 96–100); and
- mergers which would have the effect, or likely effect, of substantially lessening competition in a substantial market (ss 50, 50A).

In some situations the prohibition is absolute. In others, a test as to the effect on competition is applied. Most conduct can be protected from legal proceedings for breaches of the Act by processes of authorisation or notification (see below).

Anti-competitive agreements (ss 45–45EA)

Section 45 deals with a variety of contracts, arrangements or understandings (agreements) between businesses or professionals. Entering into, or giving effect to, the following types of agreements is prohibited.

- Agreements that have the purpose or effect (or likely effect) of substantially lessening competition in a market (s. 45).

This is the general catch-all provision dealing with anti-competitive behaviour by businesses. It catches behaviour such as competitors agreeing to share a market between them.

- Agreements that contain an exclusionary provision (ss 45 and 4D).

Sometimes referred to as a primary boycott, these are agreements between persons in competition with each other which exclude or limit dealings with a particular supplier or customer or a particular class of suppliers or customers. Such agreements are per se breaches of the Act (i.e. no assessment as to the effect on competition is carried out in respect of this type of conduct).

- Agreements that have the purpose, effect or likely effect of fixing, controlling or maintaining prices (s. 45A).

Agreements between competitors under this provision are deemed to substantially lessen competition. This provision also catches agreements which purport only to recommend prices but which in reality fix prices between competitors.

There are some exceptions to the per se nature of this provision. In particular:

- some joint venture pricing is excluded (s. 45A(2));
- the price for goods or services collectively acquired by the parties to the agreement is not caught (s. 45A(4)). 'Collective acquisition' generally requires collective negotiation (or negotiation by a collectively appointed negotiator) and individual acquisition at the price negotiated;
- joint advertising of the price of the goods or services collectively acquired (s. 45A(4)).

These exceptions, however, fall for review under the substantial lessening of competition test in s. 45.

- Secondary boycotts (s. 45D-EA).

The Act prohibits action by one person in concert with a second person (where a 'person' can be an individual, corporation or trade union) which hinders or prevents a third person from:

- supplying goods or services to a business;
- acquiring goods or services from a business; or
- engaging in trade or commerce involving the movement of goods between Australia and places outside Australia.

Where the first and second person engage in the conduct in concert with one another and are members of the same organisation of the employees, then that organisation is deemed to have engaged in the secondary boycott as well (s. 45DC).

Employees are allowed to engage in secondary boycott action if the dominant purpose substantially relates to their pay or employment conditions (s. 45DD).

A person is prohibited from making an agreement with a union for the purpose of preventing or hindering trade between that person and a target person, where the person is accustomed to or under an obligation to supply goods or services to the third person (s. 45E). The giving effect to such an arrangement is proscribed by s. 45EA.

Misuse of market power (s. 46)

A person with a substantial degree of power in a market is prohibited from taking advantage of that power for the purpose of:

- eliminating or substantially damaging a competitor;
- preventing the entry of a person into any market; or
- deterring or preventing a person from engaging in competitive conduct in any market.

In determining whether a person has a substantial degree of market power, a court will take into account the extent to which the activities of the person are constrained by the conduct of actual or potential competitors or by the behaviour of its suppliers or customers.

A court may, in the absence of direct evidence of purpose, infer a purpose from surrounding circumstances.

While s. 46 prohibits the misuse of substantial market power it does not prohibit the mere possession of that power or use of that power as long as it is not for a proscribed anti-competitive purpose.

Exclusive dealing (s. 47)

Section 47 prohibits anti-competitive exclusive dealing. Broadly speaking, exclusive dealing involves one person who trades with another imposing restrictions on the other's freedom to choose with whom, or in what, to deal.

For example, it is a breach of s. 47 to supply goods or services on condition that the purchaser:

- will not acquire, or will limit the acquisition of, goods or services from a competitor of the supplier; or
- will not resupply, or will resupply only to a limited extent, goods or services to a particular person, class of person or particular place(s) if the conduct has the purpose or effect of substantially lessening competition.

One form of exclusive dealing prohibited outright by the Act is 'third line forcing', which involves the supply of goods or services on condition that the purchaser acquire goods or services from a particular third party or a refusal to supply because the purchaser will not agree to that condition.

Resale price maintenance (ss 48, 96–100)

Suppliers, manufacturers and wholesalers are prohibited from specifying a minimum price below which goods or services may not be resold or advertised for resale.

A supplier may recommend a resale price for goods or services, provided that the document setting out the suggested price makes it clear that it is a recommended price only and the supplier takes no action to influence the reseller not to sell or resupply below that price.

Mergers or acquisitions (s. 50)

Section 50 generally prohibits mergers or acquisitions which would have the effect or likely effect of substantially lessening competition in a substantial market for goods or services.

Authorisation and notification

Authorisation (ss 88–91)

The Commission has the power to grant immunity from legal proceedings for some arrangements or conduct that might otherwise breach the restrictive trade practices provisions of the Act.

Authorisation is available for all restrictive trade practices (including mergers) except misuse of market power (s. 46).

For agreements that may substantially lessen competition, the applicant must satisfy the Commission that the agreement results in a benefit to the public that outweighs any anti-competitive effect. For other anti-competitive conduct (such as boycotts, third line forcing, resale price maintenance and mergers) the applicant must satisfy the Commission that the conduct results in a benefit to the public such that it should be allowed to occur.

The Commission does not have the power to grant an authorisation to make an agreement in circumstances where a contract has already been entered into. However, the making of a contract will not breach s. 45 if the contract is conditional on authorisation and an application for authorisation is lodged within 14 days. Where an authorisation is granted to give effect to an agreement, the authorisation protects only conduct engaged in after the grant of the authorisation.

Notification (ss 93–93A)

Exclusive dealing conduct (except for third line forcing) gains automatic and immediate immunity from legal proceedings under the Act when notification of it is given to the Commission. The immunity can be revoked if the Commission is satisfied that the conduct substantially lessens competition and the competitive detriment outweigh the public benefit. For third line forcing, the immunity generally starts 14 days following lodgement with the Commission.

Statutory exemptions (s. 51)

Statutory exemption from certain prohibitions is available under the Act in limited circumstances. For example, conduct specified in, and specifically authorised by, Commonwealth, State or Territory legislation is exempt where authorising provision in the legislation expressly refers to the Act.

Penalties and remedies

Breaches of Part IV of the Act can lead to civil proceedings but not to criminal prosecution.

The following penalties and remedies may be imposed by the Federal Court for breaches of Part IV of the Act:

- monetary penalties of up to $10 million per breach for companies and up to $500 000 per breach for individuals;

- injunctions, damages, divestiture of illegally acquired shares or assets and ancillary court orders.

The Commission may seek monetary penalties, injunctions or divestiture. Other persons may, through a private action, seek injunctions (except in the case of a merger), divestiture, damages or other ancillary court orders.

3.2 Unconscionable conduct and industry codes

Part IVA of the Act prohibits unconscionable conduct in both commercial dealings and consumer transactions.

Section 51AA provides that a corporation must not, in trade or commerce, engage in conduct that is unconscionable within the meaning of the unwritten law of the Australian States and Territories.

Section 51AB prohibits unconscionable conduct by corporations when they supply goods or services that are ordinarily acquired by consumers for their personal, domestic or household use. In such a transaction the stronger party may not take advantage of its position by behaving in an unfair or unreasonable manner.

Recent legislative amendments to the Act aimed at fostering a fair and competitive operating environment for small business have included the addition of two new provisions in the Act:

- section 51AC protects small business from unconscionable commercial conduct; and

- section 51AD provides for codes of conduct to be enforceable under the Act (Part IVB).

Section 51AC gives small business the same strong legal protection against unconscionable conduct that is available to consumers under the Act; however, it only applies to transactions of less than $1 million.

Although the Act does not define ‘unconscionable conduct’ s. 51AC does include a non-exhaustive list of factors which may be taken into account by the court. These include for example:

- the relative bargaining strengths of the parties;

- whether, as a result of the stronger party’s conduct, the other was required to meet conditions not reasonably necessary to protect the stronger party’s legitimate interests;

- the use of any undue influence, pressure or unfair tactics by the stronger party;
- the terms and conditions in which the weaker party could have engaged in a similar transaction with another party;
- the extent to which the stronger party's conduct was consistent with its conduct in similar transactions with other business;
- the extent to which the stronger business was willing to negotiate with the target business the terms of any supply contract; and
- the extent to which each party acted in good faith.

Breaches of provisions in Part IVA can lead to civil proceedings but not criminal prosecution.

Remedies for a breach of Part IVA can include injunctions, as well as orders declaring the whole or part of a contract or arrangement void, varying a contract or arrangement, or refusing to enforce any or all of the provisions of the contract. Damages remedy is available to a business which suffers loss or damage by the actions of another business in breach of s. 51AC.

The Act has been amended to also include Part IVB which provides for industry codes of conduct to be prescribed in regulations to the Act and thus enforced by the Commission (or private parties).

Stated simply, s. 51AD prohibits contraventions by corporations of such prescribed industry codes of practice. Section 51AE provides for industry codes of conduct to be prescribed in regulations proposed by the responsible Minister.[1]

Regulations may declare a code to be mandatory or voluntary:

- mandatory codes are binding on all industry participants;
- voluntary codes are only binding on those members of the industry or profession who have formally subscribed to the code. The Commission is to keep a public register of companies bound by voluntary codes.

The Franchising Code is the first code to be covered by the new provision.

Remedies for breaches under Part IVB includes injunctions, corrective advertising, damages and ancillary orders of various kinds.

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[1] Policy guidelines on making industry codes of conduct enforceable under the Trade Practices Act have been published by the Treasury. See *Prescribed codes of conduct*, Treasury, May 1999.

3.3 Consumer protection

Part V

Part V of the Act contains a range of provisions aimed at protecting consumers, including buyers of all kinds. The Commission is responsible for enforcing provisions related to unfair practices, product safety, information standards and banning orders for unsafe goods.

Section 52 of the Act is a general prohibition of misleading or deceptive conduct. Generally, providers of goods or services such as health funds, hospitals, medical and other health practitioners are required to tell the truth or refrain from giving an untruthful impression. Failure to disclose material information may in some circumstances be a breach of the Act.

Other sections of this part of the Act relate to specific prohibitions. Section 53 prohibits the making of false or misleading representations concerning, for example:

- the price, standard, quality or availability of goods or services;
- the need for any goods or services; and
- the existence, exclusion, or effect of any condition, warranty, guarantee, right or remedy.

Breaches of some of the provisions in Part V of the Act can lead to either civil proceedings or criminal prosecution.

The Act provides for the following penalties and remedies for breaches of Part V:

- fines of up to $200 000 per breach for companies and up to $40 000 for individuals, however, fines cannot be imposed for a breach of s. 52;
- injunctions, damages, orders for corrective advertising and ancillary orders of various kinds in favour of persons who have suffered loss or damage.

The Act also provides a limited number of defences to a criminal prosecution (for fines) — for example, if it can be shown that the offence was committed due to a reasonable mistake.

Product safety and product information

Division 1A of Part V of the Act is designed to ensure that certain goods meet particular standards and dangerous goods are not sold or can be quickly withdrawn from sale.

Conditions and warranties

Divisions 2 and 2A imply certain conditions and warranties in consumer contracts for the supply of goods or services. These statutory conditions and warranties cannot be excluded or limited by other provisions in contracts.

Among others, the terms implied by these provisions include conditions that the goods are of merchantable quality and are fit for their purpose (s. 71), and warranties that the services will be carried out with due skill and care and will be fit for the purpose for which they were supplied (s. 74).

The Commission cannot bring an action for breach of any of the statutory conditions and warranties.

A consumer may bring a private action for damages in any court or tribunal of competent jurisdiction against a provider be it a fund, hospital, medical or allied health practitioner.

Part VA

Part VA addresses the liability of manufacturers and importers for defective goods. It provides that a person who is injured by, or whose domestic property is damaged by, a defective good, will have a right to compensation from the manufacturer of the good.

3.4 Information powers

Section 155 of the Act confers powers on the Commission to obtain information, documents and evidence when investigating possible contraventions of the Act and in some of its adjudication work.

4 ACCC's involvement in the health sector

Over the last few years, the health sector has been a priority area for the Commission, which has devoted considerable resources to guidance programs and investigations in this sector.

4.1 Early involvement

Although the involvement of the Commission in the health sector has become more important since 1996 when the application of the Act was extended to all businesses, its predecessor, the Trade Practices Commission (TPC), had been involved in that sector as early as 1974. Indeed, the TPC had considered several applications for authorisation concerning the health sector. For example:

- **Australian Medical Association** [2] (boycott arrangement)

  This was an application for authorisation of a contract, arrangement or understanding that may be in restraint of trade. The parties were most of the medical practitioners in private practice in the ACT. The nature of the agreement appeared from a declaration made by the parties following a meeting on 2 July 1974, which opened with these words:

  > We, the private medical practitioners of Canberra, are united in our determination to halt encroachment on private medical practice in the ACT, whether caused by the appointment of full-time salaried specialist staffs to the Canberra hospitals, or by the establishment of health centres staffed by salaried general practitioners in areas adequately served by existing practices.
  >
  > In order to demonstrate our determination, we will, from the date of commencement of duty of the first full-time salaried specialist appointed in response to advertisements for staffing the proposed Canberra Hospital Service Scheme:
  >
  > - Disassociate ourselves entirely from the salaried system of specialist medical care in the Canberra hospitals by ceasing to give the system any clinical support. We are not prepared to support a scheme which is designed eventually to destroy our chosen mode of practice.
  > - Make arrangements to ensure that the private medical service which has served Canberra citizens so well for so many years, continues to operate to the satisfaction of our patients despite the difficulties created by the Government.
  >
  > Thus, patients will have a choice of opting for medical care through an untried, wholly salaried system, or of accepting wholly private medical care of the type they have been used to, supported through membership of health insurance funds. The two systems will become separate and exclusive.

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[2] (1974–75) ATPR (Com) ¶13-840 at p. 8,866

The essence of the AMA's contentions was that the then existing hospital scheme was in the best interests of the public of the ACT and that it was in danger of being eroded to the detriment of the public.

In its decision, the Commision noted that for it to grant authorisation, it would first have to be satisfied that the arrangement or understanding results or is likely to result in a substantial benefit to the public. That is to say that the preservation of the status quo was a substantial benefit as against the introduction of the changes being resisted. This would involve decision between competing views at the professional, political and even emotional level.

The Commission would have to be satisfied further that the substantial benefit to the public, if it existed, would not otherwise be available, that is, that the preservation of the status quo could not be achieved otherwise than by what would amount to a boycott arrangement. The Commission was not satisfied. There had been a good deal of discussion between the applicants and the administration. The issues were the subject of public debate and political disputation at a time when politics were more than ordinarily volatile.

The final point on which the Commission was also not satisfied, was that the public benefit, if it existed and was not otherwise available, must in all the circumstances justify the authorisation. This involved balancing the benefit against the detrimental effect of the arrangement such as the dominance it accorded to the parties and the clog it set on further development, which might have to be at a rate and in a direction approved by the applicants collectively. The Commission did not authorise the conduct.

- **David Ashby on behalf of members of the Pharmacy Guild of Australia** [3]

  This was an application made on behalf of the Pharmacy Guild of Australia for authorisation of a contract arrangement or understanding referred to in the application as 'recommended pricing services for Guild members'. In its decision of 24 November 1977 the Commission concluded that in the circumstances there was no causal link between the operation of the Guild Economic Information Service (GEIS) and the adequate provision of pharmaceutical services to the community as had effectively been claimed by the guild. The Commission did not grant the authorisation application but extended the duration of its interim authorisation to enable the guild to make proposed changes to the GEIS.

- **Sterling Pharmaceuticals Pty Ltd** [4] ('chemist only' arrangements of Winthrop Laboratories and Nyal Company Divisions)

  These were three applications for authorisation of a traditional method of working and course of dealings whereby the applicants (Winthrop and Nyal) supplied their

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[3] (1977) ATRP (Com) ¶35–340 at p. 16,910

[4] (1977) ATPR (Com) ¶35–220 at p. 16 ,748

products only to pharmacies or hospitals or to wholesalers who supplied only to pharmacies and hospitals.

> The Commission concludes that Sterling's "C.O." arrangements limit competition between pharmacy and non-pharmacy retail outlets. The Commission considers that the public would benefit if market forces were allowed to operate unfettered by the restrictions on competition resulting from the "C.O." arrangements; prices are then likely to be lower and more non-viable pharmacies would leave the industry.

And

> It is not suggested that the applicant's Chemist Only policy is purely unilateral and independent of any understanding with other parties, and the Commission is not discussing that hypothetical situation. In the absence of authorisation, the applicant will have to decide whether to discontinue its Chemist Only policy or whether to continue it, wholly or partly, as a matter of purely unilateral decision that it is prepared, if necessary, to defend as not being in contravention of either sec.45 or sec. 47 of the Act.

- **Deputising Medical Services Pty Ltd** and **Radio Doctor Service Pty Ltd**[5]

The Commission dealt with these applications for authorisation which were lodged by solicitors for each applicant on 6 January 1975. The conduct the subject of the application is the requirement that subscribing medical practitioners do not employ any locum tenens during the applicant's normal hours of operation and the requirement that the subscribing medical practitioners do not engage the services of companies providing similar services.

The Commission denied authorisation. As the Commission did not receive any public benefit submissions in support of this application, it was not satisfied that the requirements of s.90(6) of the Act had been met.

Private hospitals have also utilised the authorisation procedure in the Act, for example:

- **Calvary Hospital A.C.T Incorporated**[6] (common form contract)

In May 1979 and March 1982 the Commission granted authorisation to Calvary Hospital in respect of the:

> Proposed medical staffing structure for the hospital with accompanying common forms of contract between private medical practitioners and Calvary Hospital A.C.T Incorporated for appointment to the hospital —
>
> - for the treatment of hospital patients and for the provision of remuneration for that treatment,
>
> - for the treatment of private patients admitted to the hospital under private medical practitioners.

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[5] (1979) ATPR (Com) ¶35-200 at p. 16,414 and 16,415

[6] (1979) ATPR (Com) ¶35-100 at p. 15,581; (1982) ATPR (Com) ¶50-032 at p. 55,362

From the facts placed before it, the Commission concludes that it is being asked to decide not only on the standard form of contract proposed by the applicant but also in respect of the method to be adopted in the appointment of visiting medical officers.

- **The Private Hospitals Association of NSW Inc**[7]

The Commission's decision was made on 27 April 1990.

This decision covers two applications for authorisation by the Private Hospitals Association of NSW Inc ("the Association"). The first relates to the Association's proposed statement of objects and rules. One of the rules relates to a condition of membership of the Association which is compliance with a code of ethics and business practice. The second requires members of the Association (private hospitals and freestanding day care centres) to be accredited by the Australian Council on Healthcare Standards ("ACHS"); or be an applicant for accreditation, or satisfy such other assurance requirement approved by a general meeting of members.

ACHS is an independent, non profit and financially self –sufficient organisation which amongst other things, establishes optimal standards for administration, quality of care, essential services and plant safety for hospitals and health care facilities.

The Commission believes that the accreditation requirement for membership of the Association will raise standards in the industry. On the balance of public benefit and anti-competitive effect the Commission proposes to authorise the application in respect of the accreditation requirement for membership.

In general terms the Commission must be satisfied that this self-regulatory scheme delivers public benefits outweighing any detriment flowing from the arrangements.

In the Commission's draft determination the Commission said it was not satisfied that this test was met and had particular reservations about the adequacy of such key aspects of the code of ethics and business practice as its complaint-handling and reporting procedures and provision for external participation. It said it would be prepared to grant authorisation if these aspects were addressed.

The Commission had a number of reservations concerning the objects and rules which it said would need to be met prior to it granting authorisation. As a result of amendments by the Association to its objects and rules and the statutory requirements of the N.S.W *Private Hospitals and Day Procedure Centres Act, 1988* the Commission is now satisfied that an adequate complaints handling mechanism will be put in place.

The Commission is of the opinion that the amended objects and rules will result in a level of public benefit which will outweigh any anti-competitive concerns.

The Commission proposes to authorise the application in respect of the objects and rules. It is satisfied that the amendments to the objects and rules meet the concerns which were set out in the Commission's draft determination.

Even under its former identity the Commission had been concerned about competition issues in the private health sector and the freedom of private hospitals to set their fees for hospital services — unencumbered by pressure of collusive arrangements between competing health funds.

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[7] (1990) ATPR (Com) ¶50-097 at p. 54,223.

In *TPC v St. Luke's Medical and Hospital Benefits Association & Ors*, four Tasmanian health funds and their senior managers gave undertakings in the Federal Court on 25 August 1993 not to enter into any arrangement that could prevent or hinder Tasmania's private hospitals from setting their own fees for the supply of services to the Department of Veterans' Affairs.[8] The funds also undertook to inform the hospitals that they would not seek to unlawfully influence the hospitals' fee scales. The fifth fund provided a similar undertaking to the Federal Court in Sydney on 29 July 1993.

The undertaking followed the institution of proceedings by the Commission on 13 October 1992 against the five funds. The Commission's action stemmed from a decision by the Commonwealth Department of Veterans' Affairs to seek tenders in 1989 and 1990 from private hospitals in Tasmania for the provision of hospital services for repatriation patients.

The Commission had alleged that the funds and five senior managers had arrived at an arrangement or understanding that they would attempt to prevent the State's private hospitals from discounting their fees to the Commonwealth for hospital services to Commonwealth repatriation patients.

4.2 Enforcement and investigation

The Commission's investigations into the health sector, as in any other sectors of the economy, necessarily centre on the search for evidence of a breach, regardless of whether subsequent action involves litigation or some alternative strategies.

4.2.1 Enforcement objectives and priorities

Commitment to active enforcement of the competition and consumer protection provisions of the Act is fundamental to the achievement of the Commission's broad objectives. It is obviously not possible to pursue all perceived breaches of the Act. The effective use of resources in the public's best interest requires the Commission to have clear priorities in its selection of matters for enforcement and that it chooses the enforcement method most appropriate to the circumstances.[9]

The Commission must give priority to action that is likely to have the greatest positive influence on compliance generally and, where possible, will achieve redress or compensation for interests adversely affected.

The Commission does not take litigation action unless it believes there is a breach of the law or likely breach appropriate for pursuance by a public agency.

In broad terms, the Commission's selection of enforcement actions is influenced by whether a particular matter involves:

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[8] Federal Court of Australia, Tasmania, No. TG 13 of 1992.

[9] This issue is discussed in more detail in the ACCC publication, *Making markets work – Directions and priorities*, October 1999.

- apparent blatant disregard of the law;
- a history of previous contraventions of the law, including overseas contraventions;
- significant public detriment and/or a significant number of complaints;
- the potential for action to have worthwhile educative or deterrent effect;
- a significant new market issue; and
- a likely outcome that would justify the use of the resources.

In addition, the Commission also applies specific priorities and selection criteria to anti-competitive conduct, consumer protection and small business issues, among other things.

Irrespective of the industry or market involved, the Commission is likely to be most concerned with the following forms of anti-competitive conduct:

- anti-competitive agreements, with particular emphasis on price collusion and primary boycotts;
- mergers which would, or would be likely to, substantially lessen competition in a substantial market (especially in non-traded sectors);
- misuse of market power;
- resale price maintenance imposed by major suppliers or induced by major customers;
- conduct in breach of the Act which inhibits structural reform, especially in sectors with a significant impact on input costs throughout the economy;
- exclusive dealing where it significantly affects consumers or businesses; and
- secondary boycott conduct with a major detrimental community impact.

In relation to the consumer protection provisions, the Commission selects its enforcement priorities according to whether or not:

- the conduct in question is multi-state, national or international;
- significant consumer detriment is involved;
- Commission involvement has the potential to have a worthwhile national educative or deterrent effect; and
- a significant new market issue, for example resulting from economic or technological change, has arisen.

In assessing potential breaches by and against small business, the Commission takes the following considerations into account:

- the size of the firm and/or its market power;
- the seriousness of the conduct in question;
- the gain expected or obtained from the illegal conduct;
- the likely impact of the cost of the remedy/penalty on the firm;
- the action taken by the firm once the breach was discovered to ensure such conduct is not repeated; and
- the action taken to overcome the adverse effects of the conduct.

When undertaking enforcement action, the objectives of the Commission include:

- stopping the unlawful conduct;
- obtaining compensation/restitution for the victim;
- undoing the effects of the contravention;
- deterring/preventing future unlawful conduct (either repetition by the same person or first contravention by another who might be tempted to breach); and
- punishing the wrongdoer.

Wider responsibilities, and growing public expectations of the Commission's ability to deliver, have underscored the importance of securing speedy resolution of matters without necessarily resorting to litigation.

The available tools in addition to litigation are varied — administrative settlement, adjudication, promotion of self-regulation, compliance program, information and liaison. Frequently the most appropriate response to a particular problem is a combination of these tools in an integrated strategy. For example, completed litigation may trigger information and liaison activities to maximise its deterrent and educative effect.

4.2.2 Complaints

The Commission relies mainly on complaints to find out about possible breaches of the Act. Over the last few years, it has received a large number of complaints about the health sector, as indicated in table 4.1 below. The Commission believes that the high profile and priority it has given to health matters has contributed to the number of complaints received.

Table 4.1 Commission complaints in the health sector — 1996 to 1999

	1996	1997	1998	1999
Anti-competitive conduct (Part IV)	113	138	171	148
Unconscionable conduct (Part IVA)	6	0	10	12
Consumer protection (Part V)	81	83	107	147
Other	30	22	50	92
Total complaints	**230**	**243**	**338**	**399**
Total pursued[10]	**60**	**86**	**109**	**59**

4.2.3 Consumer protection

The Commission has received several complaints involving consumer protection issues in the health sector as indicated in table 4.2.

Table 4.2 Consumer protection complaints — 1996 to 1999*

	1996	1997	1998	1999
Health insurance	21	28	27	43
Hospitals	2	3	4	2
General practice medical services	1	3	8	8
Specialist medical services	3	10	16	16
Dental services	5	3	2	1
Pathology services	1	1	0	1
Optometry and optical dispensing	15	12	12	11
Ambulance services	0	1	1	1
Physiotherapy services	2	1	2	2
Chiropractic services	2	0	1	6
Other health services	32	21	37	58
Total	**84**	**83**	**110**	**149**

* Also includes 8 complaints about unconscionable conduct in consumer transactions (health insurance 6; other health services 2).

The major areas of complaints over the last four years have concerned the advertising and promotional activities of private health insurers and providers of medical and other health services. The Commission has also received complaints with regard to optometry and optical dispensing, including alleged breaches of the product information and product safety standards provision of the Act.

[10] Pursued complaints include all matters where additional information was sought to establish whether a possible contravention was involved and whether the Commission action was appropriate.

The Commission has conducted several investigations into the health sector, where it succeeded in changing advertising material without having recourse to undertakings or litigation. The resolution of those matters illustrates how the Commission and the health professions can work together for the benefit of consumers.

For example, the Commission received a complaint that certain advertisements for laser eye surgery contained statements that were false or likely to mislead consumers. It investigated this complaint and as a result the advertisements were stopped with the advertisers agreeing not to place similar advertisements in the future. However, in these circumstances the Commission always keeps the option open of taking further action if the conduct re-occurs.

Rather than instituting proceedings, the Commission increasingly chooses to settle matters administratively with the use of s.87B undertakings. That is, a business or person who has allegedly breached the Act agrees to comply with, or follow, a list of undertakings which could include one or more of the following:

- compensating consumers who suffered from the conduct;
- running corrective advertisements of similar frequency and prominence to those which misled consumers;
- paying for a company or industry trade practices compliance program; and/or
- making administrative changes within the business to reduce the risk of future misleading conduct.

Once entered into by a business, undertakings are not optional. The Act provides for undertakings to be enforceable in the Federal Court. That is, if they are not honoured, the Commission will ask the court for an order telling the business or individual to comply with the undertakings. A business or individual who ignores a court order will be at risk of being in contempt of court which may lead to fines or imprisonment. This administrative approach with the possibility of enforcement action as backup offers quicker and less costly resolution, tangible benefits for affected parties and the prospect of lasting improvement in market conduct by the corporation involved.

Over the last few years, the Commission has resolved several matters in relation to health services and products in this manner.

- On 8 November 1995 the Commission accepted a court enforceable undertaking from the Medical Benefits Fund of Australia Ltd (MBF) in respect of representations made by MBF in correspondence sent to some of its contributors in September 1995. In particular:
    - In correspondence that was sent to certain Queensland contributors of MBF (Queensland letter) the following statement was included:

      > You may decide to keep your existing level of hospital cover, however new legislative requirements mean that all members must transfer to our 100 per cent hospital service by July 1997.

- In correspondence that was sent to certain South Australian contributors of MBF (South Australian letter) the following statement was included:

  > From 1 July 1997, under new government legislation introduced this year, all health funds will only be able to make available 100 per cent hospital cover. As a result, your current level of hospital cover must be phased out by that date.

- In correspondence that was sent to certain New South Wales contributors of MBF (New South Wales letter) the following statement was included:

  > MBF offers Basic Hospital Cover as a legal requirement at present, but by legislation this level of cover will cease as of July 1997. You will therefore be required to transfer to an alternative level of cover by that date.

  Following an investigation, the Commission concluded that MBF contravened s. 52 and 53(f) of the Act in respect of the representations in the Queensland letter which implied that it was a legislative requirement that MBF contributors transfer (or subscribe) to MBF's 100 per cent hospital cover product when, in fact, there was no such legislative requirement.

  In October 1995 MBF brought to the Commission's attention:

- the South Australian letter which in the Commission's view contravened ss 52 and 53(f) of the Act by stating that under new legislation health funds will only be able to make available 100 per cent hospital cover; and

- the New South Wales letter which in the Commission's view contravened ss 52 and 53(f) of the Act by implying that, as a consequence of legislation, MBF contributors would have to transfer to a hospital cover of a different leave from the cover which was then known as 'basic hospital cover'.

  MBF admitted that its conduct contravened the Act and gave formal undertakings not to repeat any such conduct, to send corrective notices to affected contributors, place corrective advertisements in specified newspapers and implement a trade practices compliance program.

- In December 1996 in the matter of the Proctology Centre of Australia (PCA), the Commission accepted court enforceable undertakings to correct representations made in advertisements and to patients by PCA regarding its treatment of haemorrhoids. The representation included that the treatment was 100 per cent effective, had minimum discomfort, gave instant relief and needed only one visit.

  The Commission had received complaints from patients and PCA acknowledged that in some cases the treatment may be unsuccessful, some pain and discomfort may be experienced, sometimes more than one treatment was necessary and that the procedure is new and has not yet been scientifically validated by long-term study. In addition to placing corrective advertisements PCA was also required to stop making the representations to patients and to introduce written instructions to staff to ensure accurate information is given to consumers.

- In September 1999 Beautician's Laser Clinic Pty Ltd and a former director, Ms Linda Tait, provided separate court-enforceable undertakings to the Commission in

relation to its claims that its laser service could achieve permanent hair removal and had US Food and Drug Administration (FDA) certification for permanent laser hair removal. The Commission considered the claims to be false and misleading as the laser does not permanently remove hair in all cases and the FDA had certified the laser for permanent hair reduction rather than removal.

The clinic published corrective advertisements apologising to consumers and competitors and also offering a refund to consumers who had been misled by the claims. The clinic also undertook not to make similar claims in future advertising and promotion and implemented a trade practices compliance program.

The Commission has taken several companies to court for breaches of the consumer protection provisions of the Act in the health care sector.

- In August 1996 the Commission took action against On–Clinic Australia Pty Ltd in respect of misleading and deceptive advertising in newspapers of impotency treatment services.[11] As well as obtaining declarations that the advertising breached the Act and injunctions to prevent such representations being made again, the Commission also obtained orders for corrective advertising and another for On-Clinic to provide refunds to consumers.

  In reaching the conclusion that the respondents' conduct was misleading and deceptive, Justice Tamberlin made the following instructive comments:

  > Language which can reasonably suggest either a true proposition or a false one can come within the ambit of misleading conduct. It has been held, for example, that a statement that a product will relieve pain will be misleading if it relieves only one type of pain but not another: see *Grove Laboratories v Federal Trade Commissioner (1969) 418 F2d 489.*
  >
  > If it is sought to attract public attention and custom by the use of **unqualified** assertions of fact, then such assertions should be true as a matter of fact, if they are not to mislead and contravene the norms of conduct prescribed by the Act.

  In deciding that some corrective advertising was warranted, Justice Tamberlin took into account, among other things, the following matter:

  > The subject matter of the advertisements is emotive and of a highly sensitive and delicate nature and therefore the claims are likely to be impressed strongly in the consciousness of person suffering from or in fear of impotence.

- In July 1997 the Commission obtained Federal Court declarations and injunctions against Buyers Network International trading as Nu-Life Publications and also against its director, Mr Donald James Scott Finlay, regarding false and misleading claims in national advertising concerning the promotion of the following publications, *Foods that make you lose weigh*" and *Honey, Vinegar & Garlic — Nature's Miracle Trio*.[12]

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[11] *ACCC v On–Clinic Australia Pty Ltd & Others* (1996) ATPR ¶41–517.

[12] *ACCC* v *Buyers Network International Pty Ltd & Ors*, Federal Court of Australia, NSW No. NG 467 of 1997.

The orders and declarations were made by Justice Beaumont who granted injunctions to prevent Buyers Network International and Mr Finlay from making certain misleading claims about the health and weight loss benefits of honey, garlic and vinegar including claims that, by using the products as specified in the books, persons can dramatically increase the rate at which they burn calories and achieve substantial weight loss benefits (doubling their rate of weight loss overnight).

The injunctions granted also restrain the making of representations that particular foods contain 'negative calories', and that the consumption of such foods can produce weight loss by burning up the excess calories in other fattening foods.

Justice Beaumont also ordered Buyers Network International to publish corrective advertisements. The widespread nature of the original advertisements meant that the representations had been extensively and regularly advertised in publications such as national and state newspapers with wide circulations.

The advertisers were required to offer to pay refunds to any dissatisfied customer, who purchased the publications as result of the advertisements. Refunds would include the initial publication cost, the initial postage and handling charges together with any costs of returning the publications. If Buyers Network International does not pay the refunds, the court ordered Mr Finlay to make good those refunds.

Buyers Network International was also ordered to implement a Trade Practices compliance program, a component of which is to adopt a complaints handling system which complies with Australian Standard AS 4269–1995 (complaints handling).

Mr Finlay was also restrained from participating in the exercise of control of any company solely or jointly where that company has not implemented such a Trade Practices compliance program.

Buyers Network International and Mr Finlay were also ordered to pay the Commission's costs of $10 000 in the proceedings.

- In November and December 1997 the Commission obtained declarations and injunctions for breaches of various consumer protection provisions of the Act by Jayco.[13] The company was restrained from making claims about:
  - Medex Diet Patch (a band aid like patch impregnated with iodine);
  - Thermoslim (a wafer said to contain thermogenetic [calorie burning] properties);
  - E-Z Trim (tablets said to possess thermogenetic properties);

[13] *ACCC* v *Jayco Pty Ltd & Others* , Federal Court of Australia, Victoria No. VG 567 of 1997.

- Acu-Stop 500 (an ear piece inserted inside the ear operating through acupressure);
- Chitoslim 5000 (a powder said to bind fat before absorption by the body); and
- a publication concerning negative calories (a book claiming that negative calories can offset the weight increasing effect of positive calorie foods).

Mr David Francis, a promoter, consented to orders restraining him from making unsubstantiated representations about a series of weight-loss products and any other products promoted as methods or aids to slimming in the future.

The Commission's case was that:

- the representations made were untrue;
- people could not lose the weight claimed in the promotional material by using the products; and
- the representations about the products were not based on or supported by appropriate scientific or other recognised and accepted research or studies.

The Commission worked closely and cooperatively with the Victorian Office of Fair Trading and Business Affairs in its investigation of this matter.

- In April and June 1998 the Commission obtained declarations, injunctions and refund orders in a representative proceeding on behalf of more than 500 former clients of Swiss Slim who were enticed to join the program through 'hard-sell' tactics which often played on individuals' insecurities about their weight.[14]

  Orders made by Justice Wilcox on 19 June 1998 required Swiss Slim and its director, Mr Gerhard Hassler, to pay $1 327 657 by way of compensation and $142 667.66 by way of interest.

  The Commission received assistance and cooperation from the New South Wales Department of Fair Trading in investigating the matter.

- On 26 August 1999 the Commission received judgment from Justice Lindgren of the Federal Court of Australia regarding promotion by Giraffe World Australia of an 'ion mat' which the Commission alleged had led to 38 misleading or deceptive representations about the health benefits of using the mat which were in breach of the Act.[15]

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[14] *ACCC* v *Swiss Slimming and Health Institute Pty Ltd & Others*, Federal Court of Australia, NSW No. NG 482 of 1997.

[15] *ACCC* v *Giraffe World Australia Pty Ltd & Others*, [1999] FCA 1161. Benefits represented were wide-ranging, for example reducing stress and fatigue, better blood circulation, reducing cancer-causing cells, building up immune system, curing skin problems, curing insomnia and neck pain etc.

After a contested hearing Justice Lindgren was satisfied that the representations were made by Giraffe World Australia. The Commission also adduced a considerable body of expert evidence including evidence directed to establishing that there is no credible body of research supporting the proposition that the mat would cure or relieve any particular ailment or health condition or promote good health.

Justice Lindgren concluded as follows:

> GW represented that the Mat emitted negative ions or generated them within the body of a person lying on the Mat. It does not. GW should be restrained from making representations to that effect.
>
> GW represented that there was scientific support for the proposition that the Mat, by means of negative ions, produced and would produce benefits for human health. There is not. GW should be restrained from making such representations.
>
> GW represented that various official bodies supported its claims that the Mat offered the health benefits claimed for it. They do not. GW should be restrained from making representations to that effect.

Justice Lindgren also found that a director of Giraffe World and other companies which were beneficiaries of large sums of money paid by Giraffe World and the president of Giraffe World had contravened both the referral selling and pyramid selling provisions of the Act.

On the basis of the referral selling and pyramid selling breaches, the Commission is pursuing representative action on behalf of former clients of Giraffe World to obtain compensation and/or refunds. Some 800 former clients have been identified. The ion mat was sold for about $3000–$3250 each and it is believed some 8000–9000 people were affected by this conduct. Obviously the adverse financial impact as well as personal disappointment and embarrassment, particularly for any vulnerable client, was enormous. The promotional conduct in this case was not in newspaper, radio or television advertising — it was essentially by word of mouth.

- In legal proceedings instituted in July 1999 the Commission has alleged that Vital Earth has breached ss 52 and 53(c) of the Act through advertisements of complimentary health products known as the Vital Silver 2000 Automatic and Vital Silver 2000.[16] In essence the Commissions allegations deal with representations as to the medical or health benefits of the products advertised. The legal proceedings are currently continuing and defended. The Commission has also joined a director of the company to the proceedings.

- After the Commission instituted legal proceedings in July 1999 against Raylight Pty Ltd, alleging a breach of ss 52 and 53(c) of the Act through advertisements of complimentary health products, the company and its director, Mr Herbert Nathan,

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[16] *ACCC* v *Vital Earth Company Pty Ltd & Others*, Federal Court of Australia, NSW No. N711 of 1999.

and an operator of two Internet sites, Mr Colin Dixon, gave undertakings to the Federal Court of Australia.

Raylight markets alternative therapy products included the 'Parasite Zapper' and the 'Colloidal Silver Generator'. Advertisements claimed that the 'Parasite Zapper' passes an electric current through a person's blood and that this, amongst other things:

- is capable of neutralising HIV and other parasites in the body; and
- is effective in treating a number of serious medical conditions including HIV, hepatitis, herpes as well as obesity.

The Commission was also concerned by Raylight's claims about colloidal silver produced by the Colloidal Silver Generator including that it:

- is effective at killing intestinal bacteria and viruses;
- is helpful to AIDS sufferers when used together with the Parasite Zapper; and
- prevents opportunistic infections originating from the stomach and intestines.

Raylight gave undertakings to the Federal Court that it would not make such representations and would provide refunds to persons who may have been misled into purchasing either product.

Raylight's director, Mr Nathan, gave an undertaking not to design, create, settle or procure the publication of advertisements or promotional material containing the above representations concerning the Colloidal Silver Generator and Parasite Zapper. Mr Nathan also gave an undertaking to attend a trade practices seminar to ensure future compliance with Part V of the Act.

Mr Dixon published representations on two Internet sites alleging that the Vital Silver 2000 and the Vital Silver 3000 Zapper marketed by Vital Earth Company Pty Ltd including:

- that the colloidal silver allegedly made by the Vital Silver 2000 and/or the Vital Silver 3000 Zapper kills, in less than sixty seconds, inter alia, anthrax, tuberculosis, shingles, cerebrospinal meningitis, gonorrhoea, whooping cough;
- that the colloidal silver allegedly made by the Vital Silver 2000 and/or the Vital Silver 3000 Zapper could be used as an antibiotic for all the acquired diseases of active AIDS; and
- that the colloidal silver allegedly made by the Vital Silver 2000 and/or the Vital Silver 3000 Zapper has been used successfully against, inter alia, meningitis, diabetes, leprosy, lupus, skin cancer, syphilis and whooping cough.

Mr Dixon gave undertakings to the Federal Court to stop making these representations and to display corrective advertisements at the two Internet sites which had contained these representations.

Proceedings against Vital Earth Company Pty Limited and its director, Mr Darryl John Jones, in relation to representations made about the Vital Silver 2000 Automatic, the Vital Silver 2000 and the Vital Silver 3000 Zapper continue.

The Commission has also investigated matters raising important health and safety issues for consumers. The Commission has taken several companies to court in that regard.

- In October 1996 the Commission instituted legal proceedings against Hungry Jack's alleging that the sunglasses sold by the company failed the mandatory product safety standard, as they were not marked as being unsuitable for driving. The Commission instituted proceedings, as it did not consider Hungry Jack's minor alteration to its television advertisements, small newspaper notices and in-store sign amendments were adequate corrective action to warn purchasers that the sunglasses were not suitable for driving.

In November 1996 the Federal Court accepted undertakings by Hungry Jack's not to supply sunglasses which are not marked as required by the standard and to refund consumers. The company was also ordered to undertake a national television and print sunglasses safety warning campaign.

In his reasons for the decision, Justice Carr said:

> Viewing the evidence overall, I find that it is likely that there is a substantial (or at least a significant) number of the respondent customers who, having bought these sunglasses without being warned that they were not suitable for driving, may wear them while driving. I have already held that in those circumstances there is a significant risk of an accident occurring when they drive from bright sunlight into a shady or dark area. I do not think that sufficient has been done to warn those customers.

- In February 1998 the Commission obtained penalty orders against MNB Variety Imports Pty Ltd for supplying swimming aids and sunglasses which failed to comply with the relevant mandatory consumer product safety standards. The product and packaging of the swimming aids did not contain the words 'warning: use only under competent supervision', required by the standard on children's flotation toys and swimming aids. The sunglasses failed to comply with the field of view, refractive power, density matching and labelling provisions of the relevant standard.

- In late 1996 the Commission instituted proceedings against Glendale Chemical Products Pty Ltd, supplier of Glendale Caustic Soda, after complaints from a consumer who claimed he suffered injuries and property damages as a result of using the product in his home. The Commission alleged that the instruction and warning on the product's label were inadequate as to its use.

  On 3 December 1996, following negotiations between the Commission and Glendale, the company provided a series of undertakings to the court, on an interlocutory basis.

  In March 1998 Justice Emmett of the Federal Court awarded damages to the complainant after finding Glendale liable for injuries and damage suffered by this man (an appeal to the Full Federal Court was dismissed in December 1998).

Justice Emmett declared the warning labelling affixed to the caustic soda containers insufficient.

Glendale undertook to relabel the product with adequate safety instructions and warnings — in particular instructions that the product should not be mixed with hot water. Glendale also had to publish a public safety notice warning consumers about the dangers of caustic soda and to implement a compliance program.

The Commission was subsequently able to persuade other manufacturers of caustic soda to relabel their products to avoid the problems that had come to light in the Glendale matter.

This was the first Commission action brought under the product liability provisions of the Act.

- In August 1999 the Federal Court fined Dimmeys stores $60 000 for supplying children's bicycles which failed to comply with the mandatory consumer product safety standard for pedal bicycles. The importer of the bicycles, Starite Distributors Pty Ltd, was also fined $30 000. The orders follow criminal proceedings instituted by the Commission against the companies for contravening s. 65C(1)(a) of the Act.

  In his judgement, Justice Weinberg made the following comments –

  > The offences committed by Starite and Dimmeys must, in my opinion, be regarded as being extremely serious. The conduct of the defendants has resulted in a significant number of defective bicycles being supplied to children, among the most vulnerable members of our community. The appearance of these bicycles is calculated to entice those who use them into still more danger. It may fairly be said that each of the bicycles supplied was, and is, an accident waiting to happen.

- In January 2000 the Commission instituted proceedings in the Federal Court in Melbourne against Pacific Dunlop Limited (Pacific Dunlop), seeking compensation for a consumer who has allegedly developed a serious form of latex (rubber) allergy through her use of Pacific Dunlop's Ansell brand of disposable (single use) and non-disposable household rubber gloves.

  The proceedings are being brought under the representative action and product liability provisions of the Act. The Commission alleges that Pacific Dunlop is liable to compensate the consumer due to the absence of warning labelling as to the risk of latex allergy and appropriate use instructions at the time the product was originally sold.

Other matters involving health and safety issues were resolved via the use of court enforceable undertakings.

- During October and November 1996 the Commission undertook a random survey of sunglasses from a variety of retail outlets in Perth, Brisbane and Adelaide to check for compliance with the relevant mandatory consumer product safety standard. The sunglasses were tested and several failed to meet some of the requirements of the standard. After raising its concerns with the suppliers of the sunglasses, the Commission accepted enforceable undertakings from nine suppliers in Queensland and Western Australia. The Commission also negotiated

administrative settlements with three suppliers in Adelaide who acted swiftly on the problems identified by the Commission.

- In May 1999 Lay and Sons Organisation, trading as Asian Importer-Exporter and Company, withdrew several brands of cigarettes from sale after advice from the Commission that they had failed to meet the requirements of the Consumer Product Information Standard for Tobacco.

  Lay and Sons gave a court enforceable undertaking to cease supplying cigarettes which fail to meet the standard and to ensure that all future cigarettes supplied by them meet the standard.

- In November 1999 Hot Tuna and Crumpler gave undertakings to the Commission in relation to bean bags they manufacture and distribute.

  In both instances, the bean bags failed to comply with a mandatory safety standard under the Act that requires bean bags, bean bag covers and packages containing the bag filling to carry a warning. They also failed to comply with that part of the standard which requires that all bean bags and bean bag covers must have child resistant slide fasteners on every opening through which the bean bag filling can be inserted or removed.

  Both companies gave undertakings to take immediate action to notify retailers to withdraw remaining bean bags from sale and to make alterations to their stock to ensure compliance. Both also undertook to publish product safety recall notices in major newspapers in those States where sales took place.

- In December 1999 Zodiac Group Australia gave undertakings to the Commission in relation to children's swimming aid vests that failed to comply with the labelling requirements of mandatory product safety standard on flotation toys and swimming aids for children.

  The non-complying swimming vest was detected by Commission staff conducting a product safety survey as part of its on-going mandatory product standard monitoring program.

  Zodiac gave enforceable undertakings to immediately notify all relevant retailers to withdraw the swim vests from sale. The company also undertook to publish product safety notices in major newspapers in those States where the swim vests have been sold.

4.2.4 Restrictive trade practices

With regard to restrictive trade practices and unconscionable conduct in business transactions, the Commission has concentrated its effort on education of the health profession, encouraging and providing assistance to health professional associations to take on the role of helping their members comply with the Act (see section on 'Information and education').

The Commission has received several complaints involving alleged breaches of the competition provisions of the Act as shown in table 4.3.

Table 4.3 Health sector RTP complaints — 1996 to 1999*

	1996	1997	1998	1999
Health insurance	21	11	34	33
Hospitals	9	4	10	17
General practice medical services	17	26	34	20
Specialist medical services	15	23	45	36
Dental services	7	15	8	13
Pathology services	5	3	3	0
Optometry and optical dispensing	5	8	6	4
Ambulance services	2	0	3	3
Physiotherapy services	7	6	10	6
Chiropractic services	7	7	7	6
Other health services	22	35	18	20
Total	**117**	**138**	**178**	**158**

* also includes 21 complaints about unconscionable conduct in business transactions (health insurance 10; hospitals 1; general practice medical services 1; specialist medical services 1; optometry/optical dispensing 2; physiotherapy 2; chiropractic services 1; other health services 3)

Major areas of complaints include the following:

- complaints from private hospitals alleging anti-competitive conduct and/or unconscionable conduct by health insurers in the context of contracting;
- complaints alleging price fixing, agreements lessening competition and/or misuse of market power by groups of specialists;
- complaints and queries about agreement lessening competition and price fixing by groups of GPs or medical centres, including allegations of agreement between GPs not to bulk bill;
- complaints by doctors against hospitals or other doctors for refusal of credentialling at particular hospitals.

It should be noted that Part IV matters, irrespective of the industry, are usually more complex, time consuming and resource intensive than Part V matters. Therefore, as a general rule, the Commission tends to pursue fewer matters under Part IV of the Act. This applies equally to the health sector as to other sectors of the economy. In addition, as parts of the health sector have only recently come under the coverage of the Act, it has taken time to understand the complex issues associated with applying trade practices legislation for the first time to some of the participants in this sector.

The Commission is committed to investigate alleged breaches of Part IV of the Act in the health sector and take enforcement action as required.

Anaesthetist case

On 17 December 1998 the Commission settled injunction proceedings it had instituted in the Federal Court of Australia against the Australian Society of Anaesthetists (ASA) and four individual anaesthetists from the State of New South Wales. This was the Commission's first enforcement action against medical professionals following the competition policy reforms

In its proceedings instituted in October 1997 the Commission alleged that unlawful agreements were reached by anaesthetists at three private hospitals to charge $25 per hour for 'on-call' services which ensured an anaesthetist, although not on site, was available for emergency and after hours anaesthetic services at the hospitals.

The Commission also alleged that on 3 April 1996 certain anaesthetists reached an unlawful agreement to tell the administrators at one of the private hospitals that unless the hospital agreed to pay for the supply of on-call services from 1 May 1996 those anaesthetists would not supply such services (a 'boycott agreement').

The Commission alleged that in late 1994, the ASA (NSW section) formed a sub-committee to formulate guidelines for the provision of on-call services in private hospitals. A sub-committee report was circulated to members in 1995. It said the ASA should 'recommend and set an appropriate on-call fee to be paid by private hospitals to on-call anaesthetists' and that this fee should be $25 per hour.

It was alleged that the sub-committee's recommendations were endorsed by the ASA (NSW) Committee of Management in September 1995 and further endorsed at the annual general meeting of the NSW ASA in March 1996.

It was alleged that the anaesthetists, through their medical practice companies, arrived at agreements with other anaesthetists to charge a $25 per hour on-call services fee. The Commission also alleged that the ASA and its NSW Chairman induced or attempted to induce and were knowingly concerned in, or a party to, one or more of the agreements.

The anaesthetists and the ASA gave undertakings to the Federal Court that they would not engage in fixing, controlling or maintaining prices offered or charged by them for the supply of on-call services, and that they would not enter into agreements having the purpose, effect or likely effect of substantially preventing, hindering or lessening competition in the market for the supply of on-call services.

The ASA also undertook to the Federal Court to develop and implement, at its own expense, a program of compliance with the Act. The Federal Court ordered that the respondents pay $60 000 toward the Commission's costs.

In this case, the Commission did not seek penalties as it was the first enforcement action against medical professionals following the competition policy reforms. However, a breach of the undertakings to the court would put the specialists or their association at risk of contempt of court.

Investigations into the conduct of specialist colleges

Entry into medical specialties is restricted by the fact that some colleges, who have responsibility for medical specialist training in Australia, are only providing a limited number of advanced training positions for their particular specialties. This situation has led to persistent allegations that certain specialist medical colleges and affiliated associations restrict entry to advanced medical and surgical training for anti-competitive purposes, so that incumbents maintain their workload and income. Such allegations have been raised in several reports and in many complaints to the Commission.

If a college makes decisions on advanced training numbers in order to protect the privileged position of its Fellows, that is for anti-competitive reasons, then it would be at risk of breaching s. 45 and possibly s. 46 of the Act. The Commission is currently investigating the conduct of a Royal Australasian College of Surgeons (RACS) in that regard.

The Commission appreciates that the issue of restrictions placed on trainee numbers is complicated by government funding constraints, the availability of suitable hospital posts and government medical workforce planning policies. The Australian Medical Workforce Advisory Committee (AMWAC) has been reviewing medical specialties where there are current or expected shortages of supply, and has recommended increases in trainee numbers in a number of specialties. The Commission understands that many colleges reviewed by AMWAC have increased the numbers of trainee positions by at least the quantum recommended by AMWAC.

The Commission appreciates that some colleges may be uncertain as to the impact of the Act on their conduct in relation to trainee numbers, in particular when these are in line with the recommendations of AMWAC. However, they are encouraged to approach the Commission directly to clarify any uncertainty. Irrespective of any AMWAC recommendation, colleges may be in breach of the Act if they are limiting trainee numbers for anti-competitive purposes.

Some colleges have argued that there are some public benefits in imposing restriction on entry to advanced medical and surgical training. This may well be the case; however, this is not relevant when determining whether a college may be in breach of the Act. It is only through the authorisation process that public benefit claims can be taken into account by the Commission (see section on ‘Adjudication role’).

The Commission has received several complaints from overseas trained specialists whose specialist training, qualifications and/or experience have not been recognised by the relevant college, and therefore are unable to practice in their chosen specialty in Australia.

The Commission understands that some colleges accept very few applicants with overseas qualifications and experience without requiring a period of further training. In addition, some colleges have very few training positions set aside for these specialists, which creates an additional barrier to entry.

The Commission is currently investigating whether the conduct of the Royal Australasian College of Surgeons (RACS), in failing to recognise qualification, training

and experience of particular overseas-trained surgeons, could constitute a breach of the Act.

Contracting between health funds and hospitals

The Commission has investigated several complaints from private hospitals alleging unconscionable conduct and other breaches of the Act by health insurers relating to the negotiation process and content of hospital contracts.

Unconscionable conduct and its possible application to the private hospital sector is an important priority area for the Commission.

In particular, the Commission has investigated a complaint from a small private country hospital alleging a large health insurer had acted unconscionably by inserting a restrictive clause in its contract with the hospital. In the course of negotiations, the hospital and the health insurer had agreed to a range of prices that the hospital could charge for various medical procedures. The contract contained an additional clause that stated that these negotiated prices were subject to any other lower price negotiated with any other user of the hospital facilities, other than another health fund. The effect of this clause was that the lowest price the hospital charged to private patients became the price available to the health fund. In this case the hospital had no real choice but to accept this additional clause as otherwise its patients who were insured with the particular health fund would have to pay a gap if the fund withdrew.

The Commission investigated the matter and came to the view that this clause could amount to unconscionable conduct. The health insurer in question, however, changed the clause before the Commission could take further action.

In August 1999 the Commission received a complaint from the Private Hospital Association of Queensland (PHAQ) alleging misuse of market power, exclusive dealing and unconscionable conduct by MBF in its tendering for MBF Network in Queensland. The Commission was particularly concerned about the tight timeframe in which hospitals were required to respond to the tender and the high level of misunderstanding between the parties.

The Commission immediately met with MBF to raise the concerns of PHAQ. Subsequently, MBF twice extended the deadline and addressed several PHAQ concerns.

The Commission is currently investigating another unconscionable conduct matter involving a large fund.

Hospital credentialling

The Commission has received several complaints from medical specialists regarding their failure to obtain credentialling at particular hospitals, and alleging they are denied access by the action of their competing colleagues in hospital.

Hospital credentialling of specialists may raise a number of issues under Part IV of the Act.

In addition, some complainants have alleged that rejection was based on the applicant not being an Australian Fellow and/or a member of the relevant specialist society or association. The imposition of either criterion may constitute third line forcing.

Some complainants have further alleged that groups of competing professional colleagues may enforce their rejection by threatening to boycott the particular hospital if the applicant is given access to the hospital, which conduct would constitute a breach of the Act.

The Commission has investigated a number of complaints about hospital credentialling raising such issues, but found there was not sufficient evidence to justify taking the matters to court. However, these are serious issues and priority would be given to the investigation of any such complaints.

Dealings between medical practitioners and their association with hospitals

Joint negotiations by competing medical practitioners and/or their associations with any third party such as a hospital or a health insurer regarding the fee to be charged by medical practitioners, would be likely to fix, control or maintain fees and thus breach the Act.

The Commission is currently investigating the conduct of several medical practitioners and their association in their dealings with a hospital owner for possible breach of the Act.

4.3 Adjudication role

4.3.1 Authorisation and notification — an overview

Authorisation provides protection from action by the Commission or any other party for potential breaches of the Act. In the case of mergers and acquisitions, once authorisation is granted no action can be taken by the Commission, the Minister or third parties to overturn the arrangement.

Authorisation does not take effect until granted by the Commission. Notification (which applies only to exclusive dealing) provides similar protection and takes effect when notification is lodged (or soon after in the case of third line forcing).

Immunity from legal proceedings in respect of a breach of the Act can give competitive advantage to the parties, to the authorisation or notification. Authorisation is intended to be granted only where benefits to the public result from the conduct and the detriment resulting from the conduct, including the lessening of competition, is outweighed by those benefits. Where there is notification of exclusive dealing conduct other than third line forcing, it is deemed not to have, or be likely to have, the effect of substantially lessening competition and is therefore not in breach of the Act. Notification of third line forcing conduct attracts exemption where any public benefit from the conduct outweighs the public detriment from the conduct.

Authorisation and notification can only be initiated by parties to the conduct. Third parties cannot apply for authorisation or give notification and the Commission cannot demand an application for authorisation or a notification.

Authorisation and notification do not provide a blanket exemption from the requirement to comply with all provisions of the Act. The Act allows the Commission, on application, to grant authorisation in relation to:

- making or giving effect to a contract or arrangement or arriving at or giving effect to an understanding where a provision of the contract, arrangement or understanding substantially lessens competition;
- covenants affecting competition;
- primary boycotts;
- secondary boycotts;
- anti-competitive exclusive dealing;
- exclusive dealing involving third line forcing;
- resale price maintenance; and
- mergers leading to, or likely to lead to, substantial lessening of competition.

Misuse of market power may not be authorised. However, s. 46 (which prohibits misuse of market power) provides that conduct, which is protected by authorisation or notification and is therefore not caught by ss 45, 45B, 47 or 50, will also not be caught by s. 46 (see s. 46(6)). In other words, such exempted conduct will not constitute a misuse of market power.

Notification is available in respect of exclusive dealing. Exclusive dealing conduct occurs where:

- one person trading with another imposes restrictions on the other's freedom to choose with whom, or in what, it deals; or
- one person supplies goods or services to others on condition that the other party acquires goods or services from a particular third party or refuses to supply goods or services because the purchaser will not agree to that condition. This conduct is called third line forcing.

A person engaging in exclusive dealing conduct may lodge an application for authorisation or a notification. An application for authorisation should be lodged if the anti-competitive effect of the conduct is likely to be substantial.

Authorisation may be granted only after a public process of assessment. The onus is on the applicant to satisfy the Commission that there is public benefit arising from the conduct and that the public benefit outweighs any detriment, including any caused by a lessening of competition. The Commission's decision can, on application by a party with sufficient interest, be reviewed by the Australian Competition Tribunal. The

authorisation will generally not take effect until any such review process is finished, but the Tribunal may grant interim authorisation pending its decision.

The Act takes a different approach to notification, which takes effect upon lodgment of the details of the conduct. In the case of third line forcing, notification takes effect after a short initial assessment period. In examining a notification, except for third line forcing, the Commission considers public benefit issues only if it first concludes that the conduct is likely to substantially lessen competition.

4.3.2 Authorisation

The Commission has been very active in its adjudication role in the health sector since 1995 and this is likely to increase in the future.

The Commission has considered applications for authorisation from professionals as well as hospitals.

Australian Medical Association

On 31 July 1998 the Commission granted authorisation until 30 June 1999 to the South Australian and Federal Australian Medical Associations who had applied to collectively negotiate and give effect to a fee for service agreement for the remuneration of visiting medical officers treating public patients in South Australian rural public hospitals.

South Australia has 65 rural hospitals ranging from some with only one doctor to others with 25–50. There are very few resident specialists in rural SA and hospitals arrange periodic visits by particular specialists to cover their needs. Emergency support for complicated matters is arranged by flying 'recovery' teams from Adelaide or by airlifting patients to Adelaide. A major issue in the South Australian rural medical system is trying to attract doctors. Current estimates indicate that the system is short by 30–40 doctors.

In a draft written determination dated 3 April 1998 the Commission indicated that it considered that the fee for service agreement had anti-competitive effects because it acted as a price floor for all hospitals in South Australia. Hospitals in regions that have little trouble attracting doctors have to pay the same rate for medical services as those in regions that have difficulty. Sometimes negotiations are conducted to provide doctors with a package over and above that provided by the fee for service agreement, but negotiations never result in a discount to the hospitals.

While the Commission agreed that the provision of medical services provides many public benefits, it was not convinced that the fee for service agreement was the only method that would produce them. It did, however, recognise that the South Australian Health Commission and the AMA and its members have established collective negotiation techniques. In light of the fact that doctors carrying on their professional businesses in SA without incorporating were not subject to the Act until July 1996, the Commission indicated that it recognises some public benefit in allowing the parties to phase in a less regulated system.

Australian Society of Anaesthetists

On 8 October 1999 the Commission dismissed an application for authorisation lodged by the Australian Society of Anaesthetists (ASA) to undertake negotiations with health funds regarding rates and conditions on behalf of its members. The ASA also wished to be able to inform its members as to whether the ASA considers any standard form agreement (including rates of payment) arising from the negotiations to be fair and reasonable. It would make clear that the final decision rests with the individual anaesthetist and that he/she retains the right to negotiate individually.

The Commission was of the view that:

- the proposed conduct was likely to lead to an agreement in relation to minimum prices at a State level. The Commission considers price agreement to be one of the most serious anti-competitive practices. In this case, it considered that substantial weighting should be given to the detriment arising from the likely price fixing effects of the proposal;

- while the ASA claimed that anaesthetists do not compete with each other, the Commission's view was that , as alternative providers of anaesthesia services, anaesthetists are in competition with each other for the purpose of the Act;

- the development of 'no gap' or 'known gap' products would represent a public benefit. However, the Commission was not satisfied that the proposal would lead to such products being made available;

- the proposal to have negotiations conducted at a State level did not satisfy the Commission's concern with respect to equalising negotiating power. It remained of the view that the proposal had the potential to reverse the balance of negotiating power and not lead to a true equalisation of any imbalance that may exist. The Commission also had reservations concerning the effectiveness of the proposed barriers to the exchange of information given the corporate structure of the ASA;

- the ASA could provide guidance to its members on issues that needed to be addressed in their negotiations without conducting centralised negotiations through State Committees of Management. This would enable some of the concerns expressed about the possible introduction of US style managed care to be mitigated. The Commission was encouraged to note that anaesthetists were not implacably opposed to contract as other sections of the medical profession seem to be.

Five Queensland private hospitals

On 1 September 1999 the Commission granted an application for authorisation by 5 private hospitals in Queensland to exchange non-fee related information; exchange fee related information; and establish a common agent to facilitate the exchange of aggregated data and to assist in the negotiation of a hospital purchaser provider agreement (HPPA), with certain health funds.

The application was lodged by:

- Bundaberg Associated Friendly Societies' Medical Institute trading as the Friendly Society Private Hospital;
- St Andrew's Toowoomba Hospital;
- St Andrew's War Memorial Hospital Brisbane; and
- the Uniting Church in Australia Property Trust (Queensland) trading as St Stephen's Private Hospital in Maryborough and the Westley Hospital in Brisbane.

In terms of the public benefits claimed by the applicants, the Commission considered that there are likely to be some efficiency gains arising from operation of the agreement and that this represents a public benefit. These efficiency gains may make the applicants more competitive in the market and even result in enhanced competition overall. The Commission accepts that the applicants will enhance their negotiating position through implementation of the IHA and that in relation to MBF and Medibank Private this also represents a public benefit. The Commission was of the view that there may be some efficiency gains in using a common agent to negotiate HPPAs, but that these efficiencies could be achieved and are likely to be achieved without entering into the IHA.

The Commission concluded that in all the circumstances the proposed conduct would likely result in a benefit to the public which would outweigh the detriment constituted by any lessening of competition that would be likely to result from the conduct.

The Commission was concerned, however, that certain elements of the proposed agreement were relatively open ended and was not prepared to authorise the IHA in its current form. The current agreement provided for actions such as adding network members and changing the common agents functions which, if authorised, would give rise to the possibility of the public benefits being negated. The Commission believed that a number of conditions should be placed on the authorisation to ensure the overall balance of public benefit and detriment is not changed.

Three Sydney private hospitals

On 3 December 1999 the Commission released its draft determination regarding three Sydney private hospitals, St Vincent 's Private Hospital, Mater Misericordia Private Hospital Ltd and Sydney Adventist Hospital, in which the Commission indicated that it does not intend to authorise the conduct.

The three hospitals are seeking authorisation to enter into an arrangement, or to arrive at an understanding, under which they will act together in their discussions and negotiations with health insurance funds regarding reimbursement levels for health fund members.

Reasons for the Commission's conclusion are the following:

- The proposed arrangement would inevitably see agreement between the applicant hospitals on price levels to be sought in negotiations with health insurance funds

even if the same prices are not agreed for equivalent services. The Commission considers agreements or arrangements between competitors in relation to prices to be among the most serious forms of anti-competitive conduct and highly likely to result in a lessening of competition.

- The applicants do compete for patients and the proposed arrangement for collectively negotiating with health funds, to the extent that it leads to agreement on prices, would ultimately lead to a lessening of competition in the hospital services–patient market.

- The proposed conduct would result in an anti-competitive detriment in the private hospital–health insurance market through the impact of agreements on prices and increases in prices. The detriment would in particular be reflected by:

  - increased costs to health funds, potentially impacting on health insurance premiums and membership level; and

  - the easing of competitive pressure on the applicants to improve quality and efficiency of operations and services as a result of their being given an opportunity to pass on cost increases, pursuant to a 'cost plus' mentality 'whereby negotiations are to relate to the level of reimbursement to be received by Hospitals to reflect their ever increasing costs of operations'.

- As to the public benefits, the applicants claimed that the proposed arrangement would give them countervailing power against the health funds. The Commission considered that this has been sought in order to achieve higher reimbursement levels from health funds than would be obtained if the applicants negotiated individually. Noting that higher reimbursement levels do not constitute a public benefit, the Commission examined the ramifications of higher reimbursement levels in light of other public benefits claimed. It was not convinced that the higher reimbursement levels sought from collective negotiations were essential for the applicants' viability or to the continuation of community services.

- Any reduction in costs accruing from collective negotiation were likely to be minimal given that three HPPAs would still need to be negotiated and that the combined spending of the applicants on negotiations was a relatively small amount. Some of the other savings would not require Commission endorsement and therefore do not have sufficient nexus wit the proposed arrangement.

Authorisation still under consideration

The Commission has received an application for authorisation from a group of twelve smaller hospitals in New South Wales, located in both urban and rural areas.[17] The

[17] These hospitals are Alwyn Rehabilitation Hospital, Peninsula Private Hospital, Cape Hawke Community Private Hospital, Westside Private Hospital, Hunter Valley Private Hospital, Wolper Jewish Hospital, Calvary Hospital Wagga Wagga Inc, Hornsby Day Surgery Centre, Longueville Private Hospital, Taree Mayo Private Hospital, Poplars Community Hospital, St David's Private Hospital.

application for authorisation is at two levels. An interim authorisation is sought by the applicants for the proposed conduct of:

- collection and sharing of fee and non-fee related information through an appointed agent;
- negotiation by the agent of purchaser/provider contracts on behalf of individual hospitals with health funds having over 10 per cent market share.

Authorisation is subsequently sought by the applicants for the following proposed conduct:

- collection and sharing through the agent of current and one-month old fee and non-fee related information on either a disaggregated or aggregated basis;
- joint negotiation through the agent with either all health funds and the Department of Veterans' Affairs or with health funds or groups of health funds having over 10 per cent market share; and
- joint negotiation and acquisition of goods and services.

4.3.3 Notifications

The Commission has considered several notifications in the health sector.

Medical Benefit Fund (MBF)

In November 1998 the Commission decided not to take any action to remove the immunity provided to Medical Benefit Fund (MBF) by the lodgement of a notification of exclusive dealing arrangement requiring private hospitals to obtain quality accreditation before it would enter into a hospital purchase provider agreement.

The Commission received 31 submissions concerning the notification and met with a number of interested parties. As a result of the concerns expressed in submissions and discussions with the Commission, MBF amended its notification. Rather than limit quality accreditation to ACHS EQuIP only, MBF proposed the following five criteria which any accreditation scheme should meet:

- It is health care specific, or able to be adequately modified, and that standards are externally set, covering the continuum of care, leadership and management, human resource management, information management, safe practice and evaluation and are regularly updated.
- It involves peer review by an independent external auditor who is clinically trained and accredited as a health care auditor by a national or internationally recognised authorising body.
- It concentrates on best practice clinical standards, patients and outcomes.
- It provides mechanisms for internal and external continuous quality improvement and ongoing review of organisational accreditation status.

- It conducts a nationally coordinated clinical evaluation program for benchmarking, performance evaluation and quality improvement using scientifically tested indicators.

The Commission assessed the notification in light of the amendments made by MBF and decided that it was unlikely that the detriment to the public from the conduct would outweigh the likely benefit to the public. Accordingly, the amended notification was allowed to stand.

However, the Commission may review this decision if it receives any information leading it to believe that the conduct is not likely to result in a net benefit to the public.

American Express

On 23 July 1996 American Express lodged a notification in relation to its Health Fund Plan. Under the plan, AMEX will allow employees access to Hospitals Contribution Fund (HCF) health insurance at reduced rates. The Commission allowed the notification to stand on the basis that the public benefit resulting from the plan outweighed any anti-competitive detriment arising from the plan.

On 18 October HBF filed an application under the *Administrative Decisions (Judicial Review) Act 1977* to review the Commission's decision. It was concluded that, in the light of the possible illegality of the Plan under the *National Health Act 1953* and the failure of the Commission to accord the applicant an opportunity to make submissions, the decision of the Commission be set aside and the matter returned reconsideration.

The Commission subsequently sought submissions from HCF, AMEX and HBF. Submissions were received from the parties. The Department of Health and Aged Care was asked to provide advice as to illegality under the National Health Act. The Commission has received preliminary advice but is awaiting the final advice of the Department.

In addition, the following notifications were allowed to stand by the Commission:

- Medical Benefit Fund of Australia Ltd (MBF).

  Providing benefits to members in respect of acupuncture services only if they obtain such services from a group of acupuncture providers who are recognised by MBF (third line forcing).

- Hospital Benefit Fund of Western Australia.

  Participants in HBF MemberSaver scheme agree not to enter into an agreement with other health or general insurers to provide the same or similar discounts to the insured of another insurer (third line forcing).

- National Mutual Health Insurance (1996).

  Offering reduced health cover costs and reduced home loan application fee on condition the loan is taken out with a National Mutual subsidiary company.

- Government Employees Health Fund, Australian Health Management (1996).

  Members receive enhanced financial and care outcomes on condition they acquire private hospital services from a class of nominated suppliers.

- Australian Dental Association.

  Supply by the Australian Dental Association of professional indemnity assistance to members on condition they are members of the Medical Defence Union.

- Australian Dental Association.

  Requirement that dental practitioners seeking to join membership of a State/Territory branch of the Australian Dental Association must also become a member of the federal body.

- Australian Medical Association.

  Requirement that medical practitioners joining the AMA (federal) also join the AMA (State/Territory) branch (third line forcing).

- Chiropractors Association of Australia.

  Requirement to join both a State branch and the National branch (third line forcing).

4.3.4 Mergers

The Commission has examined the proposed acquisition of the St Andrews War Memorial Hospital in Brisbane by the Uniting Church of Australia Property Trust, which manages the Westley Hospital and Turrawan Private Hospital in Brisbane, St Stephen's Private Hospital in Maryborough and Westley Park Haven Private Hospital in Townsville. On 29 February the Commission indicated it would not intervene in the proposed acquisition.

4.4 Information and education

The Commission also seeks to achieve compliance with the Act by informing the community about the Act through compliance material, speeches and education programs to prevent future breaches of the Act. The Commission has been particularly active in the health sector in that regard.

Prior to the extension of the Act and commencement of the State and Territory competition codes, which became effective on 21 July 1996, the Commission undertook a major educational campaign focusing on the health sector to highlight to those who would be covered by the Act for the first time their obligations and responsibilities under the Act.

For example, the Commission wrote to each of the medical colleges with an offer of assistance. The aim was to assist those colleges with possible changes that may have

been necessary to the Constitution, rules or by-laws of such college **if** they contained anti-competitive restrictions. The response was mixed. The Commission's offer was taken up enthusiastically by some colleges, whereas others adopted a 'we are a voluntary private association and you do not have any role over our activities' approach to the offer. The Commission is not concerned whether or not its offer to assist is taken up (especially as it does not give legal advice,- it simply highlights areas of potential concern from a competition law perspective), it is concerned to ensure that the colleges are complying with the law. This could readily be achieved by the colleges obtaining private sector legal advice, as a number of colleges have already done.

The Commission initiatives generally included contacting relevant associations to inform them of the need for their articles, codes, and/or by-laws to be amended to comply with the Act; presenting addresses at health sector forums; and meeting with representatives of health sector participants to discuss issues particular to their members. In November 1995 the Commission published a *Guide to the Trade Practices Act for the health sector* (see below), which was widely distributed.

The culmination of the Commission's initial educational campaign was the presentation of health sector workshops in all capital cities except Darwin. One of the primary aims of the workshops was for those attending to gain a better understanding of their own and their association's rights and obligations under the Act.

Since July 1996 the Commission has continued to inform and assist medical and health sector professionals and their associations to understand their rights and obligations under the competition laws. The Commission has given well over 50 presentations at various conferences, seminars and formal meetings of professional associations.

As well as a number of general guidelines on competition law matters and the workings of the Act, the Commission has also published specific compliance material for, and in cooperation with, the health sector.

- *A guide to the Trade Practices Act for the health sector*

  Published in November 1995, the guide aimed to help professionals in the health sector identify their right and obligations under the provisions of the Act, following the enactment of the *Competition Policy Reform Act 1995*.

- *Guide to the Trade Practices Act for the promotion of private health insurance*

  This guide was developed by the Commission and the Private Health Insurance Ombudsman (then the Private Health Insurance Complaints Commissioner), with input from major health funds.

  The main objective of the guide is to help the industry and individual companies develop strategies which would improve compliance with the Act and reduce the need for regulatory intervention. The guide provides basic information about the provisions of the Act which affect promotional activities, with examples directly relevant to health fund promotions.

- *Fair treatment? A draft guide to the Trade Practices Act for the promotion of medical and health services*

  On 14 November 1999 the Commission and the NSW Health Care Complaints Commission (HCCC) released a consultative draft guide to the Act for the promotion of medical and health services.

  Recent changes to some State and Territory legislation have relaxed many of the previous restrictions on advertising of medical and other health services, giving professionals much wider opportunities to communicate directly with consumers. However, for many medical and health professionals, advertising and other promotional activities are unfamiliar territory. Accordingly, the transition to this new environment appears to have created some problems, and the community, regulators and medical professionals have raised concerns with the Commission and the HCCC about inappropriate advertising.

  The main objective of the guide is therefore to help the health and medical sectors and individual practitioners develop strategies that will improve compliance of advertising and other promotional activities with the Act.

  The draft guide is in the process of being finalised.

The Commission has organised several conferences dealing with trade practices issues for the health sector and the professions more generally.

- The Commission jointly sponsored and organised, with the University of Western Australia, Murdoch University and University of Notre Dame, a conference on competition law and the professions, *Can the professions survive a national competition policy?,* held in Perth on 11 April 1997.

  The conference provided an opportunity to improve the understanding of participants about the application of competition laws to the professional sector and the concerns that practising professionals may have about such laws applying to them, therefore helping to bring a more informed debate about these issues.

  The Commission has also published the proceedings from this conference.

- On 24 June 1999 the Commission, in conjunction with the AMA (WA branch), organised a conference in Perth entitled, *Caring and Competition*, which dealt with issues concerning the Act and competition policy generally.

- On 14 October 1999 the Commission jointly hosted a conference with the NSW Health Care Complaints Commission (HCCC), *Advertising medical services — In whose interest?,* dealing with advertising and promotion of medical services.

  The conference brought together specialist speakers from a variety of relevant fields to allow conference participants to gain an insight and understanding into a range of important issues arising from the advertising and promotion of medical services.

With the development of the Internet, the Commission is also concerned to ensure that Internet websites do not mislead or deceive consumers about health products and services, and that website operators understand their responsibilities under the Act. In that regard, the Commission coordinated the second International Internet Sweep Day held by the International Marketing Supervision Network (IMSN) in September 1998, which targeted Internet websites making misleading or deceptive health claims. The sweep day involved more than 60 enforcement agencies from 28 countries.

The sort of claims targeted included miracle cure claims, exaggerated efficacy claims (i.e. the product is advertised as a quick and effective cure-all for a wide range of ailments or for an undiagnosed pain), simple efficacy claims (i.e. the product/treatment is advertised as effective in treating, curing, mitigating, ameliorating or improving a health condition), testimonials to promote a product or treatment, establishment claims about the amount of support the advertiser has for the advertised product or treatment, and terms like 'scientific breakthrough', 'secret ingredient' and 'ancient remedy'.

Once suspicious sites were identified, the site operators were sent educational messages outlining the fact that the activities they appeared to offer may be regulated in some countries. They were referred to the Commission's homepage, which contains information on how to comply with the Act and how to obtain more information about the legislation applicable in other countries.

More than 1400 suspicious websites were identified, of which 25 per cent were removed or altered within a month, giving a good indication of the success of the educational messages sent to website operators.

4.5 Coordination with other agencies

When undertaking actions to ensure compliance with the provisions of the Act in the health sector, it is important that the Commission does not duplicate the effort of other agencies, which also have responsibilities in this area. Therefore, coordination with other agencies has been and continues to be essential.

4.5.1 Private Health Insurance Ombudsman

The Private Health Insurance Ombudsman (formerly the Private Health Insurance Complaints Commissioner) is an independent statutory corporation, whose main role is to deal with private health insurance arrangements.

The Commission has developed a strong, bilateral relationship with the Ombudsman, both as a referral point for specific consumer complaints and as a source of information about emerging trends in the industry.

Following a large number of complaints from health funds and their members about the promotional claims of some funds made to the Commission and the then Private Health Insurance Complaints Commissioner, the two agencies jointly produced a *Guide to the Trade Practices Act for the promotion of private health insurance*, to help overcome these problems (see section on 'Information and education').

4.5.2 State and territory consumer affairs/fair trading agencies

The consumer protection provisions of the Act are substantially mirrored in the State and Territory Fair Trading Acts. To ensure coordinated action, consultation arrangements between the Commission's regional offices and the consumer affairs/fair trading agencies of the States and Territories have been formalised in memoranda of understanding. These set out the criteria for referring complaints to either the state agency or the Commission. For example, both the Swisslim and Giraffe World Australia cases involved some coordination between the Commission and the NSW Department of Fair Trading.

When the Commission receives a complaint which does not fall within its priorities, it may refer the complaint to a state consumer affairs agency when the complaint involves:

- a breach of the State Fair Trading Act or other legislation administered by the state agency; or
- a dispute relating to consumer protection or fair trading considerations which may be mediated or investigated by the state agency; and/or
- matters identified by the state consumer affairs agency as priority issues.

4.5.3 Health complaints agencies

Complaints about health care providers can also be made to health complaints agencies in each jurisdiction. These bodies have been established to investigate and conciliate complaints about the health sector.

On 20 July 1999 the Commission signed a Memorandum of Understanding with the NSW Health Care Complaints Commission (HCCC). The Commission had been liaising with the HCCC since 1998 on several matters, including:

- referral of complaints about health care services;
- exchange of information about the Commission's involvement in particular matters; and
- inquiries into particular areas of health care chaired by the HCCC. In April 1999 the Commission provided a submission to the NSW Cosmetic Surgery Inquiry.

The agreement formalised the liaison between the two agencies and provided for better coordination and cooperation between them with regard to both enforcement and education activities. Under the memorandum, the Commission and the HCCC are to refer complaints to the most appropriate agency, exchange information where that is permitted by law and undertake joint responses to problems in the market. For instance, the Commission and the HCCC organised in October 1999 a conference on advertising of medical services and are currently working together to develop a guide to the promotion of medical and health services.

In November 1999 the Commission wrote to all State and Territory health complaints agencies, to explore the possibility of similar cooperation agreement between the

Commission and each of these agencies. The Commission is of the view that such agreements would be beneficial to both parties and would contribute to achieving better protection for consumers of medical and other health services.

The Commission has started developing a cooperation agreement with the Office of Health Review, Western Australia. The Northern Territory Health and Community Services Complaints Commission and the Victorian Health Services Commissioner have expressed interest in developing such agreements.

5 The private health industry

5.1 Private health insurance industry

At 30 June 1999 there were forty-four registered health benefits organisations.

Organisations operating health funds are either open membership organisations, which are available to the general public or restricted membership organisations whose members are drawn from an employment group, professional association or union.

At 30 June 1999 there were twenty-nine open funds covering 92.8 per cent of persons insured for hospital and ancillary service. The remaining fifteen funds were restricted membership organisations covering 7.2 per cent of the market.

The majority of registered organisations are non-profit but there are also four for-profit organisations (AXA Health Insurance, SGIO Health, Grand United Corporate and Grand United General).

From 1 October 1995 open membership organisations were no longer required to conduct separate health funds in each State. This placed open funds on an equal footing with restricted funds in being able to conduct a single health benefits fund covering members throughout Australia with a single pool of reserves.

Table 5.1 summarises the market share of the top six funds in all States and Territories

Table 5.1 Market share of the six largest health funds

FUND	NSW[4]	VIC	QLD	SA	WA	TAS	NT	AUST
Medibank Private	**21.7**	**41**	**31.3**	**17.9**	**15.0**	**25.8**	**46.7**	26.4
MBF	**22.4**	4	**41.9**	0	0.7	**44.4**	**28.3**	17.5
HBF	0.1	0	0.2	0	**74.6**	0	0	10.7
AXA	0.9	**24**	3.2	**46.1**	1.0	0.5	**17.5**	10.4
HCF	**22.5**	1	1.7	0.3	0.1	0	0	8.7
NIB	11.5	1	1.5	0.5	0.2	0	0	4.7
Other	20.9	29[3]	20.3	35.1[1]	8.3	29.3[2]	7.6	21.6
	100	100	100	100	100	100	100	100

Source: PHIAC Annual Report 1998–99
Notes:
1. SGIO has a significant market share in SA with 12.9 per cent of the market.
2. St Lukes health fund has a significant share in Tasmania with 18.2 per cent of the market.
3. Australian Unity has a significant share in Victoria with 10.1 per cent of the market.
4. The ACT is included with NSW.

The following points can be noted from the information contained in the above table:

- The traditional State basis of fund registration has resulted in two or three insurers dominating in each State despite the large number of funds operating in Australia.
- The six largest health funds cover 78.4 per cent of the market but their market share varies significantly between States and Territories.
- MBF, HCF and Medibank Private have around the same market share in NSW.
- The market share leader in a State with the highest market share is HBF in WA with 74.6 per cent of the market.
- Medibank Private is the only health fund with a significant market share in all States.

It should also be noted that the size of the organisation does not relate simply to its open or restricted membership status. For example, of the restricted membership funds, NSW Teachers is the largest fund with over 142 731 persons covered. Mildura District Hospital Fund, on the other hand, is an open membership organisation that operates only in Victoria with just 23 081 persons covered in June 1999.

There are also a number of regionally based funds that cover a large proportion of local members including Yallourn Medical and Hospital Society, Goldfields Medical Fund, Latrobe Health Services Inc and Mildura District Hospital Fund with just 1.1 per cent of the total market.

Table 5.2 shows that there has been a turn around in the financial performance of health funds in 1998–99. The industry incurred substantial losses in 1995–96 through to 1997–98. These losses were made despite increases in contribution income, which increased by 2.2 per cent in 1995–96, 4.2 per cent in 1996–97 and 7 per cent in 1997–98.

In 1998–99 the industry made a net profit of $126 million and revenue from contribution income rose 4.5 per cent. Total reserves also improved with a rise of $131 million to $1304.4 million.

Table 5.2 Financial performance of the health funds

Year	Contribution income $ million	Hospital table benefits $ million	Ancillary table benefits $ million	Net profit $ million	Net assets (total reserves) $ million
1995–96	4226.4	2834.1	1059.7	(74.4)	1295.3
1996–97	4404.2	3026	1115.3	(130.6)	1173.5
1997–98	4712.7	2978	1119.9	(10.8)	1173.1
1998–99	4926.6	3065.6	1143.5	126	1304.4

Source: PHIAC Annual Reports 1995-96 to 1998-99

5.1.1 Management expenses

Table 5.3 shows that management expenses have been increasing steadily since 1995-96. Total management expenses in 1995–96 were $503.6 million or an average cost per

member of $145.7. By 1998–99, total management expenses had increased to $590.7 million or an average cost per member of $173.8. However, the ratio of management expenses to contribution income has remained steady over the period.

Table 5.3 Health fund management expenses

Year	Total management expenses $ million	Management expenses per member $	Management expenses as percentage of contribution income
1995–96	503.6	145.7	11.9
1996–97	530.3	155.5	12.0
1997–98	540.1	162.2	11.5
1998–99	590.7	173.8	12.0

Source: PHIAC Annual Reports 1995–96 to 1998–99.

5.1.2 What does private health insurance cover?

Private health insurance covers things that Medicare does not (1998–99 figures):

- private patient charges in public hospitals ($275.6 million) and charges in private hospitals ($2 325.7 million);
- the gap between the 75 per cent Commonwealth benefit and the schedule fee for in-hospital medical services provided to private patients ($240.9 million);
- the gap above the schedule fee for in-hospital medical services (where an agreement is in place with the practitioner) ($12.2 million);
- listed prostheses ($239.2 million);
- charges from dentists, physiotherapists, podiatrists, chiropractors, dieticians and a wide range of other allied health professionals, and the costs of some over the counter drugs ($1 143.5 million).

5.1.3 Membership

Table 5.4 shows that the overall participation rate (persons covered by hospital insurance as a percentage of the Australian population) for private health insurance has declined significantly since the introduction of Medicare in 1984. For example, the percentage of persons with hospital insurance declined from 50 per cent in June 1984 to 46 per cent in June 1989 and to 30.1 per cent in December 1998. The rate of decline over that period has varied somewhat between States.

However, since the introduction of the Government's 30 per cent rebate on private health insurance this decline has been reversed. Participation increased by 0.2 per cent in each of the March 1999 and June 1999 quarters, 0.4 per cent in the September 1999 quarter and 0.3 per cent in the December 1999 quarter bringing participation in private health insurance to 31.2 per cent of the Australian population.

Table 5.4 Persons Covered by Hospital Insurance from June 1984 to September 1999

As at 30 June	Number of persons covered '000	% of population covered	% increase in population covered
1984	7 784	50.0	-
1985	7 514	47.7	-2.3
1986	7 812	48.8	1.1
1987	7 859	48.3	-0.5
1988	7 770	47.0	-1.3
1989	7 643	45.5	-1.5
1990	7 588	44.5	-1.0
1991	7 548	43.7	-0.8
1992	7 164	41.0	-2.7
1993	6 967	39.4	-1.6
1994	6 632	37.2	-2.2
1995	6 304	34.9	-2.3
1996	6 149	33.6	-1.3
1997	5 916	31.9	-1.7
1998	5 728	30.5	-1.4
1999	5 793	30.5	0
Quarter Ended			Increase from last quarter
Mar. 98	5 814	31.1	-0.5
June 98	5 728	30.5	-0.6
Sept. 98	5 699	30.3	-0.2
Dec. 98	5 676	30.1	-0.2
Mar. 99	5 733	30.3	0.2
June 99	5 793	30.5	0.2
Sept. 99	5 890	30.9	0.4
Dec. 99	5 970	31.2	0.3

Source: PHIAC

Table 5.5 shows that the proportion of insured persons under and over age 65 has also changed over time with the decline in coverage from 1989–90 to 1998–99 mainly reflected in the category of persons under 65.

Table 5.5 Coverage by age category

	1989–90			1998–99		
	Age <65	Age 65+	Total	Age <65	Age 65+	Total
Number of persons covered ('000)	6 814	773	7 587	4 950	843	5 793
Proportion of total (%)	90.1	9.9	100.0	85.4	14.6	100.0

The increasing proportions of over 65s in the insured population reflects a shift in the contributor base to those with a higher health risk through either the failure to join, or withdrawal, of younger, healthier insured members rather than simply the ageing of the insured population.

The impact of increasing proportions of people over 65 in the insured population has a direct impact on the level of benefits paid by health insurance funds over time. This relates to the fact that people with private health insurance aged 65 or more are more likely to use hospital services than insured people under 65.

5.1.4 Product trends

Front-end deductible (FED) products

A FED product is one where the fund member assumes some initial risk in return for lower premiums. The products may require the member to pay an agreed amount in any year before any benefits will be paid, or they may require the member to pay an agreed amount for each episode up to an annual maximum. The excess typically varies from between $100 to $1000 for a single contributor and between $200 and $2000 for other contributors.

FED products have had a degree of 'success' in recent years (as measured by the degree of uptake). Between June 1989 and June 1999, the number of people covered by FED products that had hospital insurance rose from 6 per cent to 35 per cent.

Exclusionary products

Before the *Health Legislation (Private Health Insurance Reform) Amendment Act 1995* (see chapter 6) came into effect, several funds were offering so-called ‘exclusionary products’. While these followed the law in paying basic table benefits for all episodes in all hospitals, they excluded supplementary benefits for various types of episodes, such as elective surgery used mainly by the elderly (cataract removal, hip replacement, cardiothoracic surgery) and some episodes used mainly by ‘hit and run’ members of funds (obstetrics and orthopaedic surgery).

The 1995 legislation allowed the further development of exclusionary products by allowing funds to exclude episodes of any kind from any level of benefit (with the

exception of rehabilitation, psychiatric and palliative care). However, these products still contribute to reinsurance and therefore to the cost of the aged and chronically ill.

5.1.5 Health insurance cover for ancillary services

All health funds offer ancillary products. Ancillary cover can be purchased as a stand-alone product (ancillary only cover) or can be purchased as part of a combined hospital and ancillary health insurance product.

Consumers of ancillary products expect to make claims every year. They purchase the product because they believe they will receive more back in benefits than the cost of the annual premium. Unlike other types of insurance (including hospital insurance) it does not cover catastrophic events.

Ancillary services are self referred and thus funds find it necessary to apply benefit limits on different services and to apply a much larger gap between benefits and charges than occurs with hospital and medical insurance. Fund benefits on average met only 56 per cent of charges for ancillary services in 1998–99.

Types of ancillary cover

The following benefits are covered by all funds in their ancillary-only products:

- dental
- physiotherapy
- optometry
- hydrotherapy
- orthoptics
- speech pathology
- occupational therapy
- chiropractic
- acupuncture
- pharmaceuticals not listed on the Pharmaceutical Benefits Scheme (PBS)
- hearing aids
- home nursing

Most also offer ambulance and osteopathic cover in their ancillary-only products.

However, there is considerable variation from fund to fund as to other types of cover offered in ancillary-only cover. For example, some funds offer cover for dietetics, podiatry, massage therapy, antenatal and postnatal education, health management

programs, psychology, school accidents, hypnotherapy, artificial aids and travel, blood glucose monitors, sleep apnoea devices, alternative medicines such as naturopathic and homoeopathic medicines.

The size of the health fund is not the determining factor in relation to the variety of ancillary benefits covered.

Premiums for ancillary-only cover range from around $200 to $800 for singles, and from $400 to $1600 for families. All funds place limits on the benefits members can receive for each type of cover in a one-year period.

Ancillary membership

In its *1998–99 Annual Report*, PHIAC reported that 76.3 per cent of all persons covered by hospital insurance are also covered by ancillary insurance. The number of persons covered by ancillary insurance tables has reflected the steady decline in hospital insurance membership declining from 40.3 per cent of the Australian population in June 1989 to 31.9 per cent in June 1999.

However, there has been a steady increase in the number of people taking out ancillary only cover since June 1989. The number of ancillary-only memberships has increased from around 350 000 in June 1988 to around 750 000 in June 1999.

5.2 Private hospital industry[18]

5.2.1 Overview

In 1997–98, there were 492 private hospitals in Australia. Of these, 294 were acute overnight facilities, 23 were specialist psychiatric hospitals and 175 were free-standing day hospitals.

Figure 5.1 provides evidence of strong growth in the number of free standing day hospital facilities and a slight decline in the number of private acute and psychiatric hospitals between 1991–92 and 1997–98. The number of day hospital facilities more than doubled from 72 to 175 and the number of private acute and psychiatric hospital declined over the same period from 319 to 317.

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[18] There are relatively few psychiatric hospitals and some of these are owned by the same parent company. To maintain confidentiality of their data, the Australian Bureau of Statistics combines psychiatric hospitals with acute hospitals in most tables.

Unless otherwise stated all information is derived from the Australian Bureau of Statistics (ABS) publication, Private Hospitals Australia.

Figure 5.1 Numbers of private hospitals, 1991–92 to 1997–98

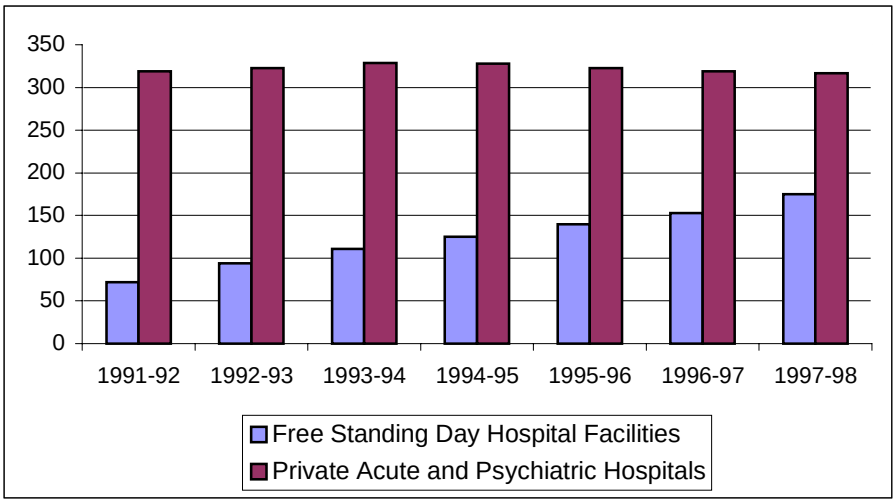
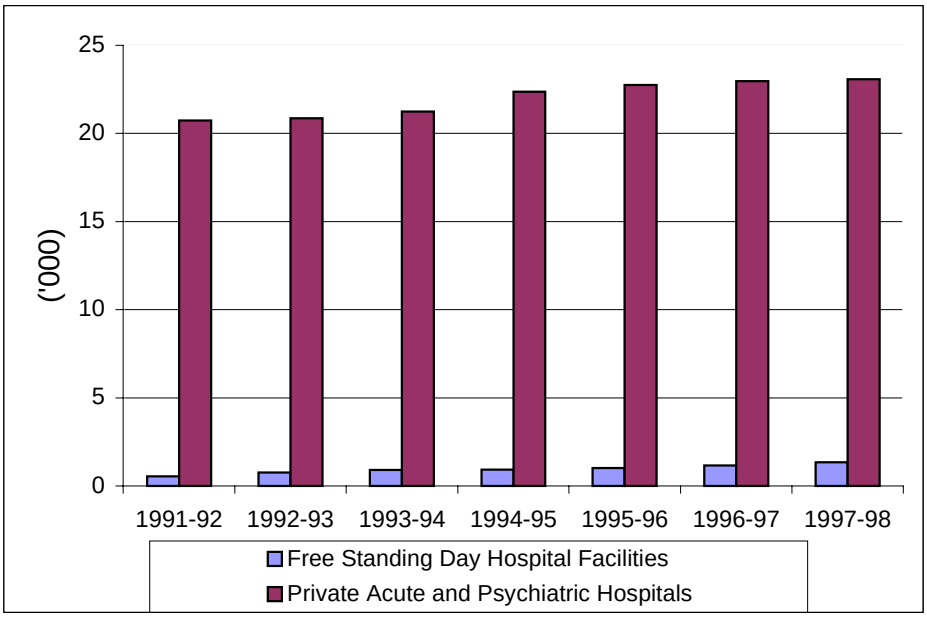


Figure 5.2 provides further evidence of strong growth in the day hospital sector. The number of hospital beds in free standing day hospital facilities more than doubled from 556 in 1991–92 to 1348 in 1997–98. The number of beds in private acute and psychiatric hospitals also increased from 20 745 to 23 091 over the same period.

Figure 5.2 Hospital Beds, 1991–92 to 1997–98

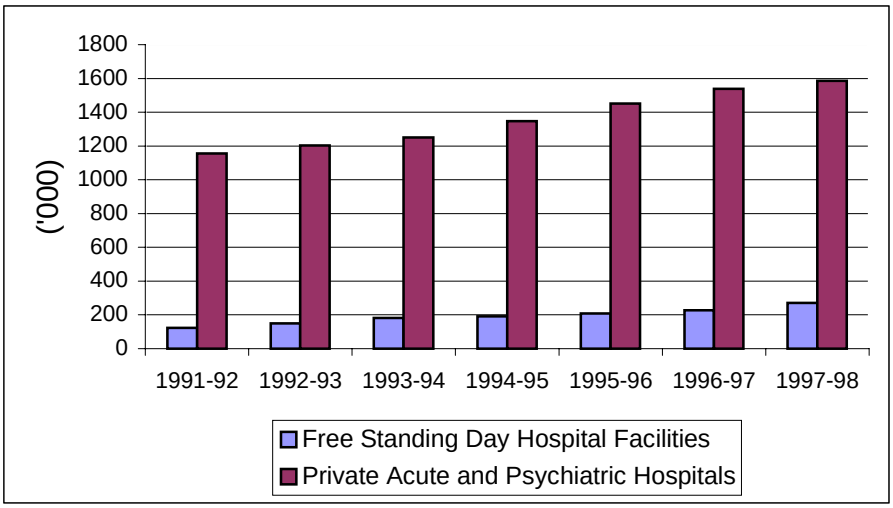


The number of separations is possibly the best measure of activity in the hospital sector. Figure 5.3 provides evidence of strong growth in separations in freestanding

day hospital facilities with the number of separations more than doubling from 123 400 in 1991–92 to 271 700 in 1997–98. The number of separations in private acute and psychiatric hospital also grew strongly from 1 157 200 to 1 585 300 over the same period.

It should also be noted that despite evidence of strong growth in freestanding day hospital activity this sector accounted for only 14.6 per cent of all private hospital separations in 1997–98.

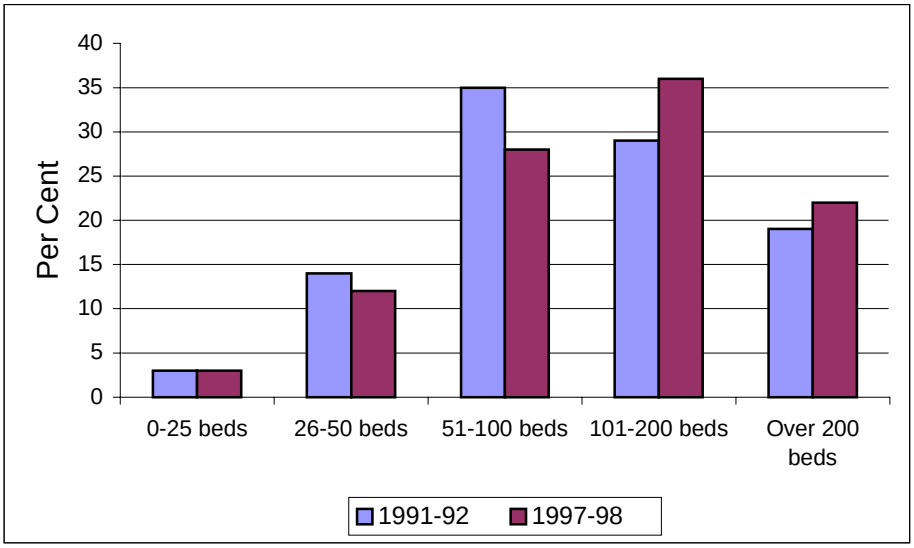
Figure 5.3 Number of separations, 1991–92 to 1997–98



The Australian Bureau of Statistics notes that although the number of private acute and psychiatric hospitals remained fairly constant between 1991–92 and 1997–98, the average number of beds has increased by 11 per cent. The ABS says this phenomenon indicates a tendency towards larger hospitals. Over the seven-year period the number of hospitals with 26–50 beds declined by 14, mostly because of closures, while the number of hospitals with 101–200 beds increased by 12, mainly because of new hospitals and the expansion of smaller existing hospitals.

Further evidence of this shift from smaller hospitals to larger hospitals is provided in figure 5.4. The share of separations has declined in hospitals with 100 beds or less and increased in hospitals with over 100 beds with the strongest growth in the 101–200 bed size group.

Figure 5.4 Private acute and psychiatric hospitals — share of separations by hospital size, 1991–92 to 1997–98



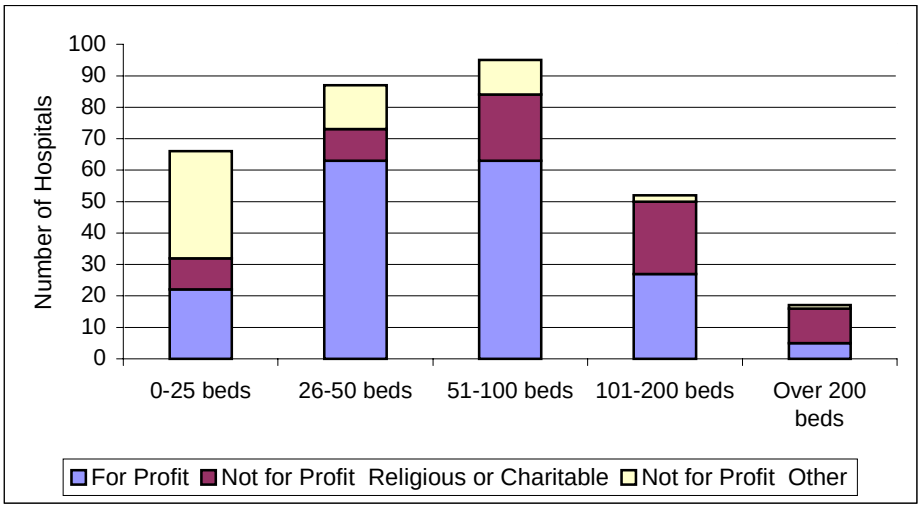
5.2.2 Private hospital ownership

Private hospitals are either for profit or not for profit. Non-profit hospitals can be further categorised as either religious/charitable hospitals or other non-profit hospitals. Most of the other non-profit hospitals consist of bush nursing, community and memorial hospitals.

Figure 5.5 indicates that:

- the majority of other non-profit hospitals have less than 50 beds;
- religious and charitable not for profit hospitals are more likely to be between 51 and 200 beds with an increasing proportion of the market as hospital size increases beyond 50 beds; and
- the for-profit ownership type dominates in the 26 to 200 bed ranges but with a decreasing proportion of the market as hospital size increases.

Figure 5.5 Private acute and psychiatric hospitals by ownership type, 1997–98



The largest owner of private hospitals in Australia is Health Care of Australia. This company operates 45 overnight facilities and has a total market share of 20 per cent of the available private hospital beds. The market share of the largest groups is provided in the table 5.6:

Table 5.6 Private hospitals largest groups[1]

Group	National Market			Key State[2]		
	Hospitals[3]	Beds	Share[4] %	State	Hospitals	Bed Share %
Health Care of Australia	45	4653	20.1	NSW/ACT	19	29.9
Australian Hospital Care	16	2027	8.8	VIC	12	21.8
Ramsay Health Care Ltd	14	1718	7.4	NSW/ACT	6	8.3
St John of God Health Care	9	1308	5.7	WA	5	34.7
HealthScope	11	871	3.8	VIC	5	5.3
Benchmark Health Care Group	8	693	3.0	VIC	5	7.7
Alpha Healthcare	9	612	2.7	NSW/ACT	9	9.5

Source: Australian Private Hospitals Association information paper 'Structure of the Private Hospital Industry' (October 1999).

Notes:

1.Some religious orders operate multiple hospitals that operate as independent facilities.

2.The key State is the State where the group has the largest market share and at least three hospitals.

3.Hospitals that are open and running as at 30 June 1999. Some of these hospitals may be management contracts rather than owned by the organisations.

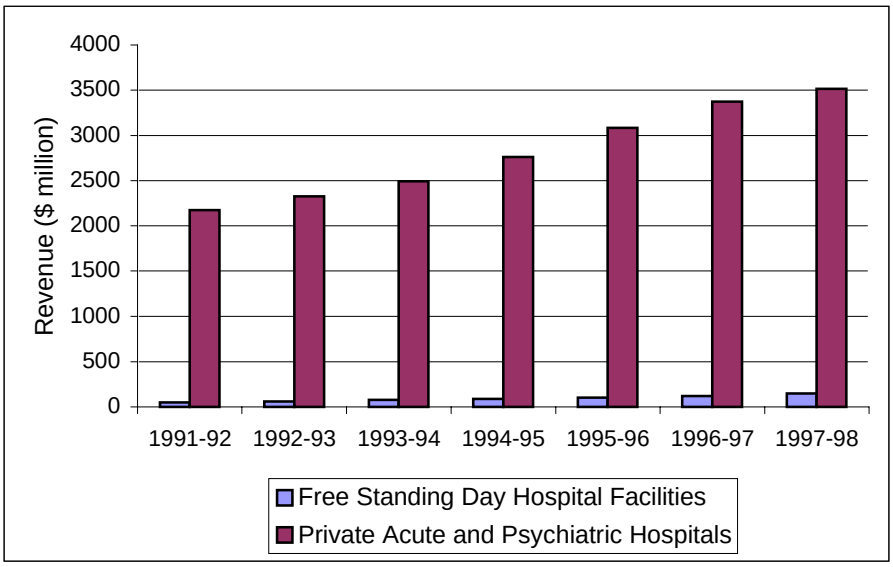
4.Shares are calculated as known current beds for the group divided by total national or state beds for 1997–98. This will slightly overestimate the market share as the total bed number is increasing.

5.2.3 Financial viability of private hospitals

Around 92 per cent of private hospital revenue is received in respect of patient liability for accommodation and other fees regardless of the source of payment e.g. health fund, Commonwealth, patient. The remaining revenue comes from such things as income received for staff and visitor meals, accommodation and facility fees paid by doctors, investment income, bequests etc.

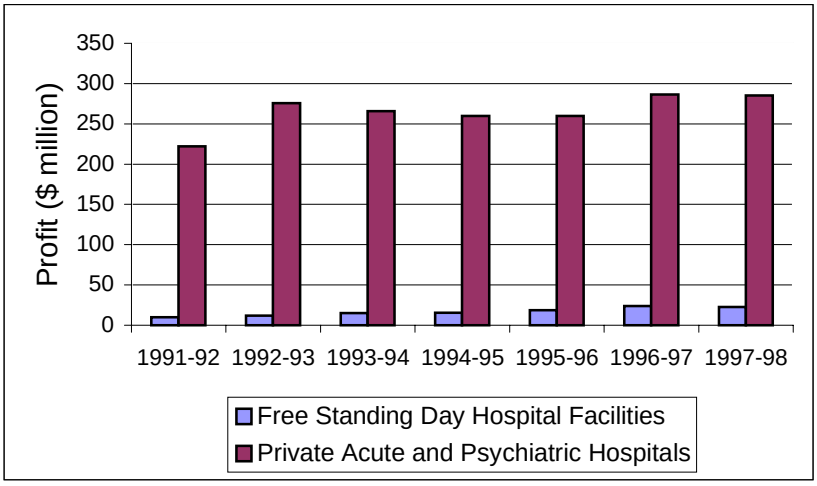
Figure 5.6 shows hospital revenue sharply increasing between 1991–92 and 1997–98. Private acute and psychiatric hospital revenue grew by 62 per cent and freestanding day hospital revenue grew by 219 per cent during this period.

Figure 5.6 Hospital revenue, 1991–92 to 1997–98



Despite this dramatic increase in revenue there has not been a corresponding increase in private hospital profitability. Figure 5.7 shows that gross profit (revenue minus recurrent expenditure) experienced by freestanding day hospital facilities increased from $10.1 million in 1991–92 to $23 million in 1997–98. Gross profit experienced by private acute and psychiatric hospitals increased from $222 million to $285 million over the same period.

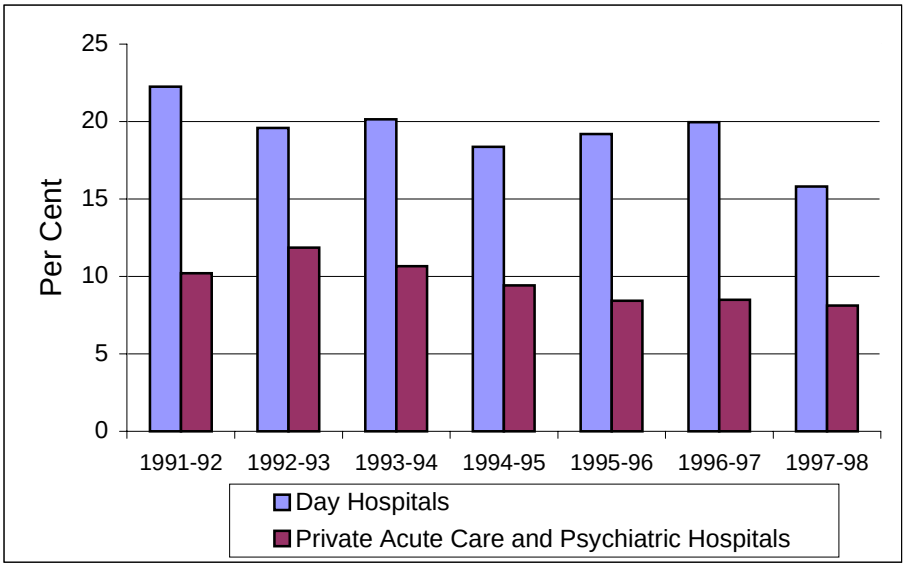
Figure 5.7 Gross profit (revenue minus recurrent expenditure), 1991–92 to 1997–98



There are a number of different measures of profitability. Figure 8 measures profitability in terms of net profit (total revenue less total recurrent expenditure) as a proportion of total revenue. This is referred to as the net operating margin.

Figure 5.8 shows that there was a decline in profitability as measured by net operating margins from 22.3 per cent to 15.8 per cent for freestanding day hospital facilities and a decline from 10.2 per cent to 8.1 per cent for private acute care and psychiatric hospitals between 1991–92 and 1997–98.

Figure 5.8 Net operating margins, 1991–92 to 1997–98

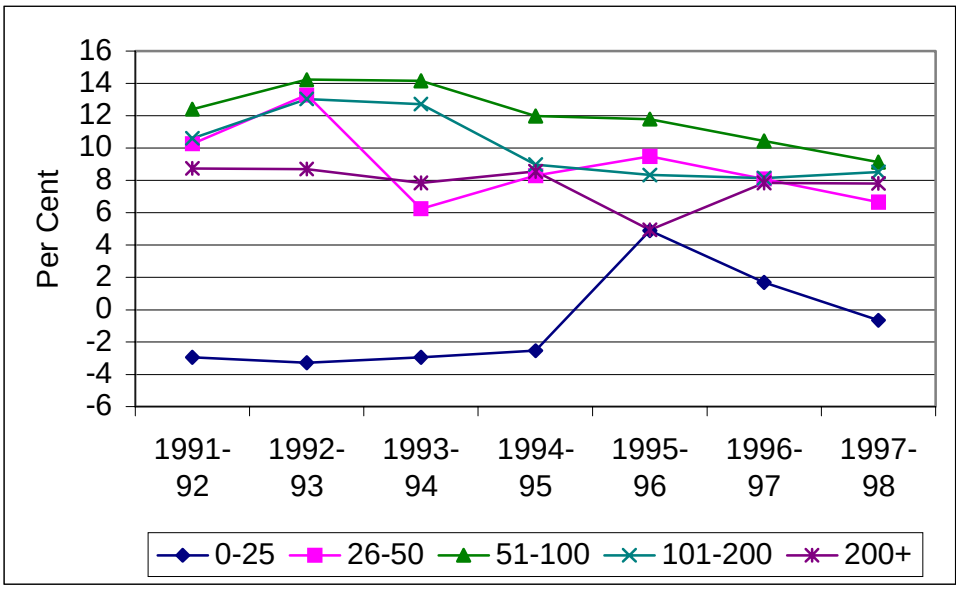


5.2.4 Profitability and the size of the hospital

Figure 5.9 demonstrates that net operating margins of all bed size groups (other than the 0 to 25 category) fell between 1991–92 and 1997–98. However, the 0 to 25 bed hospital group consistently recorded a much lower level of profitability than the rest of the industry

Net operating margins were broadly similar across the various hospital size groupings (other than the 0 to 25 bed group) with the 51 to 100 bed group showing slightly better profit margins than other groups.

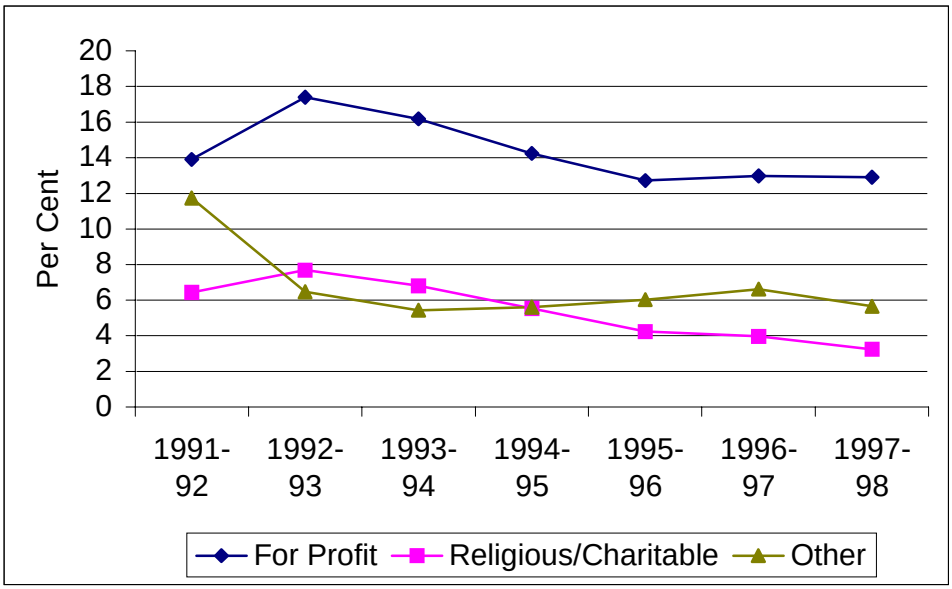
Figure 5.9. Net operating margin by hospital size for private acute and psychiatric hospitals, 1991–92 to 1997–98



5.2.5 Profitability and ownership type

Figure 5.10 indicates that profitability declined in all ownership groups between 1991–92 and 1997–98. Profitability is highest in the for-profit sector and has remained steady since 1995–96 at close to 13 per cent. The profitability of the other non-profit group of hospitals has also remained steady at around 6 per cent since 1992–93. On the other hand profitability of the religious and charitable hospitals has been steadily declining since 1992–93.

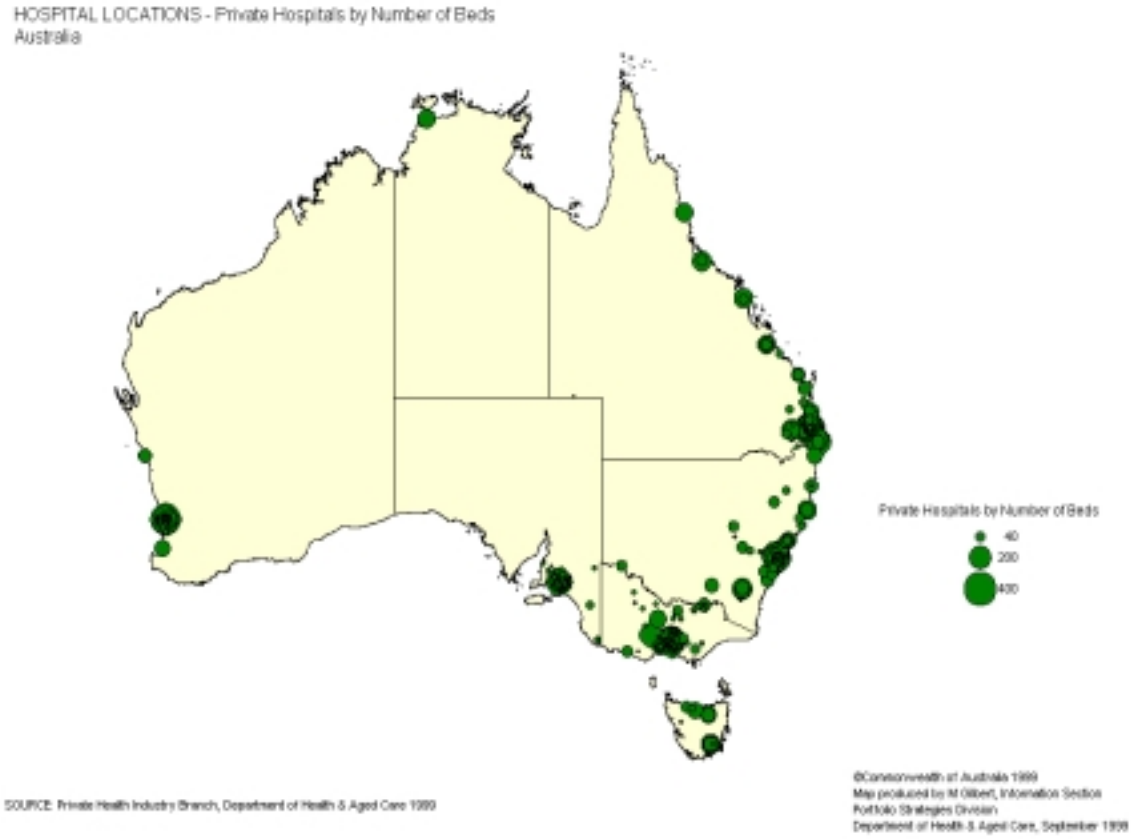
Figure 5.10. Net operating margin by ownership type, 1991–92 to 1997–98



5.2.6 Location of private hospitals by size

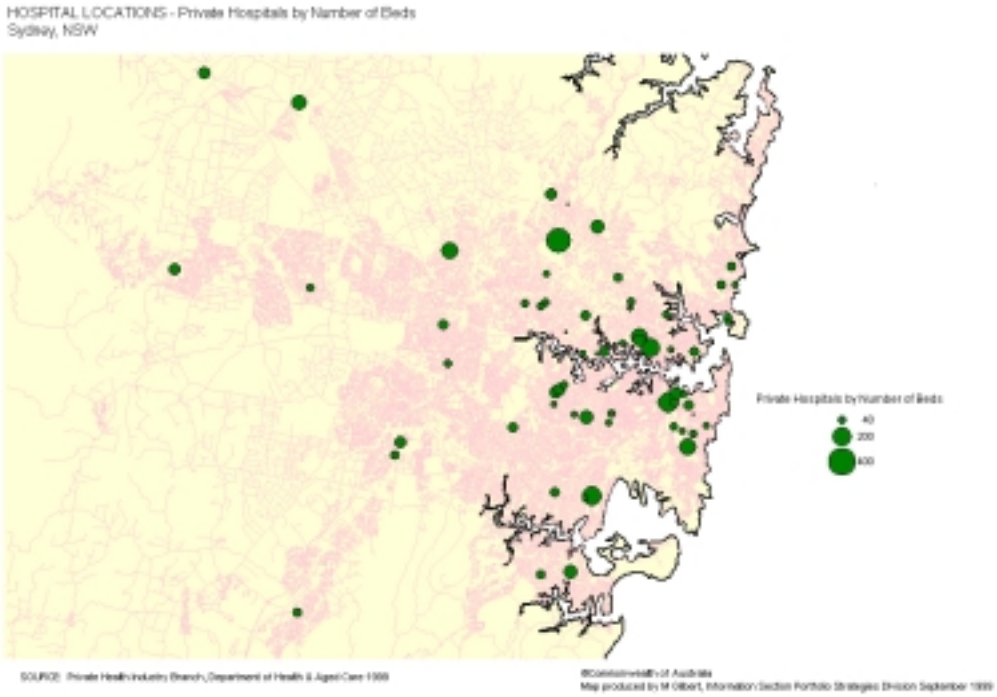
Map 5.1 below indicates that large private hospitals are mostly located within the metropolitan regions in Australia. Those in regional areas are mostly very small hospitals.

Map 5.1 Hospital locations — private hospitals by number of beds in Australia

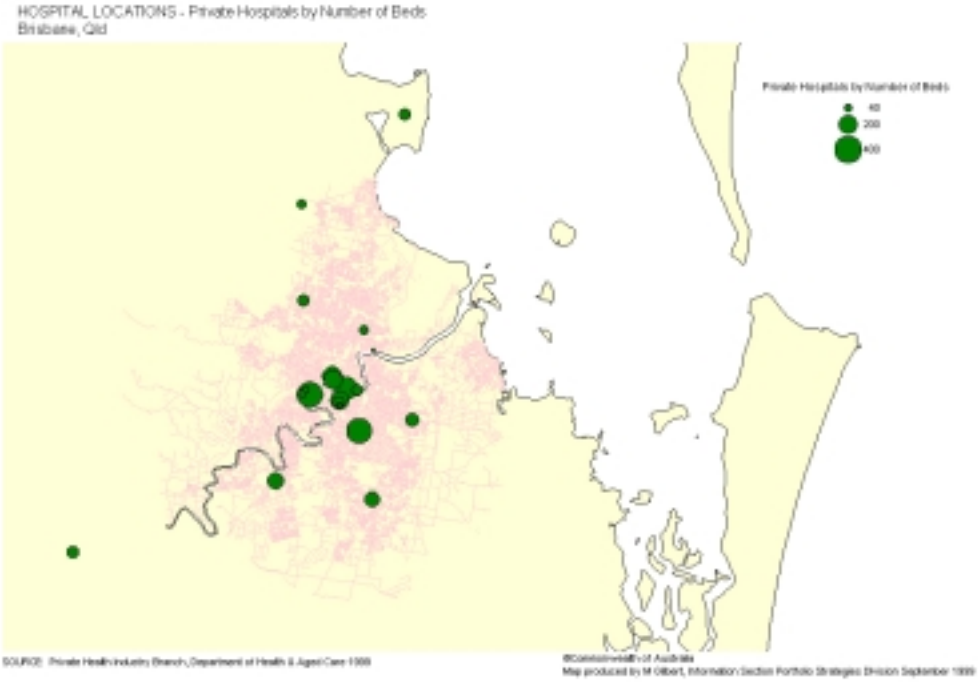


Maps 5.2 to 5.3 indicate that most of the large private hospitals are close to city centres in Sydney, Brisbane and Melbourne. This pattern is identifiable in other capital cities.

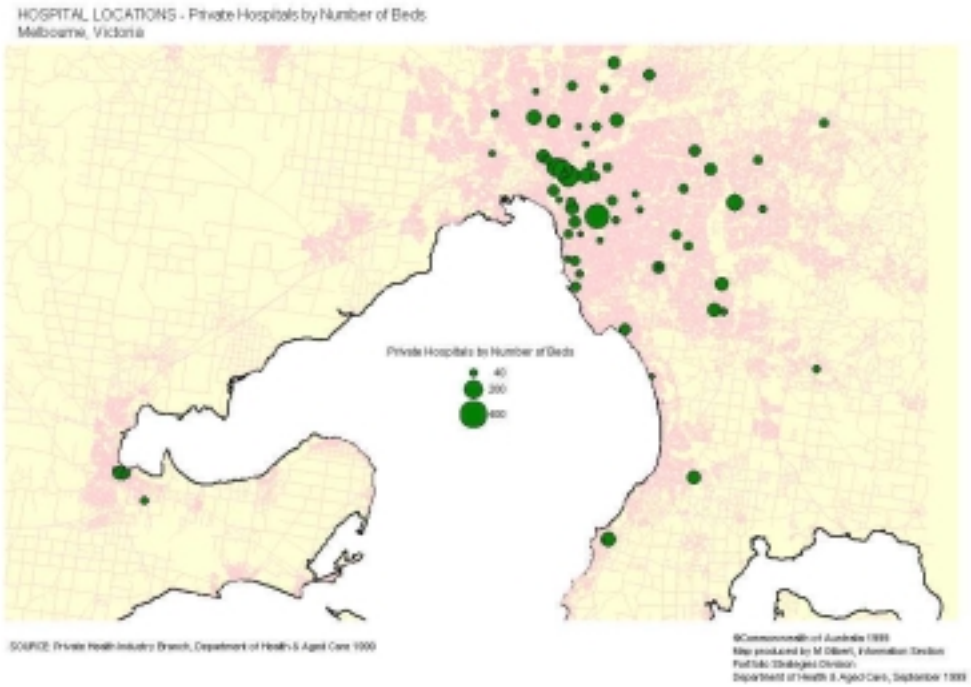
Map 5.2 Hospital locations — private hospitals by number of beds in Sydney



Map 5.3 Hospital locations — private hospitals by number of beds in Brisbane



Map 5.4 Hospital locations, private hospitals by number of beds in Melbourne



5.2.7 Location of hospitals by profit status[19]

Victoria

The majority of private hospitals outside the metropolitan region are non-profit hospitals. The majority of hospitals within the Melbourne metropolitan region are for profit hospitals with private hospitals in Melbourne mainly clustered around the city centre.

NSW

There are significantly more for-profit hospitals than non-profit hospitals in Sydney than in Victoria. However, unlike Victoria, for-profit hospitals are more numerous in regional NSW as well as in the metropolitan region.

Queensland

The number of non-profit and for-profit hospitals is about equal in the Brisbane metropolitan region, but there are virtually no for-profit hospitals in regional areas. Private hospitals are also reasonably scarce in rural Queensland.

[19] Information provided by the Department of Health and Aged Care (unpublished)

5.3 Medical services sector

Table 5.7 Numbers of doctors by specialty and State

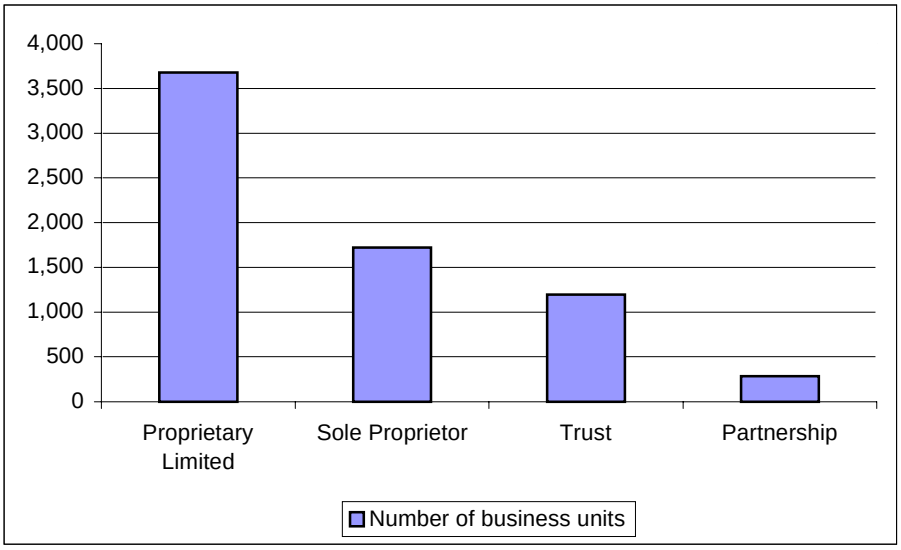
Specialists: main specialty of practice and States and Territories, 1997

	NSW	Vic	Qld	SA	WA	Tas	NT	ACT	Aust
Internal medicine	*1 544*	*1 104*	*624*	*415*	*361*	*81*	*29*	*81*	*4 238*
Cardiology	244	137	74	44	30	14	0	6	548
Clinical genetics	0	0	1	4	4	0	0	0	9
Clinical haematology	58	23	26	15	13	4	0	4	144
Clinical immunology	39	24	8	13	9	0	0	4	97
Clinical pharmacology	9	8	6	4	3	0	0	1	31
Endocrinology	86	68	26	18	13	4	0	3	219
Gastroenterology	139	95	57	46	37	7	1	9	391
General medicine	133	137	118	66	56	13	8	9	540
Geriatrics	70	63	19	13	13	4	0	6	187
Infectious diseases	27	44	18	11	4	1	4	3	112
Medical oncology	59	53	13	15	16	6	0	3	165
Neurology	121	79	27	17	20	6	0	4	274
Nuclear medicine	64	20	13	9	12	1	0	4	124
Paediatric medicine	256	188	138	65	68	10	12	13	750
Renal medicine	59	56	16	13	13	3	3	3	165
Rheumatology	78	58	23	26	23	4	0	3	216
Thoracic medicine	103	50	42	34	27	3	1	4	264
Pathology	*274*	*144*	*123*	*70*	*84*	*18*	*5*	*13*	*730*
General pathology	54	22	21	2	7	1	0	2	109
Anatomical pathology	121	63	68	44	46	8	1	9	361
Clinical chemistry	16	12	13	4	7	1	0	1	55
Cytopathology	13	3	0	0	3	0	0	2	20
Forensic pathology	11	3	1	2	0	1	1	0	20
Haematology	20	20	11	6	7	3	0	0	66
Immunology	9	3	0	0	3	0	0	0	15
Microbiology	29	19	8	13	10	3	2	0	84
Surgery	*950*	*760*	*509*	*278*	*251*	*56*	*17*	*47*	*2 868*
General surgery	351	280	183	86	85	20	12	10	1,026
Cardiothoracic surgery	30	34	17	6	7	0	0	1	95
Neurosurgery	32	30	20	15	10	3	0	4	114
Orthopaedic surgery	238	149	126	85	58	14	2	14	687
Otolaryngology (ENT)	103	87	53	31	34	7	1	6	321
Paediatric surgery	20	17	9	7	7	3	1	1	66
Plastic surgery	66	80	36	17	23	3	0	3	226
Urology	70	50	35	18	19	4	0	3	199
Vascular surgery	41	34	30	15	9	3	0	3	134
Other specialties	*2 767*	*2 289*	*1 318*	*724*	*690*	*174*	*55*	*139*	*8 156*
Anaesthesia	587	507	348	170	158	49	10	32	1 862
Dermatology	118	70	48	19	26	1	0	7	289
Diagnostic radiology	364	245	184	90	122	25	9	22	1 061
Emergency medicine	101	93	42	12	20	11	0	6	285
Intensive care	90	45	33	28	17	3	3	2	220
Medical administration	17	15	5	2	6	0	0	1	46
Obstetric & gynaecology	318	290	183	103	92	25	5	16	1,032
Occupational medicine	50	41	3	8	4	1	0	4	110
Ophthalmology	225	181	110	78	62	8	4	7	675
Psychiatry	609	621	303	180	130	43	12	23	1,921
Public health medicine	21	11	4	0	6	1	8	1	53
Radiation oncology	46	46	26	6	10	4	1	4	144
Rehabilitation medicine	85	43	8	15	7	0	1	6	166
Other	137	81	21	13	30	1	1	7	292
Total	**5 534**	**4 296**	**2 573**	**1 487**	**1 386**	**328**	**106**	**280**	**15 992**

Source: Medical Labour Force, 1997 Australian Institute of Health and Welfare

Figure 5.11 indicates that the most common business structure of medical specialists is the limited liability company. Sole proprietors represent 25 per cent of all medical specialist business units, while trust represents 17 per cent and partnership 4 per cent.

Figure 5.11 Management units of specialist medical practitioners



Source: ABS business register (unpublished)

The most recent published information on the medical services sector comes from a 1994–95 ABS survey of private medical practice businesses (general practice and specialist medical businesses).[20] This survey revealed:

- specialists accounted for 39 per cent of all medical practitioners;
- specialists contributed 61 per cent ($4 404.6 million) of the sector's total income;
- the average fee for medical service income was $300 900 per specialist medical practitioner (does not include income from work as a salaried employee);
- the specialist medical services sector recorded an operating profit margin of 24.6 per cent with medium sized and large practices having the highest rate of return 27.8 per cent and 27.2 per cent respectively.[21] Small practices had a rate of return of 24.4 per cent;
- the specialist medical services sector was dominated by specialist medical practices with one to two medical practitioners (78 per cent of all specialists);

[20] Private Medical Practice Industry Australia 1994–95, ABS.

[21] Operating margin is the percentage of sales of goods and services available as operating profit before tax times 100 divided by sales of goods and services. Operating profit is a measure of profits before extraordinary items are brought to account and prior to the deduction of income tax and appropriations by owners (e.g. dividends paid).

- specialist medical practices with total income for 1994–95 of $1 million or greater accounted for 17 per cent of all specialists, but contributed 43 per cent of total specialist medical services income and 39 per cent of total employment.

- average fee income of specialists was $300 900 in 1994–95. However, for the same period, average fee income of specialists working in practices with $1million or more annual income was $822 000.

5.4 Allied health industry

Table 5.8 provides data on the number of practitioners in various allied health professions. The table also indicates that there was a significant increase in the number of practitioners in all of these professions between 1986 and 1996.

Table 5.8 Personnel by occupation in the ancillary health sector, 1986 and 1996

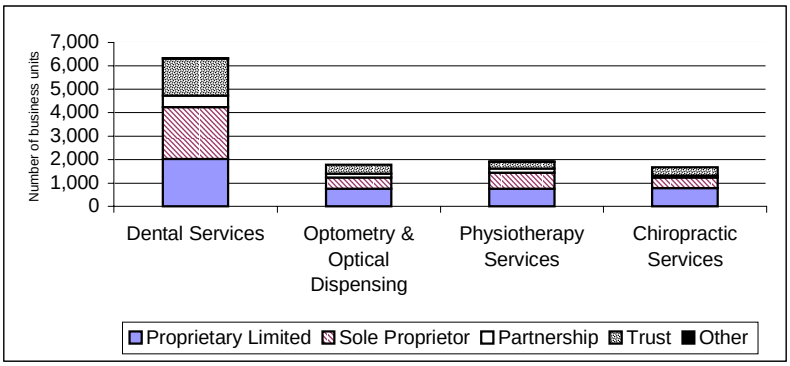
Occupation	1986	1996	Increase
Dental practitioners	6310	7601	20%
Physiotherapists	5930	8896	50%
Occupational therapists	2770	4363	58%
Speech pathologists	1320	2337	77%
Optometrists	1470	2255	53%
Chiropractors and osteopaths	1370	1988	45%
Podiatrists	980	1462	49%

Source: censuses - ABS data as reported in *Australia's Health 1998*, AIHW

The ABS business register also provides information on business structure in some allied health professions.

Figure 5.12 shows that the most common business structure for dental services is sole proprietor closely followed by limited liability company. With the other professions the most common business structure is limited liability company followed by sole proprietor. There are few partnerships among allied health practitioners compared to other business structures.

Figure 5.12 Business structure of allied health professions



Source: ABS business register (unpublished)

6 Regulation of private health insurance

6.1 Overview

The principal health insurance legislation is the *National Health Act 1953*. Only organisations registered under the National Health Act are able to provide health insurance. Registered health benefits organisations are required to adhere to the conditions of registration which covers such matters as waiting periods, portability of entitlements between funds, categories of membership and the types and levels of benefits. The conditions of registration provide a great deal of detail to the Government's regulation of private health insurance.[22]

Under the National Health Act funds are not allowed to discriminate between health fund members on the basis of their health or use of health services, age, race, sex, sexuality or claiming history. This requirement is known as community rating and is supported by the reinsurance arrangements, which share the hospital and related medical costs of the chronically ill and the aged between funds.

Other key legislation affecting the private health insurance industry includes the *Health Insurance Act 1974* (which regulates Medicare) and the *Trade Practices Act 1974* (see chapter 3).

6.2 Product regulation

The regulation of private health insurance underwent major changes with reforms introduced in 1995 and 1998. These reforms fundamentally changed the role of the health funds from price takers to active purchasers of services.

Until October 1995 all funds were required to pay benefits under the basic table for all admissions to all hospitals for all episodes of care. The Minister prescribed the level and scope of benefits payable under the basic table, and public hospitals set charges for private patients at a level that would be fully reimbursed by the basic table benefits.

However, private hospitals charged theatre fees and other facilities fees that were not reimbursed by the basic table, and their bed day charges were often more than twice the level of the basic table benefits. Funds also offered supplementary tables, which covered a proportion of these private hospital charges (see below). The Government only supervised the content and structure of these tables in a very general way.

Funds also offered ancillary tables, offering reimbursement for some or all of a wide range of other health related costs. These were registered but not regulated by the Government.

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[22] Schedule 1 of the *National Health Act 1953*

The *Health Legislation (Private Health Insurance Reform) Amendment Act 1995* removed the requirement to pay benefits for all hospitals for all episodes. Since 1 July 1996 funds have been required to pay benefits at a level corresponding to the basic table under all products for all episodes of psychiatric, rehabilitation or palliative care. Beyond that, they are only required to pay:

- benefits at a level specified in a formal contract between the hospital and the health fund (known as hospital purchaser provider agreement or HPPA) for episodes of kinds specified in the particular product;
- benefits at the average contract level for episodes of those kinds provided in an emergency in hospitals with which they do not have a contract; and
- 'default' benefits equal to or exceeding the level of benefits determined by the Minister for non-emergency admissions to non-contracted hospitals for episodes of those kinds.

As from 1 July 1997 all reference to the basic and supplementary tables was repealed from the legislation and replaced with the notion of 'applicable benefits arrangement'. Broadly speaking, these refer to any product which offers benefits for the cost of hospital treatment.

6.2.1 Default benefit

The default benefit has been set to mirror the basic table. Benefits payable under this table include:

Hospital

- benefits towards the cost of shared accommodation in a public hospital when treated by the doctor of choice;
- benefits are also payable towards accommodation charges in approved private hospitals;
- patients are charged according to the nature of illness and type of treatment they receive. These charges are based on 5 main treatment classifications (advanced surgical, surgical/obstetrics, general medical/other, psychiatric and rehabilitation) and the daily benefits are payable up to 365 days per year. Entitlement to psychiatric and rehabilitation benefits are subject to approval by the particular health fund.

Other benefits

- the difference between the MBS fee and the 75 per cent Medicare benefit for services rendered whilst an in-patient in a hospital or a day hospital facility;
- prescribed same day accommodation benefits in public, private hospital and registered day hospital facilities;

- benefits for defined surgically implanted prosthesis.

- Some funds also offer free ambulance services throughout Australia for NSW and ACT resident members and dependents.

6.2.2 Second tier default benefit

The second tier default, as it is commonly known, covers private hospitals and day hospital facilities in all States/Territories where a health fund does not have a hospital purchaser provider agreement (or similar arrangement) with these facilities.

The second tier benefits for an episode of care are 85 per cent of the average benefits for the previous six months, for the same performed episode of care in comparable private hospitals or day hospital facilities with which the fund has a HPPA in that State/Territory.

Second tier benefits are only payable where a hospital or day hospital facility can reasonably demonstrate to the fund that the hospital or day hospital facility satisfies the following conditions:

- has a simplified billing system in place that significantly reduces the number of accounts sent to the patient and results in patients receiving most accounts within a month after treatment (this would include an approved aggregated billing arrangement allowing assignment of Medicare benefits schedule benefits to a billing agency);

- has a mechanism in place to allow patients to be informed of what expenses are likely to be incurred including any known out-of-pocket costs (including medical costs), where possible, at least one week in advance of receiving treatment;

- is accredited by the Australian Council on Health Care Standards, the International Standards Organisation or by other such bodies as may be agreed between the fund and the hospital from time to time; and

- meets quality criteria relating to the episode of care which the health fund has specified within all current hospital purchaser provider agreements existing between the health fund and comparable private hospitals and day hospital facilities where the health fund has taken reasonable steps to advise private hospitals and day hospital facilities of the relevant criteria.

6.2.3 Products that provide benefits in excess of the default benefit

Supplementary tables ceased on 1 July 1997. However there continues to be Applicable Benefits Arrangements that pay in excess of default benefits which may or may not be part of a formal hospital purchaser provider agreement.

Benefits on these tables vary according to the health fund however in the majority of cases (if not all) this table covers single room accommodation in a public hospital. Additional accommodation benefits in a private hospital are also payable according to the main treatment classifications. All funds apply a limit to the number of days for

which these higher benefits apply. After this limit, members drop back to a level of benefits determined by the fund (with the default benefit the regulated minimum). Usually the limit depends on how long the contributor has been a continuous member of a particular fund.

Most funds will also pay additional benefits for:

- operating theatre fees;
- labour ward fees;
- other hospital related items (e.g. physiotherapy, day surgery surgical procedures).

6.2.4 Waiting periods

The National Health Act sets out the maximum waiting periods that health funds can apply to applicable benefit arrangements (policies providing benefits for hospital treatment). These maximum waiting periods are:

- in relation to benefits in respect of a matter related to an ailment or illness the signs or symptoms of which, in the opinion of a medical practitioner appointed by the health fund, existed at any time during the 6 months preceding the day on which the contributor made the election — 12 months; or
- in relation to benefits in respect of a matter related to an obstetric condition — 12 months; or
- in relation to benefits in respect of any other matter — 2 months.

Health funds are not restricted in the levels of waiting periods that they may apply to ancillary benefits.

All waiting periods may be waived at the discretion of the health funds.

Financial members transferring from one registered health fund to another are eligible for continuity of membership for services that were covered by the previous fund.

6.3 Contracting arrangements between doctors, hospitals and funds

Health Legislation (Private Health Insurance Reform) Amendment Act 1995

The Health Legislation (Private Health Insurance Reform) Amendment Act encouraged the development of agreements between funds, hospitals and doctors. It fundamentally changed the role of the health funds from price takers to active purchasers of services.

Under the previous legislation, arrangements had developed (particularly in Victoria and South Australia) under which funds and hospitals agreed on the price the hospital would charge a fund's members, and the fund agreed to pay benefits at that level. Fund members attending those hospitals would be guaranteed no hospital out-of-pocket expenses.

A formal structure for these arrangements (hospital purchaser provider agreements or HPPAs) was included in the 1995 legislation, which also created incentives for entering into contracts by limiting funds liability to pay benefits in non-contracted hospitals to the level of the default benefit for non emergency admissions.

The 1995 legislation also required any patient co-payment to be specified in the HPPA and the hospital to inform the health fund member prior to admission (where practicable) of any amounts they may be liable to pay in relation to the hospital component of their treatment.

The 1995 legislation also established a contracting framework between funds and doctors known as medical purchaser provider agreements (MPPAs). Significantly, an MPPA allows a health fund to pay benefits above the Medicare benefits schedule (MBS) fee, thus allowing for the elimination of medical gap payments.

This legislation also provided that where there was a HPPA between a hospital and a health fund there could also be a practitioner agreement (PA) between the hospital and a doctor. These agreements allowed hospitals to receive payment under their HPPA for medical services provided by doctors with whom they have a PA. However, the legislation did not allow payment above the MBS under these arrangements.

With both MPPAs and PAs any patient co-payment has to be specified in the agreement and the doctor is required to inform the health fund member of any amounts they may be liable to pay in relation to the professional medical service component of their in-hospital treatment.

Where medical services are provided as part of an agreement, the billing and payment arrangements are greatly simplified for the patient/fund member. The medical account goes directly to the health fund (via the hospital where there is a PA) and the Medicare benefit is assigned to the health fund. The doctor is paid the health fund and Medicare benefit by the fund (via the hospital where there is a PA) with the patient/member only involved where there is an agreed co-payment.

Health Legislation Amendment Act (No. 2) 1998

Further reforms to the contracting arrangements were introduced with the Health Legislation Amendment Act (No. 2) including:

- the provision for above MBS payments by the health fund where medical services were covered by a PA (bringing these arrangements into line with MPPAs);

- a requirement that health funds and hospitals in their agreements with doctors undertake to maintain the professional freedom of doctors to identify appropriate treatment for their patients;

- a requirement that health funds make available copies of HPPAs, MPPAs and PAs to any person requesting it. Copies must have deleted any information relating to amounts paid or that could identify an individual or medical practice; and

- provision for simplified billing agents with patients now able to assign their Medicare benefits to approved billing agents. This reform provided a mechanism

for simplifying the billing and payment arrangements for patients (including the uninsured private patient) where the medical service is not covered by an agreement.

6.4 Other key government reforms to private health

Private Health Insurance Incentives Act 1997

This Act introduced the Private Health Insurance Incentives Scheme on 1 July 1997. Under this scheme payments were provided of up to $450 per year for families with one child earning less than $70 000, up to $250 for couples earning less than $70 000 and up to $125 per year for single persons earning less than $35 000. The income threshold for families increased by $3 000 for each additional child.

The incentive payments could either be received as a reduced premium through a fund or as a rebate through the tax system

The objective of this scheme was:

- to make private health insurance more affordable and thereby assist people to keep their private health insurance;
- provide people with a greater choice between the public or private hospital system; and
- take some of the pressure off the public hospital system.

Medicare Levy Amendment Act (No. 1) 1997

On 1 July 1997 the Government introduced the Medicare levy surcharge to encourage high income earners to purchase private health insurance and to remove some of the burden from the public hospital system.

The 1 per cent surcharge is additional to the compulsory Medicare levy and affects:

- single people with a taxable income of $50 000 or more who do not have hospital insurance; and
- couples and families with a taxable income of $100 000 or more with no hospital insurance.

The threshold increases by $1 500 for each child after the first.

Private Health Insurance Incentives Act 1998

The Private Health Insurance Incentives Act provided for the introduction of the Government's 30 per cent rebate on private health insurance on 1 January 1999. The Rebate replaced the means tested Private Health Insurance Incentives Scheme that ended on 31 December 1998. The rebate:

- is equal to 30 per cent of the cost of private health insurance premiums regardless of the type of cover held by contributors (ancillary, hospital or combined cover);

- is not means tested and is available to all private health fund members regardless of whether they pay tax or not;

- is protected against inflation and future premium adjustments because it is linked to the actual cost of premiums; and

- is available as a premium reduction, or as a direct payment from Medicare, or as a tax offset.

The purpose of the rebate was similar to the former incentives scheme in that it was designed to cut the cost of private health insurance, restore the balance between the public and the private system and take some pressure off the public hospital system. It was also seen as increasing choice for people between the public and private hospital systems.

The Government accepted a Senate amendment to the Private Health Insurance Incentives Act, which introduced the 30 per cent government rebate for private health insurance premiums.

The amendment provided that if a health fund on or after 1 July 2000 does not offer its members a no or known gap policy, then the Minister must revoke its status as a participating fund in the premium reduction scheme. This would mean that members would only be able to access the rebate through their annual tax return or as a direct cash rebate from Medicare offices.

National Health Amendment (Lifetime Health Cover) Act 1999

The National Health Amendment (Lifetime Health Cover) Act provided for the establishment of Lifetime Health Cover from 1 July 2000.

According to the Department of Health and Aged Care, Lifetime Health Cover is:

> A new system of private health insurance designed to slow down the rate of premium increases and make private health insurance more affordable.

Lifetime Health Cover recognises the length of time that a person has had private health insurance and rewards that loyalty by offering lower premiums. People who join early in life will be charged lower premiums throughout their life compared to people who join later. For example, after 1 July 2000, someone joining at 30 years of age will pay lower premiums throughout their years of membership than someone who first joins at 50 years of age.

The Department of Health and Aged Care indicated that:

> Introducing Lifetime Health Cover will therefore encourage more people to join at a younger age and maintain their membership over their lifetime.
>
> Our expectation is that Lifetime Health Cover will promote a positive change in the membership profile of health funds. This will reduce the pressure on premiums, and may make it easier for health funds to finance gap elimination/reduction schemes.

This reform was recommended by the Industry Commission in 1997 as part of a strategy to ensure the long-term stability of the private health industry.

Health Legislation Amendment Act (No. 2) 1999

The Health Legislation Amendment Act (No.2) contains amendments to the National Health Act which relate to:

- discounted contribution rates;
- loyalty bonuses; and
- coverage of costs for pharmaceutical benefits.

All amendments relating to these areas took effect from 20 October 1999.

Discounted contribution rates

From 20 October 1999 health funds are able to provide discounts on premiums when the discount reflects administrative savings derived from payments made at least 6 months in advance; as a direct debit from a bank account; by payroll deduction; or for a group of contributors. This reform recognises that the savings from advances in electronic commerce should be able to be passed on to members.

Discounts are limited to a maximum of 12 per cent (the average of all funds' management expenses) to foster stability of premiums. The level of discount must not exceed the management savings resulting from the payment method. The payment of Commissions, brokerage fees, inducements and other sums paid as an incentive for groups to take out a product is to be taken into account in calculating the size of a discount. This includes waived excesses or daily co-payments for hospital treatment.

Some health funds offer products to corporate groups at very low premiums compared to very similar products that are offered to the public. These products are to be treated as 'substantially the same' product and the one with the lower premium will be taken as being discounted. By March 2001 these corporate tables will be regulated to ensure that all tables are available to all eligible members.

Loyalty bonuses

Health funds can now develop loyalty rewards for members based on length of membership. This initiative gives health funds greater flexibility to offer innovative reward schemes without contravening the principles of community rating. Health funds may offer rewards in the form of reduced premiums, access to more services or some other benefit.

Pharmaceutical cover for in-hospital treatment

The legislation provides for an expansion in the role of private health insurance by allowing health funds to cover the patient co-payment for pharmaceutical benefits dispensed in hospital.

However, funds are only able to meet the costs of the PBS co-payment where the fund member subscribes to a hospital or combined hospital/ancillary table that claims to cover 100 per cent of the cost of hospital treatment.

Health Legislation Amendment Act (No. 3) 1999

The Health Legislation Amendment Act (No.3) was given Royal Assent on 7 December 1999 and contains provisions which:

- enable the Private Health Insurance Administration Council (PHIAC) to set new, flexible solvency and capital adequacy standards that put health funds on a more commercial footing;

- streamline processes so that when a health fund is close to insolvency PHIAC can expeditiously appoint an administrator who will work in the interest of contributors;

- introduce new winding up provisions that give greater protection for contributors in the distribution of assets;

- strengthen the accountability of health fund managers by making them liable to pay a civil penalty where the organisation has breached the National Health Act and the managers have failed to take reasonable steps to ensure such contravention do not occur; and

- transfer the approval of registration, deregistration and merger functions from the Department of Health and Aged Care to PHIAC.

The Department of Health and Aged Care indicated that it is moving to transfer the registration and merger functions to PHIAC by 1 January 2000, in accordance with this new legislation. It further indicated that a Standards Consultancy Group has been established to oversee the development of appropriate solvency and capital adequacy standards for health funds, which are to be introduced by January 2001.

6.5 Ancillary health insurance

Funds have been providing cover for ancillary products since the early 1970s. In 1975 ancillary policies were extended to include natural therapies such as chiropractic, naturopathic and related products. Ancillary policies were further extended in 1984 to include fitness items such as health club membership and related products.

Ancillary health benefits are currently **very broadly** defined in s. 67 of the National Health Act as including:

- relevant health services such as medical, surgical, diagnostic, nursing, dental, chiropody, chiropractic, eye therapy, occupational therapy, physiotherapy, speech therapy or similar services or treatment;

- medical aids such as hearing aids, spectacles, contact lenses, artificial teeth, eyes or limbs;

- pharmaceuticals;

- ambulance services;

- services by an attendant of a person who is sick or disabled or any other benefit.

However, ancillary health benefits cannot include hospital services or services for which a Medicare benefit is payable.

Community rating applies to both hospital and ancillary tables.

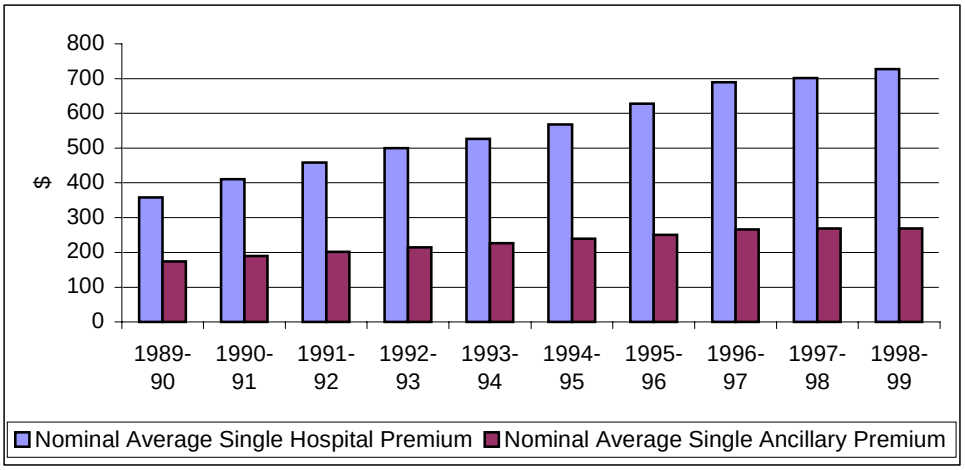
Individual health funds are free to determine the nature of services that attract ancillary benefits and any limitations on such benefits. There is no specific provision contained in the health insurance legislation relating to ancillary tables.

In general, health funds provide ancillary benefits for as wide a range of services and items as possible in an attempt to assist as many of their contributors as possible. However, at the same time, health funds generally find it necessary to impose limitations on such benefits in order to keep contribution rates within reach of contributors.

7 Premiums

Figure 7.1 shows that average hospital insurance premiums increased by around 103 per cent between 1989–90 and 1998–99. Average ancillary insurance premiums increased by around 70 per cent during the same period.[23]

Figure 7.1 Average nominal hospital and ancillary premiums, 1989–90 to 1998–99



The Industry Commission (now the Productivity Commission) in its 1997 report, 'Private Health Insurance', extensively investigated the causes for premium increases.[24] The report refers to a vicious cycle that occurs as premiums rise. Confronted with higher premiums many contributors drop their cover, preferring to rely entirely on the public system. Since it is the young and the healthy that are more likely to drop their cover this leaves health funds with a worsening risk profile (adverse selection) which in turn puts pressure on premiums and so on.

Figure 7.2 provides evidence of the strong inverse relationship between rising hospital premiums and declining private health insurance participation.

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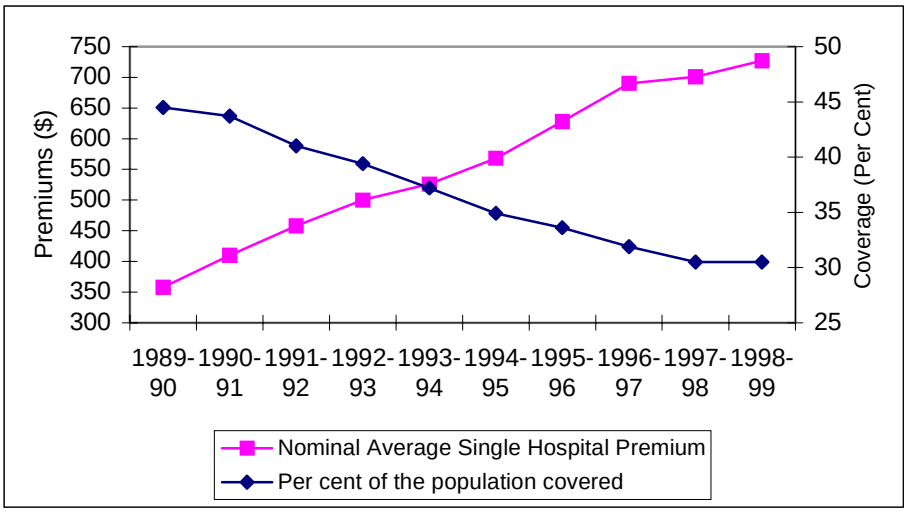
[23] This is based on nominal rather than real premiums. Nominal premiums are based on hospital benefits paid per average 'single equivalent unit'. This information is provided by the Private Health Insurance Administration Council.

[24] Industry Commission, 'Private Health Insurance', report no. 57, 1997.

Figure 7.2 Rising premiums and declining participation, 1989–90 to 1998–90



However, as noted in chapter 5, since the introduction of the Government's 30 per cent rebate on private health insurance this decline in participation has been reversed**.** The participation rate has increased in each of the last four quarters, bringing participation in private health insurance to 31.2 per cent of the Australian population.

Cost drivers for premium increases

Health fund premiums are based on the amount of claims that health funds expect to pay out to members for health treatment. Health fund benefits were equal to 85 per cent of contribution income in 1998–99. While changes in reserve levels and investment income may have an impact on premium levels on a year to year basis, over longer periods the Productivity Commission found that these factors have no impact on premium changes.

In examining the relative contributions of various cost drivers to premium increases in the 1990s, the Productivity Commission found that benefits paid per bed day was the major driver of premium increases. The main factors behind these increased benefits were:

- the shift from public to private treatment by the insured;
- increases in private hospital charges;
- changes in health insurance cover (especially moves to cover the full cost of hospital accommodation after the 1995 reforms); and
- declining length of stays.

The Productivity Commission also identified adverse selection as underlying a significant proportion of premium increases and likely to become even more significant in relative terms as other leading cost drivers (such as the shift from public to private) stabilise or decline in importance.

Importantly the Productivity Commission found:

> There is no direct evidence of excess profits on the part of two of the major industry players - the health funds and private hospitals. A mix of factors, subject to numerous influences and individual actions have worked together to raise industry costs and premiums well in excess of general inflation.[25]

[25] ibid, p. 255.

8 The gap

8.1 Definition

The gap can be defined as an out-of-pocket expense incurred by a fund member, which cannot be covered by private health insurance and/or is not due to the member's choice of cover, and is often unknown or unexpected. That is, the member will incur these out-of-pocket expenses, no matter how comprehensive his/her insurance policy is.

The medical gap is the difference between fees charged by doctors for in-hospital medical services and the combined health insurance benefit and Medicare benefit received by the patient.

The ancillary gap is the difference between the price of a particular allied health service or product and the health fund benefit for that product or service.

The hospital gap is the difference between the fee charged by a hospital and the health fund benefit. However, some out-of-pocket expenses incurred by fund members for hospital accommodation would not generally be considered as a gap, as these are due to the member's choice of a particular cover.

APHA noted in its submission that:

> Many patients are confused about their insurance and label all out-of-pocket expenses as gaps. This confusion […] creates considerable anger and anxiety for prospective patients when they are advised that their insurance will not cover the full cost of hospital care.

A product with a front-end deductible (FED) is one where the member assumes some initial risk in return for lower premiums (see chapter 5). An amount paid by the member under these arrangements does not constitute a gap as the contributor has made a decision to incur that cost in return for a lower premium. The majority of such payments have not been included in the hospital casemix protocol (HCP) data on hospital gap payments provided in this chapter.[26]

In addition to fixed co-payments provided by FED products contributors can also choose products that do not cover the full hospital charge. For example a product may require a per diem co-payment (sometimes conditional on the type of accommodation ward) or they may be basic cover products which were designed to provide cover for private patients in public hospitals i.e. benefits are less than half the average private hospital charges. If a member with a basic cover seeks treatment in a private hospital they will be faced with significant hospital payments. Such payments would generally not be viewed as gap payments because they could be covered by health insurance if

[26] The HCP data collection began in 1995–96.

the member had chosen a higher level of cover. However, these payments are included in the HCP data on hospital gap payments provided in this chapter.

Exclusionary products can exclude episodes of any kind from any level of benefit (with the exception of rehabilitation, psychiatric and palliative care). There are products which cover only sports injuries, products that offer extended cover to dependent children, products excluding cover that younger people do not feel they require and products that exclude cover for any treatment related to pregnancy. Where a member finds it necessary to receive private treatment that is excluded from cover by their particular product the member will need to cover the full cost of the episode (with the exception of the 75 per cent Medicare rebates for in-hospital medical services). Again while such payments would not generally be viewed as gap payment, nevertheless these payments are included in the HCP data on hospital gap payments provided in this chapter.

There are also products that provide full cover but only in certain settings. For example a fund may market a product that does not cover hip replacement in a private hospital, but does provide that cover in a public setting. If a member decides to receive treatment in a private hospital for a hip replacement they would need to cover the difference between charges and benefits. Again, while such payments would not generally be viewed as a gap payment, nevertheless these payments are included in the HCP data on hospital gap payments provided in this chapter.

It should be noted, however, that fund members can still incur a hospital gap payment if they are not aware, or did not understand, that their insurance policy was an FED or exclusionary product for example. This issue is discussed in chapter 9.

8.1.1 Medical gaps

For in-hospital medical services the Medicare rebate is 75 per cent of the Medicare benefit schedule (MBS) fee (or schedule fee). Health funds are required to cover the remaining 25 per cent of the schedule fee.

The health fund member must meet any medical practitioner charges above the schedule fee (unless a MPPA or a PA covers the doctor).

The Government determines the MBS fee. While this fee represents what will be covered by government and private health benefits, it does not cap the fees charged by medical practitioners, who determine their charges on the basis of their own assessment of what their services are worth tempered by reference to what the market will bear.

The medical gap is a major concern to the public in relation to Australia's private health care system. People, having paid insurance premiums, still face out-of-pocket medical expenses they would not have if they went into a public hospital as a public patient.

The Health Rights Commission in its submission noted:

> A search of the Commission's database has revealed that 9 out of 10 calls received by this Commission concerning the cost of treatment are by complainants annoyed at having out of pocket expenses for private treatment. In many cases, the complainant has received a bill that is well

> above the scheduled fee. Even though the complainant may have top level private health insurance, they are still required to pay a large gap between the scheduled and charged fees.

Medibank Private reported in its submission that:

> Given our national focus and extensive experience in providing private health insurance, Medibank Private strongly supports initiatives that address medical gaps. Our market research shows that there is an expectation that 'no or known gap' policies will significantly reduce the current drop out rate among members.

A number of health funds are currently introducing products to remove or reduce medical gaps for medical services provided to their members. These initiatives are discussed at the end of this chapter.

8.1.2 Hospital gaps

Gaps also exist for hospital accommodation services. However, if the patient belongs to a fund that has a HPPA with a particular hospital, many members will face no out-of-pocket expenses for hospital accommodation services. However, as noted above, members will face out-of-pocket expenses in situations where the member has chosen a lower level of cover.

Hospital gap payments remain with non-contracted hospitals and in relation to ancillary services received while in hospital.

Where a hospital is covered by a HPPA the hospital is required by legislation to inform the health fund member of any amounts the member will be liable to pay to the hospital. Most hospital services are covered by these agreements.

APHA notes that although a member is likely to face significantly lower out-of-pocket expenses in a contracted hospital, the decision to have the procedure at a particular hospital is usually predetermined by the admitting medical practitioner.

> Notably, doctors are credentialled to practice at particular private hospitals and normally choose to practice at certain private hospital for a variety of reasons, none of which usually involves the hospital's contracting status with a particular fund.

8.2 The size of hospital and medical gaps

This chapter on gaps uses hospital casemix protocol data, Medicare data and data from the Private Health Insurance Administration Council. This data makes extensive use of average gaps as a way to analyse the gap experienced by consumers. However, although the notion of an average gap is useful for comparative purposes it understates the gap experience of consumers.

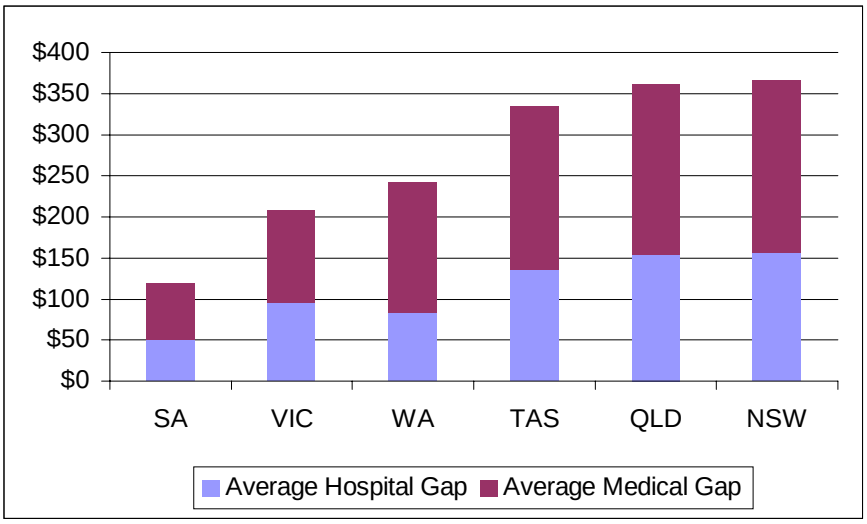
The Hospital Benefit Association of Western Australia in its submission noted that although the average gap for their fund members was $23 per Medicare benefit schedule item, the median gap for those who had to pay a gap was $200 per item. With procedures consisting of multiple items HBA believed that the average gap experienced by most people was in the range of $500 to $700.

8.2.1 Variation in hospital and medical gaps between States[27]

Figure 8.1 indicates that the average medical gap is lowest in South Australia ($69) and Victoria ($112) with NSW having the highest average medical gap of $211. It is in South Australia and Victoria that funds have had the most success in securing no-gap arrangements with doctors.

Figure 8.1 also indicates that the lowest average hospital gap varied between $51 in South Australia and $155 in NSW. This data also suggests that despite recent contracting reforms the hospital gap remains a significant element of the gap experienced by health fund members. However, as indicated earlier, an important element of this is likely to be due to the choice of cover by contributors.

Figure 8.1 Average hospital and medical gaps for all episodes 1997–98

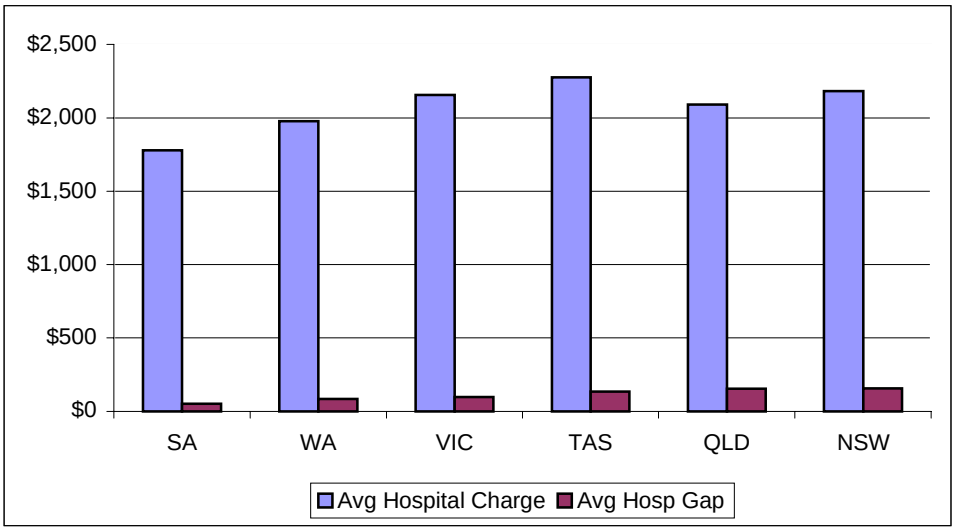


Source: HCP data

Figures 8.2 and 8.3 indicate that the average hospital gap is small compared to the average hospital charge in each State whereas the medical gap represents a more significant portion of the average medical charge in each State. In 1997–98 the average hospital gap represented only 5.4 per cent of average hospital charges whereas the average medical gap represented 16 per cent of medical charges.

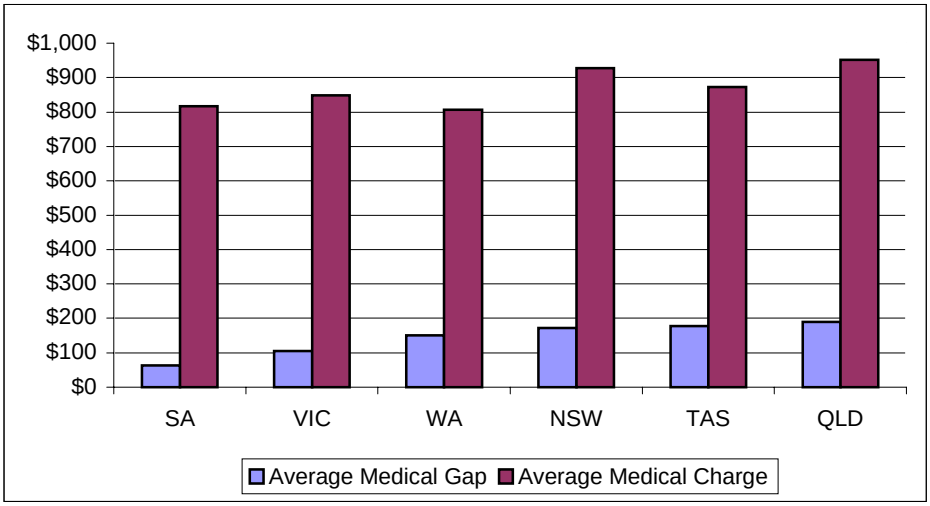
[27] In the hospital casemix protocol (HCP) data collected by the Department of Health and Aged Care the Australian Capital Territory is included with New South Wales and the Northern Territory is included with South Australia

Figure 8.2 Average hospital charge and hospital gap, 1997–98



Source: HCP data

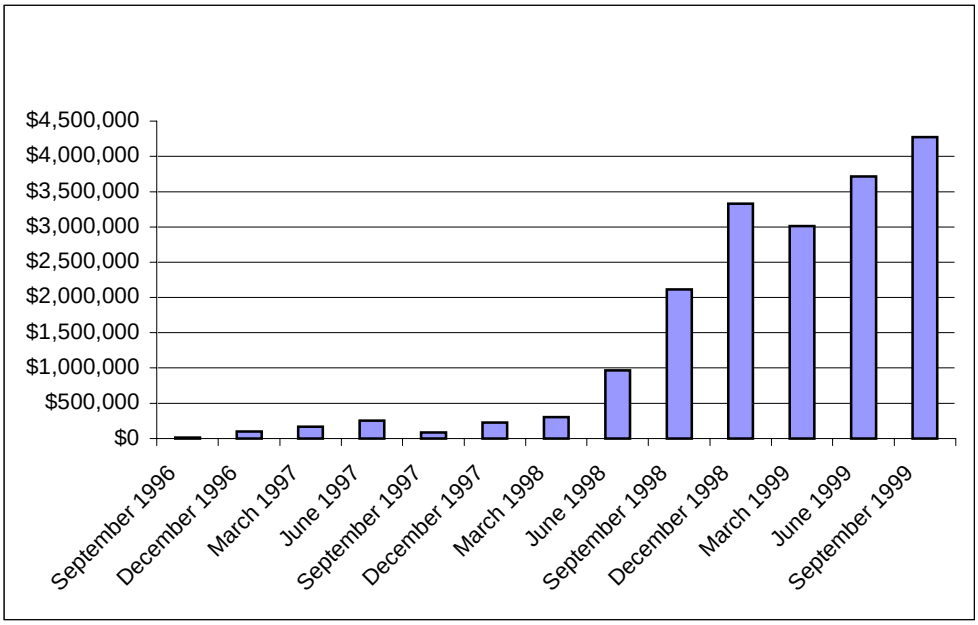
Figure 8.3 Average medical charge and medical gap for all episodes, 97–98



Source: HCP data

PHIAC data as shown in figure 8.4, provide firm evidence that there has been a recent dramatic increase in the amount of benefits paid above the MBS fee (which reduces the medical gap). Again the data points to these increases being predominantly in Victoria and South Australia where AXA Health Insurance has been very successful with its Ezyclaim arrangements which are described later in this chapter.

Figure 8.4 Health fund benefits above the MBS fee, 1996 to 1999



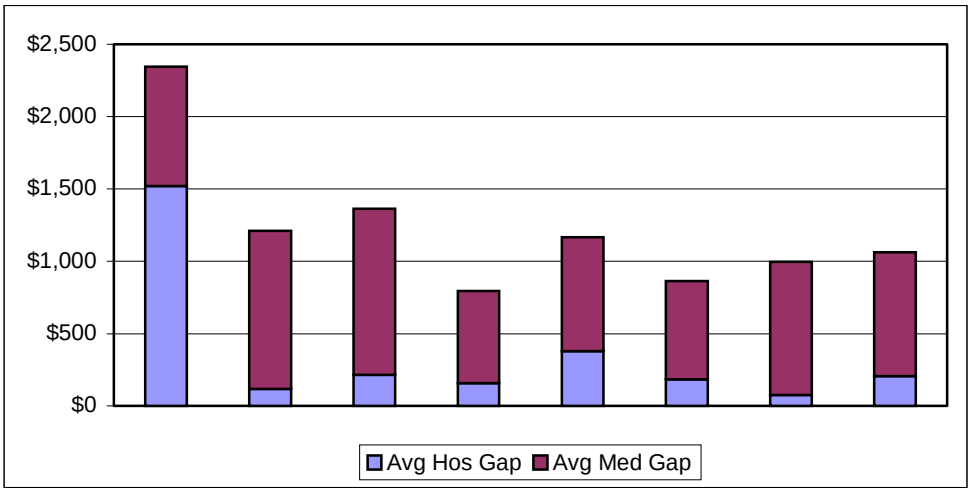
Source: PHIAC *Annual Report 1998–99* and PHIAC *Annual Report* for September 1999 Quarter

8.2.2 Variation in gaps experienced by members of different funds

There is considerable variation between funds in average hospital and medical gaps experienced by health fund members as figures 8.5 to 8.7 demonstrate. Three procedures, hip replacement, lens procedure and vaginal delivery are used to demonstrate differences in gaps experienced by members of different funds because they are representative of different combinations of hospital and medical charges involved in the range of in-hospital medical procedures. Lens procedures are high in medical charges and low in hospital charges, vaginal deliveries are low in medical charges and high in hospital charges and hip replacements are high in both medical and hospital charges.

Figure 8.5 indicates that for NSW funds the average hospital gaps for a hip replacement varied between $74 and $1520 and the average medical gaps for a hip replacement varied between $637 and $1149.

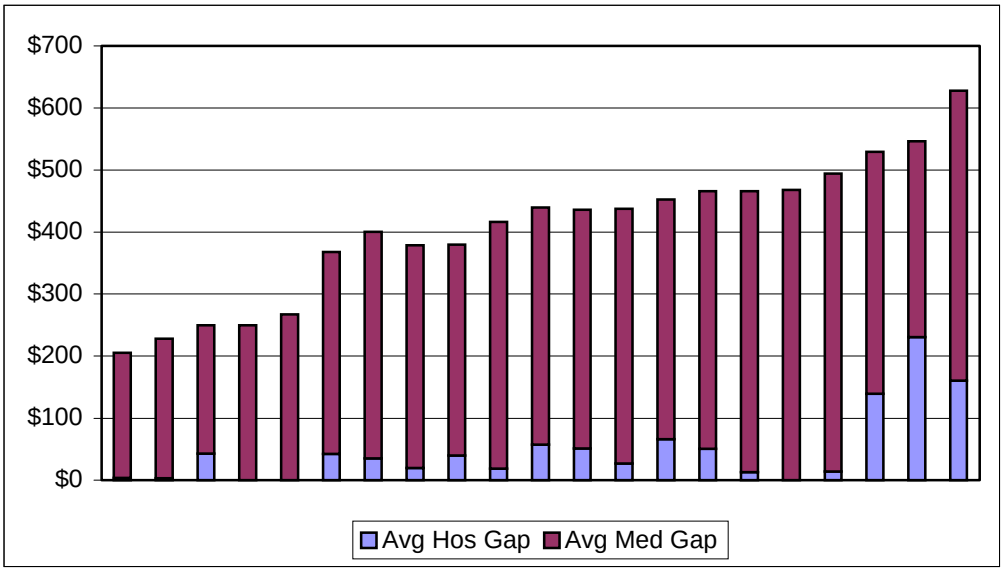
Figure 8.5 NSW funds' average hospital and medical gaps for hip replacement, 1997–98



Source: Hospital casemix protocol data for 1997–98
Note: Each bar in the figure represents one fund.

Figure 8.6 indicates that for NSW funds, the average hospital gaps for a lens procedure varied between no gap and $231, and fund average medical gap for the same procedure varied between $202 and $480.

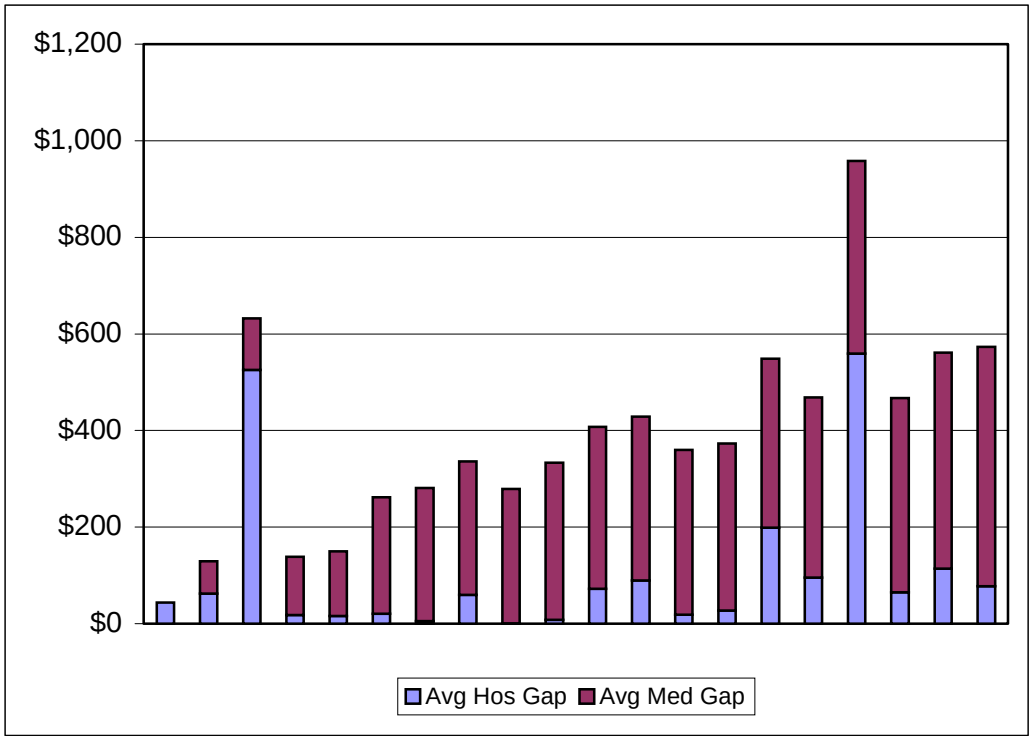
Figure 8.6 NSW funds' average hospital and medical gaps for lens procedure, 97-98



Source: Hospital casemix protocol data for 1997–98
Note: Each bar in the figure represents one fund.

Figure 8.7 below indicates that for NSW funds, the average hospital gaps for a vaginal delivery varied between no gap and $560 and the average medical gaps for the same procedure varied between no gap and $495.

Figure 8.7 NSW funds' average hospital and medical gaps for vaginal delivery, 1997–98



Source: Hospital casemix protocol data for 1997-98
Note: Each bar in the figure represents one fund.

This high level of variation between the average hospital and medical gaps for the same procedure for different funds in NSW is not inconsistent with the experience of fund members in other States.

The reasons for these variations in fund average hospital gaps could include:

- variations between funds in the proportion of their membership deciding to opt for tables that provide less than full cover for hospital accommodation (for example where the product provides a level of benefit which only covers private treatment in a public hospital);
- variations between funds in the proportion of their membership opting for tables that exclude certain types of procedures e.g. hip replacement. These products transfer risk to the member (in exchange for lower premiums);
- differences between funds in the application of rules relating to pre-existing conditions and waiting periods and differences in the quality of information provided to members about these limitations on benefits;
- use of selective tender by funds where not all hospitals are offered a contract;

- variations in the benefits negotiated with hospitals by different health funds (for example where contracts specify that benefits will only be paid for specified hospital services, drugs or products);

The medical gap is driven by doctor charges except in those markets where funds have had some success in securing agreements with doctors.

The HCP data collection does not reveal the name of the health fund yet this information could be of assistance to existing and potential health fund members in understanding the performance of particular funds in addressing the gap. People can compare funds based on premiums but information on gaps is not as accessible.

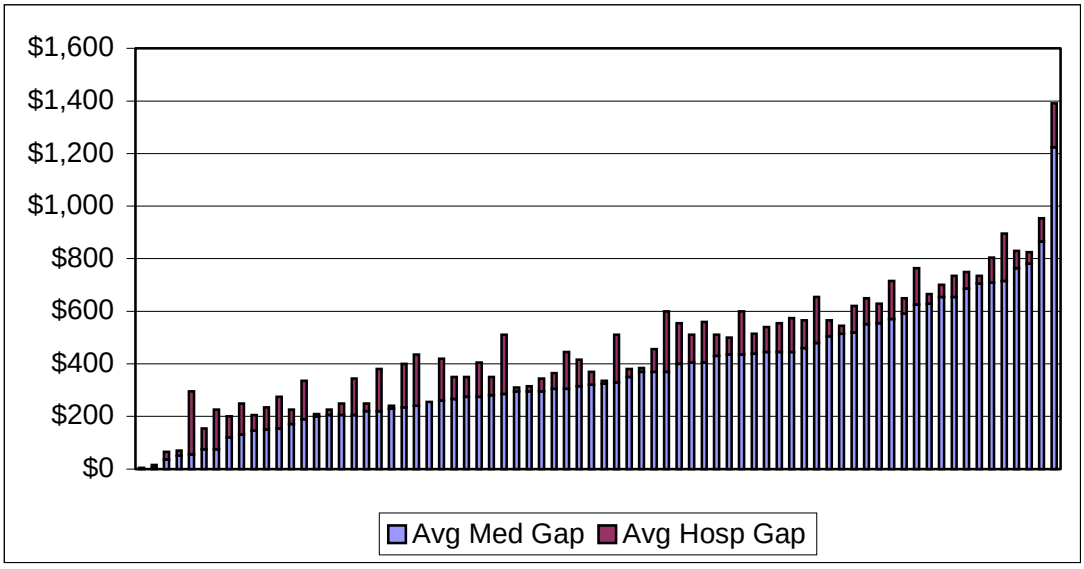
Of course information on fund average gaps is only a guide for consumers as a fund may be more or less successful in addressing gaps in particular areas or with particular hospitals. What a consumer really needs to know is which fund has eliminated gap payments in which hospitals and with which medical practitioners.

8.2.3 Variations in gaps experienced at different hospitals

The HCP data collection also reveals considerable variation in the average hospital and medical gap for the same procedure between hospitals as the following figures demonstrate. Again the data indicates these variations in the hospital and medical gaps for the same episode in different hospitals in NSW are not atypical of the variations found in other procedures and in other States.

Figure 8.8 indicates that average hospital gaps for a lens procedure varied between no gap and $240 in NSW hospitals. Average medical gaps for a lens procedure varied between $5 and $1225 in NSW hospitals.

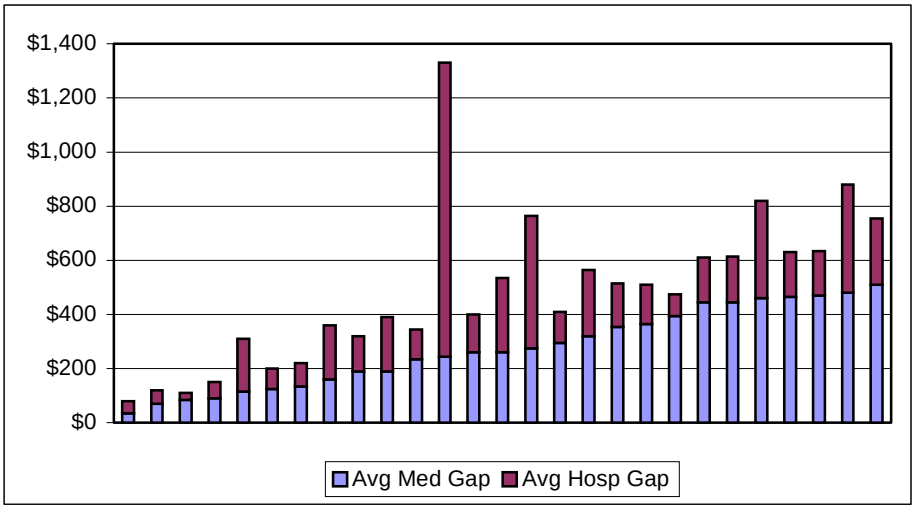
Figure 8.8 Average hospital and medical gaps for lens procedure in NSW hospitals, 1997–98



Source: HCP data
Note: Each bar in this figure represents one hospital.

Figure 8.9 below indicates that average hospital gaps for a vaginal delivery varied between $25 and $1085 in NSW hospitals. Average medical gaps for a vaginal delivery varied between $35 and $510 in NSW hospitals.

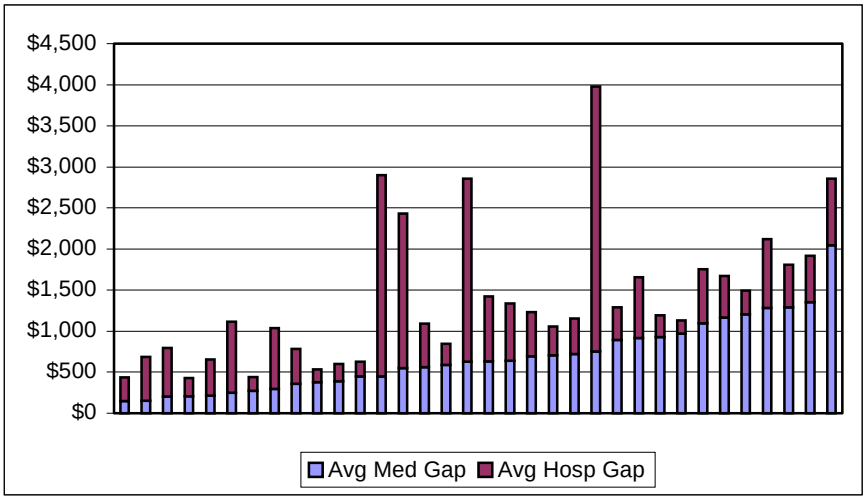
Figure 8.9 Average hospital and medical gaps for vaginal delivery in NSW hospitals, 1997–98



Source: HCP data
Note: Each bar in this figure represents one hospital.

Figure 8.10 below indicates that average hospital gaps for a hip replacement varied between $155 and $3225 in NSW hospitals. Average medical gaps for a hip replacement varied between $150 and $2045 in NSW hospitals.

Figure 8.10 Average hospital and medical gaps for hip replacement in NSW Hospitals 1997-98



Source: HCP data
Note: Each bar in this figure represents one hospital

There could be many reasons for these variations in the average hospital and medical gaps in different hospitals in NSW such as:

- failure of the hospital to secure contracts with key health funds which reduce or eliminate the hospital gap;
- variations between hospitals in the benefits negotiated with health funds (for example where contracts specify that benefits will only be paid for specified hospital services, drugs or products);
- variations between hospitals in the proportion of patients covered by tables that provide less than full cover.

As noted previously, the medical gap has been driven by doctor charges except in those markets where funds have had some success in negotiating agreements for payment of benefits above the MBS fee with doctors.

The HCP data collection does not reveal the name of the hospital yet this information could be of assistance to existing and potential health fund members in comparing the average gap experienced at different hospitals.

Of course information on average gaps at particular hospitals is only a guide for consumers as different funds may be more or less successful in addressing gaps in particular areas or with particular hospitals. What a consumer really needs to know is

which fund has eliminated gap payments in which hospitals and with which medical practitioners.

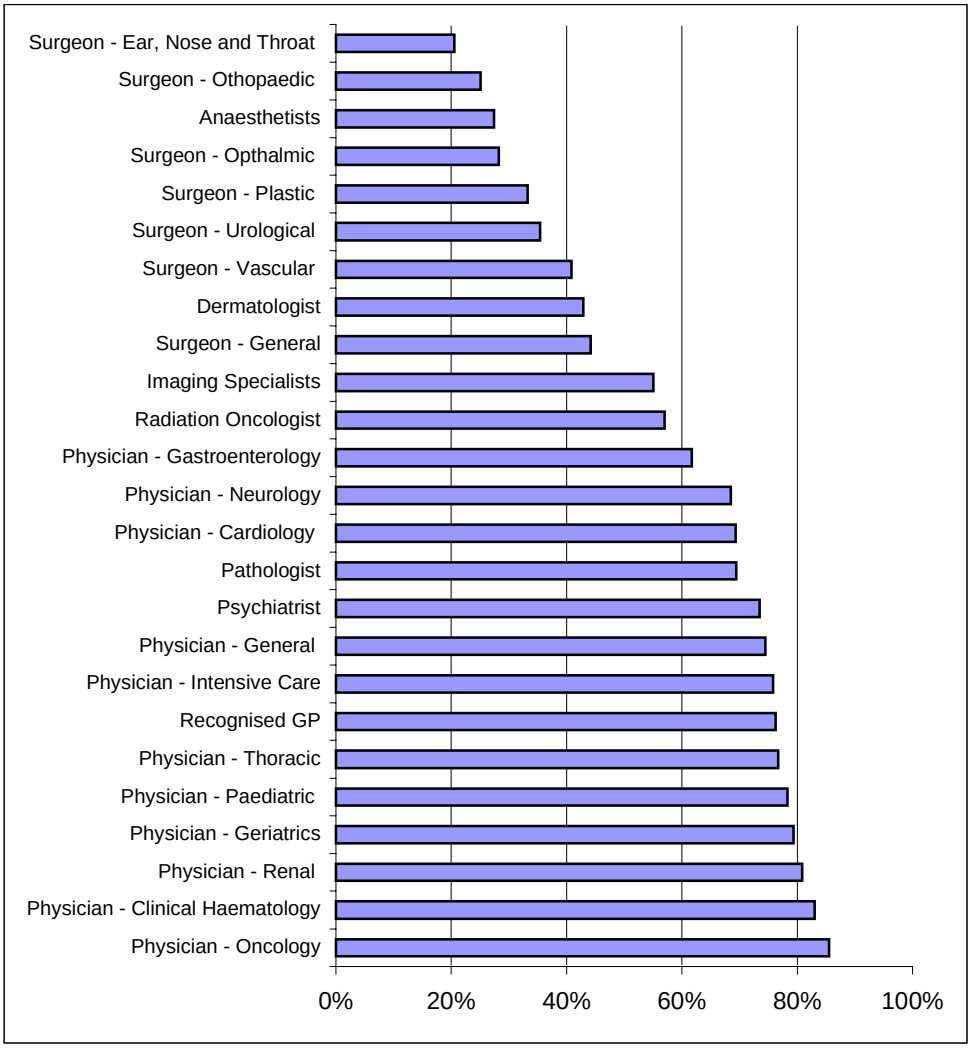
8.2.4 Variation in charges (and gaps) between specialties

Figure 8.11 shows the percentage of services billed at or below the Medicare benefits schedule (MBS) fee by specialty in 1998–99. Broadly, it indicates that there is a high degree of adherence to the schedule fee amongst physicians and low adherence amongst surgeons and anaesthetists. Around 21 per cent of services provided by ear, nose and throat surgeons were charged at or below the MBS fee compared to around 86 per cent of oncology physicians.

Figure 8.12 shows the percentage of services billed above 150 per cent of the MBS fee by specialty in 1998–99. Broadly, the specialty groups with the highest charges as indicated by figure 8.12 are the same groups that show low levels of MBS fee adherence in figure 8.11. Around 34 per cent of services by ear, nose and throat surgeons were charged above 150 per cent of the MBS fee compared to around 1 per cent of services provided by renal physicians.

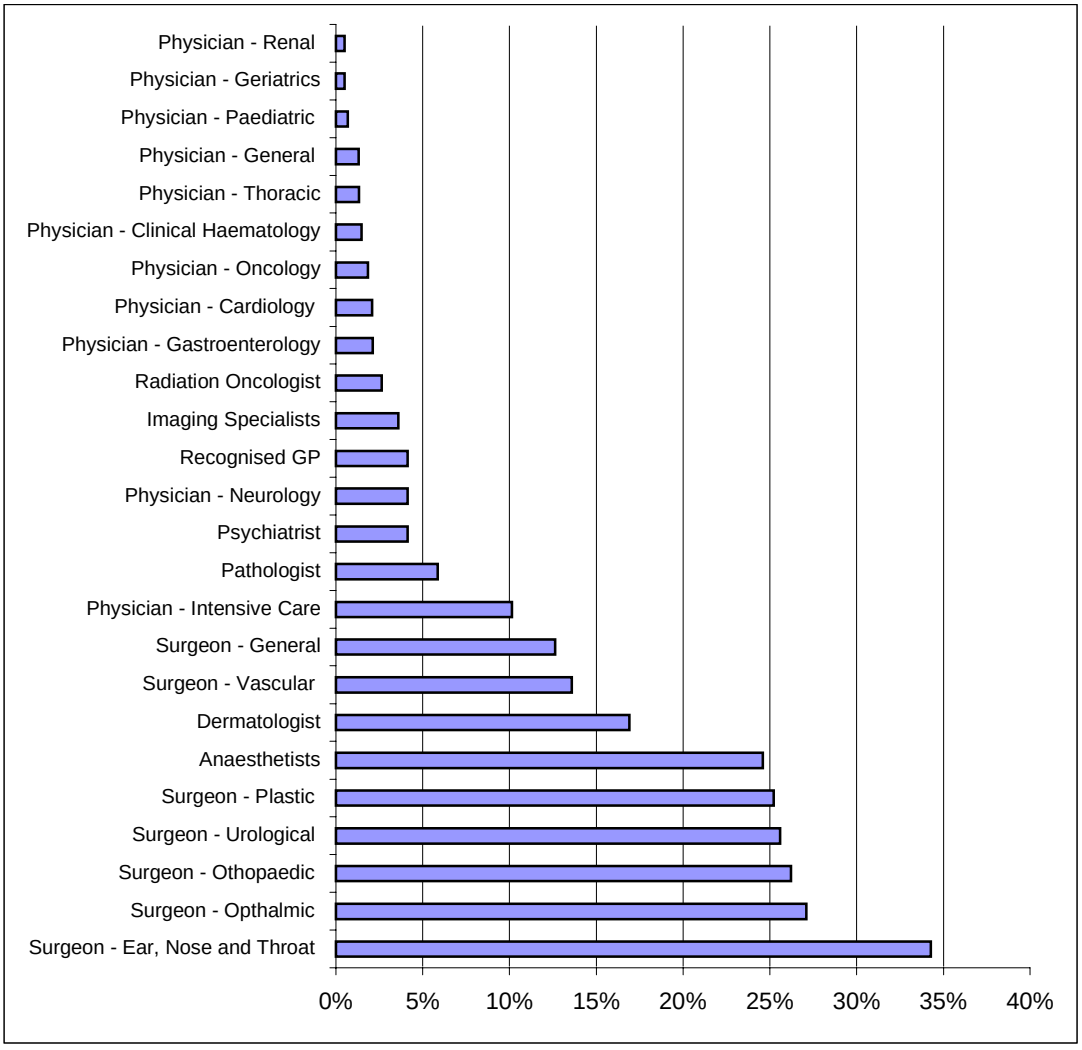
It should be noted that the Medicare data records the amounts contained on accounts submitted to the Health Insurance Commission (HIC) for payment. For direct billed services, the fee charged is equal to the benefit paid. For patient billed services paid by the HIC prior to the account being settled with the medical practitioner, the fee charged will reflect the amount recorded on the account. This may not be subsequently received by the medical practitioner, since some practitioners accept the Medicare benefits (and health fund rebate) as full settlement of the account or offer a discount for early settlement. The Department of Health and Aged Care has advised that data on average contributions must be treated with caution due to these concerns about data reliability.

Figure 8.11 Percentage of services billed at or below the MBS fee by specialty in 1998–99



Source: Medicare data provided by the Department of Health and Aged Care

Figure 8.12 Percentage of services billed above 150 per cent of the MBS fee by specialty in 1998–99



Source: Medicare data provided by the Department of Health and Aged Care

According to the Hospitals Contribution Fund of Australia (HCF) only a small number of doctors are charging well in excess of the MBS fee. Table 8.1 shows the charging practices of the 40 highest charging doctors in each specialty, as experienced by HCF members.

Table 8.1 Charging practices of 40 highest charging doctors in each specialty

Specialty	% share of all doctors in specialty	% of all treatments performed (within specialty)	% share of all charges above MBS fee (within specialty)
Orthopaedic surgeons	5	9	44
Obstetricians	6	11	51
General surgeons	2	18	30
Ophthalmologists	12	16	50
Gynaecologists	6	16	32
Cardiologists	12	32	65
Colorectal surgeons	5	19	37
Urologists	6	20	54
Ear, nose and throat specialists	8	32	62
Neurosurgeons	10	25	63
Plastic surgeons	8	17	59

Source: 1998 HCF medical charge survey

The Hospital Benefit Fund of Western Australia (HBF) also reported in its submission that 20 per cent of doctors were responsible for 50 per cent of the gap charges for any particular craft with the remaining 50 per cent is charged by 80 per cent of doctors. HBF also found over a six-month period to 30 June 1999 about 1000 items (0.14 per cent of items) where the medical gap was over $1000 and the average of these was $1920.

8.3 The development of agreements covering the medical gap

Current legislation allows the medical gap to be covered in circumstances where the service is rendered by, or on behalf of, a medical practitioner:

- with whom the registered health fund has a MPPA; or
- who has a PA that applies to the professional service provided, with the hospital where treatment occurred, and that hospital has a HPPA with the registered fund.

Industry experience with MPPAs and PAs
(Ezyclaim and other similar arrangements)

AXA Australia Health Insurance (formerly National Mutual Health Insurance) has been leading other funds in the development of no/known gaps products. Ezyclaim is a transaction-by-transaction MPPA process providing practitioners with the freedom to participate in no-gap arrangements on behalf of patients selected by the practitioner.

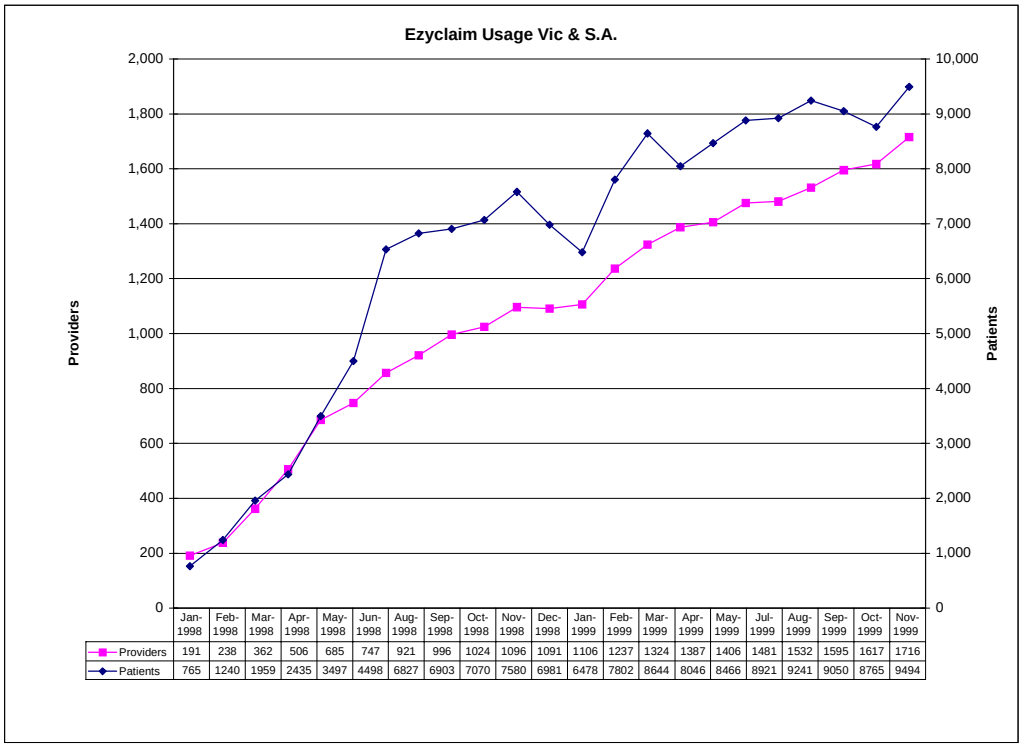
Ezyclaim can best be described as a kind of bulk-billing for in-hospital services. For those practitioners who choose to send accounts directly to AXA by-passing the patient, Ezyclaim covers an agreed gap above the Medicare benefit schedule fee. The 75 per cent Medicare benefit is assigned to the fund where the service is covered by an agreement and AXA pays both the fund and Medicare benefit directly to the doctor. Ezyclaim therefore achieves simplified billing for AXA members.

AXA indicated that:

> The acceptance of the Ezyclaim system within the medical profession has increased dramatically over recent times. AXA will shortly celebrate its 1,000,000th Ezyclaim. Over 50 per cent of medical services in Victoria and South Australia have been claimed via Ezyclaim. Over 35 per cent of hospital episodes in these States result in no gap experience for our members.

Figure 8.13 below, provided by AXA, shows the recent trends in Ezyclaim usage. The number of patients benefiting from Ezyclaim has increased from about 900 in January 1998 to over 9000 in November 1999. Over the same period the number of providers using the system has increased from around 200 to over 1600. This represents 50 000 to 60 000 claims processed per month.

Figure 8.13 Ezyclaim usage



	Jan-1998	Feb-1998	Mar-1998	Apr-1998	May-1998	Jun-1998	Aug-1998	Sep-1998	Oct-1998	Nov-1998	Dec-1998	Jan-1999	Feb-1999	Mar-1999	Apr-1999	May-1999	Jul-1999	Aug-1999	Sep-1999	Oct-1999	Nov-1999
Providers	191	238	362	506	685	747	921	996	1024	1096	1091	1106	1237	1324	1387	1406	1481	1532	1595	1617	1716
Patients	765	1240	1959	2435	3497	4498	6827	6903	7070	7580	6981	6478	7802	8644	8046	8466	8921	9241	9050	8765	9494

Source: AXA submission

Medibank Private, HCF and the Australian Health Service Alliance member funds have recently put in place arrangements of this type.

MBF initiative

In August 1999 MBF announced plans to establish the MBF Network of hospitals and day surgeries through an open competitive tender, linked to the establishment of medical gap cover arrangements. In essence, MBF's approach was based on setting HPPAs with hospitals and day surgeries incorporating PAs between hospitals and doctors that deliver no-gap arrangements on a similar basis to AXA's Ezyclaim process. Doctors at participating hospitals would be free to specify that some or all of their services can be billed to MBF through the hospital at an agreed above-schedule fee rate.

The tender was first introduced in Queensland. MBF indicated that:

> The process is at an advanced stage [in Queensland]. Tender bids were recently invited from hospitals and day surgeries in NSW and the ACT.

MBF has now changed its approach by severing the link between the introduction of the MBF network of hospitals and day surgeries on the one hand, and the introduction of medical gap cover arrangements for members through the MBF schedule of Medical fees and the MBF schedule of diagnostic imaging fees.

MBF indicated that its medical gap cover arrangements are now totally independent from the network, including in Queensland.

MBF indicated that the MBF schedule of fees was distributed to 35 000 doctors throughout Australia at the end of December 1999 inviting them to register their gap payment details and to obtain the MBF billing kit. MBF stated that -

> MBF believes that within two to three years a quite significant proportion of medical services will be offered on a no-gap basis.

With respect to gap cover arrangements for radiology, MBF indicated that:

> The MBF Schedule of Diagnostic Imaging Fees remained available, however, MBF has responded to the apparent desire of providers to negotiate on an individual/company basis and these discussions are currently taking place. MBF expects that over time a significant proportion of diagnostic imaging services will also be covered by medical gap cover arrangements.

Private hospital arrangements

Melbourne Private Hospital was one of the first hospitals to introduce a simplified billing system that also eliminated gaps for privately insured patients under PAs. It initially involved doctors agreeing to charge no more than the MBS fee, but has now encompassed above-schedule fee payments.

More recently, several other hospitals and day surgeries have been exploring HPPA–PA arrangements similar to that at Melbourne Private Hospital. HCF has signed agreements with seven NSW hospitals to ensure no gaps for HCF members. These hospitals include both public and private hospitals as well as day surgeries. HCF is also negotiating similar agreements with several other NSW hospitals.

South Eastern Endoscopy in Cheltenham, Victoria has successfully enabled all of its patients to benefit from the following forms of gap cover and simplified billing:

- AXA members benefit from an Ezyclaim (MPPA) arrangement;
- Medibank Private members benefit from an HPPA–PA arrangement; and
- all other patients benefit from an arrangement with UniBill (an independent simplified billing agency).

Agreements with pathologists

HCF has recently secured no-gap agreements with 14 leading pathology providers. According to HCF pathology services account for over 37 per cent of all medical services provided to HCF members with the contracted providers preforming more than 60 per cent of those private hospital pathology services used by HCF members.

HCF is currently seeking to negotiate similar arrangements with pathology providers.

8.4 The development of agreements which cover the hospital gap

Current legislation provides a framework for hospitals and funds to enter agreements on the price a hospital will charge a fund's members (HPPAs). It also requires a contracted hospital to inform the health fund member prior to admission of any amounts that may be liable to pay in relation to the hospital component of their treatment (hospital gap).

HPPAs between funds and private hospitals are now common. According to HCP data in 1997–98 around 70 per cent of all private hospital charges were covered by contracts (up from 64.3 per cent in 1996–97). This understates the actual extent of hospital contracting because AXA health insurance does not report any episodes as being contracted in its HCP data submissions. In fact the majority of AXA episodes are contracted.

The widespread development of HPPAs has provided more health fund members with the choice of a product that eliminates the hospital gap.

HCP data indicates that the hospital gap remains a significant component of the gap experienced by health fund members (despite the proliferation of agreements between hospitals and funds). However, as indicated earlier, this data also includes out-of-pocket expenses that would not generally be regarded as gap payments because they are due to the deliberate choice of cover by contributors.

8.5 Ancillary gaps

The following table provides information on the average gap per service in each State together with the average gap for Australia for the major types of ancillary services.[29]

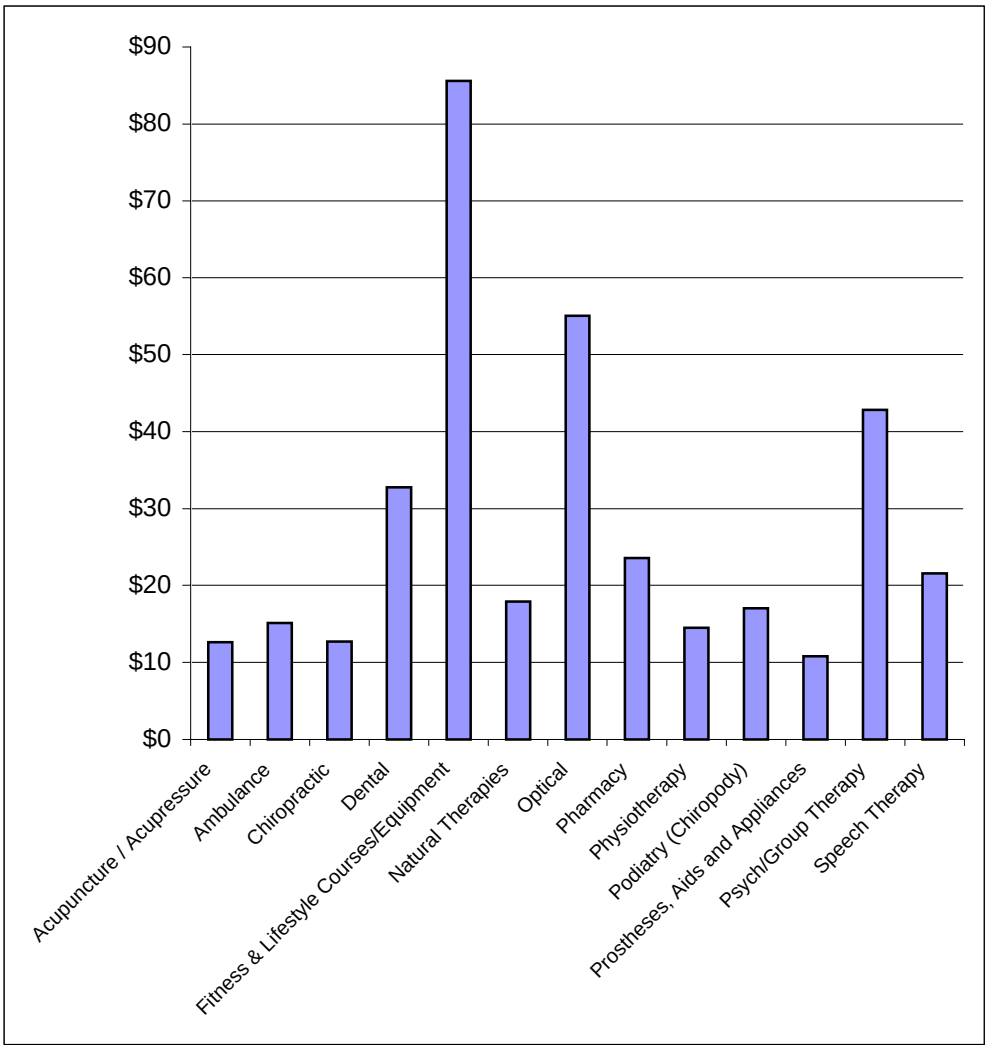
Table 8.2. Average ancillary gaps by State and type of service

Type of ancillary	Average gap per service ($)							
	NSW	VIC	QLD	SA	WA	TAS	NT	Aust
Acupuncture / Acupressure	11	15	14	20	15	15	24	13
Ambulance	2	18	31	2	1	1	0	15
Chiropractic	13	13	11	12	14	14	13	13
Dental	34	33	28	31	35	35	35	33
Fitness and lifestyle	89	119	46	83	109	109	17	86
Hearing aids and audiology	1,312	997	1,027	1,284	1,581	1,581	1,137	1,245
Natural therapies	18	18	17.0	19	14	14	17	18
Optical	57	70	61	31	59	59	50	55
Pharmacy	24	29	23	18	22	22	27	24
Physiotherapy	15	15	14	15	13	13	18	14
Podiatry (Chiropody)	15	19	14	19	22	22	21	17
Prostheses, aids and appliances	61	50	45	1	50	50	37	11
Psych/group therapy	43	43	37	46	45	45	51	43
Speech therapy	22	26	18	29	18	18	25	22

Source: PHIAC Annual Quarterly Reports for 1998–99.

[29] Although useful for comparative purposes, average gaps understate the gap experienced by consumers. For example, HBF reported in its submission that the average out-of-pocket for dentist was $36 and the median for those people who had to pay a gap was $100.

Figure 8.14 Average ancillary gaps in Australia by type of service



Source: PHIAC Annual Quarterly Reports for 1997–98.

The cost to funds of ancillary health insurance products is controlled by the application of:

- annual limits on total benefits paid by type of ancillary service;
- annual limits on the number of services by type of service;
- limits on the benefits paid per service;
- qualifying periods; and
- clinical or other need being certified before a benefit is paid.

According to HBF:

> Insurers are aware that substitution or maximising of treatment can take place and will take place if it advantages either the member or the provider, even if it is seriously detrimental to the insurer
>
> In those situations the insurer must decide between placing further limits on the product (so that it can be used for its intended purpose) but making it less attractive to the consumer or increasing the premium, again making the product less attractive to the consumer.

Simply covering the gap without some form of agreement on charges with providers can also simply result in higher charges. For example, HBA reported that some years ago they increased their benefit on physiotherapy by $15 per service as this was the gap being paid by members for physiotherapy treatment. Within a short period physiotherapy charges increased by $15. HBA commented:

> Presumably the physiotherapists were aware that consumers were prepared to pay $15 for the treatment and consequently raised their fees to a level which meant there was a $15 gap.

Industry initiatives to address the ancillary gap

Several health funds have introduced preferred provider arrangements with allied health practitioners, which seek to ensure that members have known or no-gap expenses for ancillary services.

For example, AXA has established networks of participating providers in Victoria and South Australia. These networks cover the four major allied health modalities of dentistry, physiotherapy, chiropractic and optical dispensing/optometry. AXA indicated that these modalities represent in excess of 80 per cent of the ancillary benefits paid by AXA in these markets.

AXA further stated that:

> AXA believes that the networks provide the foundation upon which an affordable "known gap" product can be delivered, thus enhancing value in ancillary product.

Table 8.3 provided by AXA, gives a snapshot of AXA's networks in the allied health sector in South Australia and Victoria, as at 31 January 2000. AXA indicated that an optical network already exists outside Victoria and South Australia.

Table 8.3 AXA's networks

	Victoria		South Australia	
Modalities	**No. of providers**	**% of services**	**No. of providers**	**% of services**
Physiotherapy	319	44	295	61
Chiropractic	111	22	59	32
Optical	84	37	28	41
Dental	52	5	122	24

Source: AXA submission

AXA indicated that:

> AXA has firm plans in place to further develop the networks and has dedicated resources to this end. It is planned that the networks will be developed to cater for at least 65 per cent of all services. Future developments will also see networks established in other States.

In June 1999 Medibank Private launched its Members' Choice arrangements nationally. Also, some of the member funds of the Australian Health Service Alliance have set up preferred provider or other contractual arrangements with optometrists or physiotherapists or own their own dental and optical clinics.

Some funds have also set up their own clinics. For example, HCF has established several dental and eyecare centres throughout the Sydney metropolitan area to provide its members with either no or known gap. These dental service centres are operated by HCF. At the dental centres there are no gaps for general preventative and diagnostic dental services and only a modest additional charge, or known gap over the fund benefit for major dental services.

According to HCF:

> The average gap to members using HCF Dental Centres in 1998–99 was $33, 10.8 per cent less than in 1997–98. This compares with an average out of pocket charge for services by private practitioners of 4215 per patient, six and a half times higher than our Dental Centres and 8.6 more than the average payment in 1997–98.

9 Health funds

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

9.1 Market dominance

The AMA stated that:

> We consider that the ACCC should closely monitor regional and State market concentration of the health funds. Had there been less concentration and more competition in the Queensland market, we do not believe that MBF would have been able to release the product it is now promoting.

As mentioned in chapter 5, the three largest funds in each State have at least 65 per cent of the market in the State, and in all States except NSW, the largest fund has a market share above 40 per cent.

The Commission deals with market concentration and market power issues to the extent that they refer to breaches of the Act. The Act does not set limits to market concentration. The Act deals with market power mainly in s. 46, which prohibits misuse of market power (the cure), and in s. 50, which prohibits acquisitions which substantially lessen competition (the prevention).

Market power is the ability of a firm to behave persistently in a manner different from the behaviour that a competitive market would enforce on a firm facing otherwise similar cost and demand conditions.[30] That is, market power is the ability of a firm or firms to profitably divert prices, quality, variety, service, innovation, or any other aspect of the competitive process or its performance outcomes from their competitive levels for a significant period of time.

Section 46 of the Act is the central provision for regulation of misuse of market power. It provides essentially that a firm with substantial market power shall not take advantage of that power for one of three proscribed purposes, namely eliminating or damaging a competitor, preventing entry into a market, or deterring or preventing competitive conduct.

Section 46 prohibits only those exercises of market power which have the purpose of damaging competition. The effect on competition is not a consideration under s. 46. A firm with substantial market power will not contravene s. 46 by using its power to obtain a low price, provided that it has not taken advantage of that power for a proscribed purpose.[31] Therefore, a health fund with significant market power may use its strong bargaining position to purchase services from hospitals or practitioners at

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[30] Kaysen and Turner, *Antitrust Policy* (1959), quoted with approval by Dawson J in *Queensland Wire Industries v BHP* (1989) ATPR ¶40-925.

[31] *ASX Operations v Pont Data Australia* (1991) 27 FCR 492.

lower prices, for the purpose of raising its own profits and/or gaining a competitive edge over its rivals.

Consistent with the court's view in the *Queensland Wire Industries* case, the Commission views s. 46 as a competition provision and not a 'catch-all' for harsh behaviour by powerful corporations.[32] In many instances where smaller or weaker businesses are damaged by more powerful corporations with which they deal, the conduct will not be caught by s. 46 because there is no anti-competitive purpose. Under some circumstances such conduct may fall within the provision dealing with unconscionable conduct, s. 51AC.

Section 50 of the Act prohibits acquisitions, which have the effect, or likely effect, of substantially lessening competition in a substantial market. It differs from other competition provisions of the Act because it regulates market structure (rather than the conduct itself), to prevent the creation of or an increase in market power and consequent anti-competitive conduct.

To determine whether any particular acquisition breaches s. 50 requires an assessment of the following matters:

- what is the relevant market;
- is that market substantial; and
- will the acquisition be likely to substantially lessen competition?

In taking account of concentration when assessing the effect on competition of a particular acquisition, the Commission uses certain thresholds as a guide in determining whether a merger or acquisition will not be likely to breach s. 50, or whether further scrutiny as against other merger factors is required before the Commission can reach a conclusion as to the competitive effects of the acquisition.[33] The Commission would examine mergers between health funds, if and when such issue arises, in accordance with the its merger guidelines.

9.2 Competition between health funds

A fund raised concerns about another fund not complying with the legislative requirements regarding community rating. It was alleged that this fund had been aggressive in targeting employers' groups, which are seen as having a better risk profile, by offering these groups products with lower premiums, not available to the

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[32] *Queensland Wire Industries v BHP* (1989) ATPR ¶40-925.

[33] With regard to concentration thresholds, the ACCC has outlined in its guidelines that, where the post-merger market share of the merged firm is 15 per cent or more and the share of the four (or fewer) largest firms is 75 per cent or more, it will want to investigate the merger further before being satisfied it does not result in a substantial lessening of competition. Similarly, if the share of the merged firm is greater than 40 per cent, no matter how fragmented or concentrated the remainder of the market may be, the ACCC will want to give the merger further consideration. These thresholds provide 'bright green lines' below which a merger is unlikely to be of concern to the ACCC.

rest of the community. It was alleged that the conduct amounts to unfair competition because it breaches community rating requirements that other funds have to abide by.

As indicated in chapter 6, since 20 October 1999, health funds are allowed under the National Health Act to provide discounts on premiums in certain prescribed circumstances.[34]

Health funds are allowed to provide discounts in the above circumstances, subject to approval by the Department of Health and Aged Care, on the basis that the discounts are offset by a reduction in management expenses. Discounts can be up to a maximum of 12 per cent.

The Department of Health and Aged Care indicated that all funds have been advised that any new contract entered into with employer groups must not offer discounts greater than 12 per cent.

The Department of Health and Aged Care indicated that it would approve a discounting arrangement for a maximum of 12 months, after which the fund will need to reapply for approval. The department further indicated that it is in the process of asking all health funds to provide information on current discounting arrangements.

9.3 Consumer issues

The Private Health Insurance Ombudsman (formerly the Private Health Insurance Complaints Commissioner) and the Commission have received several complaints from consumers about private health insurance. Some of these complaints raise issues of concern.

9.3.1 Consumer complaints

The Private Health Insurance Ombudsman has been specifically set up to deal with complaints about private health insurance arrangements.[35]

Complaints received by the Ombudsman over the last four years are presented in figure 9.1. Because complaints to the Ombudsman must be connected to a health insurance arrangement, the majority of them are about health insurance funds.

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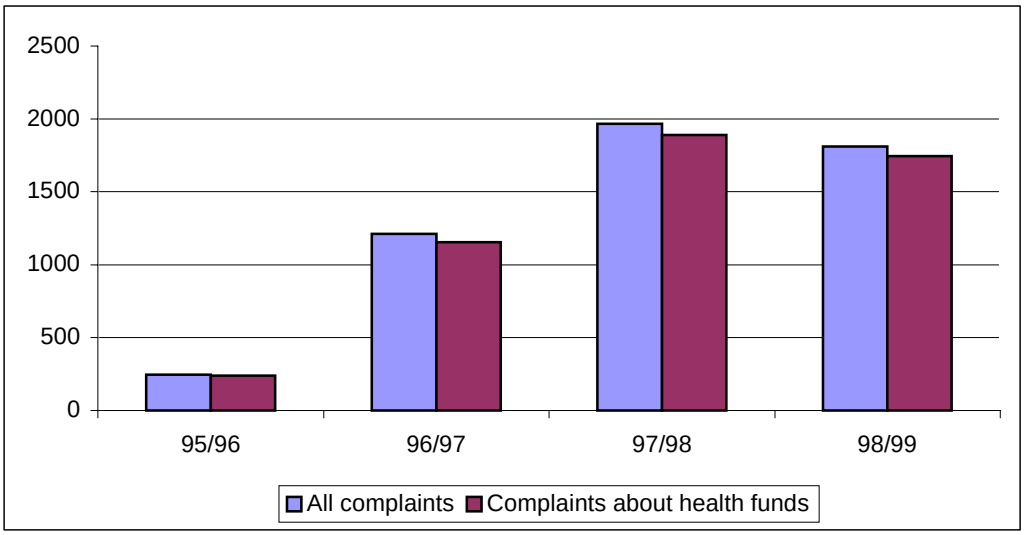
[34] *Health Legislation Amendment Act (No.2) 1999.*

[35] See Private Health Insurance Ombudsman Annual Reports for more details on the Ombudsman's role and functions.

Figure 9.1 Complaints received by the Ombudsman — 1995/96 to 1998/99



Source: Private Health Insurance Ombudsman

Although the number of complaints received by the Ombudsman's office is not small, it needs to be viewed in the context of the number of services provided to privately insured patients.[36] In addition, the Ombudsman stresses that:

> It is important to note though, that you cannot accept that all of these individual complaints reflect poorly on the system as a whole, nor to the bulk of contributors.

Figure 9.2 provides information about the issues raised in complaints to the Ombudsman. A major area of complaints over the last four years has concerned benefits. This includes issues such as the extent of cover, amount of benefit, gap payments, excess, limits, compensation, payment delays and out of pocket expenses.

In 1997/98, there were far more complaints about 'costs' than in any other years. These complaints concerned overwhelmingly the cost of health fund premiums. The Ombudsman noted that the decrease in the number of complaints in this category in 1998/99 can be correlated to the Government's 30 per cent rebate reforms.[37]

Included in the 'other' category are complaints about health fund rule changes. Complaints about the former private health insurance incentives scheme and the 30 per cent rebate, also included in this category, represented 7 per cent of all complaints in 1998/99. The remainder of this category deals with a variety of other issues including the quality of customer services, premium payment difficulties, private patient elections in public hospitals and hospital contracting arrangements.

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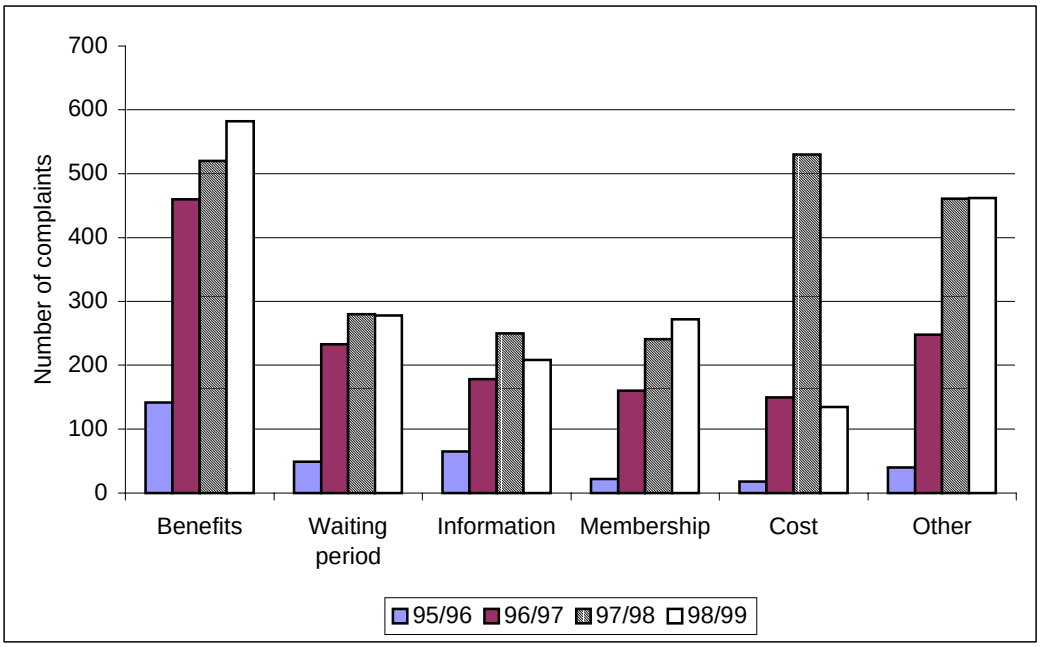
[36] In 1998/99, nearly one and a half million hospital episodes and seventy eight million ancillary services were provided to privately insured patients.

[37] Private Health Insurance Ombudsman, *Annual Report 1999*, p. 11.

Figure 9.2 Complaints by issues



Source: Private Health Insurance Ombudsman

Complaints about waiting periods accounted for around 14 per cent of complaints over the last four years. A large majority of those complaints are about pre-existing ailments.

Complaints about membership have increased over the last four years from 7 per cent to 14 per cent of all complaints. These include concerns about the cancellation or suspension of membership.

Complaints about information have remained around 11–12 per cent of all complaints. These concern issues such as misleading information, inadequate information and lack of appropriate information.

As indicated in chapter 4, the Commission has received several complaints about private health insurance. Consumer complaints to the Commission relate to allegations of misleading and deceptive conduct and/or misrepresentation about the promotion of private health insurance. Naturally, the Commission deals with far less complaints than the Ombudsman as it is not the first port of call for consumers having a problem with their private health insurance, and the Commission has a very different role. However, these complaints have represented a significant proportion of all the complaints received by the Commission over the past four years alleging breaches of the consumer protection provisions of the Act in the health sector.

The major category of complaints to the Commission concerns benefits. These have mainly been allegations of misleading representation about hospital cover and lack of disclosure of particular features of health insurance policies such as exemptions.

The Australian Consumers' Association (ACA) has conducted several surveys into patient satisfaction with private health insurance. The ACA indicated that some of the key findings of the 1997 Healthcare survey were:[38]

- One in four people were dissatisfied (26 per cent) with the level of hospital cover provided by their private health insurance policy.
- Nearly half (48 per cent) of the people hospitalised in the last three years did not get an explanation about how much their out-of-pocket costs would be. Significantly more private hospital patients received an explanation (62 per cent) about their out-of-pocket costs than average. In contrast only one third (33 per cent) of public hospital patients received an explanation.

The ACA's 1998 health insurance survey focussed on consumer satisfaction with claims handling.[39] Only 6 per cent of respondents reported having problems during their claims process. The type of problem most frequently noted were 'disputes over the size of rebate' (23 per cent) followed by 'disagreement over what policy covered' (15 per cent).

Table 9.1 provides a summary of all complaints and of the higher category of 'disputes' received by the Ombudsman for individual health funds compared with their market share for the year 1998/99.[40]

In 1998/99 Medibank Private attracted the highest number of complaints, followed by MBF and AXA (formerly National Mutual Health Insurance). While Medibank Private's share of total complaints is in line with its overall market share, MBF and AXA have a greater share of complaints when compared to their respective market share.

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38 The ACA's 1997 healthcare survey was sent to 12 000 Choice subscribers and received 6300 responses.

39 The ACA's 1998 health insurance survey received responses from 6938 Choice subscribers who had private health insurance.

40 Complaints to the Ombudsman are categorised by the degree of effort needed for their resolution. 'disputes' represent the highest level of complaints where significant intervention by the Ombudsman is required.

Table 9.1 Complaints by health funds

Name of fund	No. of complaints	% of complaints	No. of disputes	% of disputes	Health fund market share
ACA Health Benefits Fund	0	-	0	-	0.1
AMA Health Fund Ltd	0	-	0	-	0.1
Australian Health Management	57	3.3	36	3.9	2.3
Australian Unity Health Fund	41	2.3	26	2.8	2.8
CBHS Friendly Society	1	0.1	1	0.1	0.9
CDH Benefit Fund	0	-	0	-	0.0
CUA Members Benefit Friendly Society	10	0.6	4	0.4	0.5
Defence Health Benefits Society	22	1.3	7	0.8	1.2
Geelong Medical & Hospital Benefits	4	0.2	2	0.2	1.0
Goldfields Medical Fund Inc	1	0.1	1	0.1	0.2
Grand United Corporate Health Ltd	7	0.4	4	0.4	0.3
Grand United Friendly Society	29	1.7	9	1.0	0.5
Health Care Insurance Ltd	3	0.2	2	0.2	0.1
Health Insurance Fund of WA Inc	2	0.1	2	0.2	0.3
Health-partners	7	0.4	4	0.4	0.6
Healthguard Health Benefits Fund Ltd	0	-	0	-	0.1
Hospital benefits Fund of WA Inc	58	3.3	28	3.0	11.4
Hospitals Contribution Fund of Australia Ltd	98	5.6	50	5.4	8.4
IOOF Friendly Society of Victoria	3	0.2	2	0.2	0.2
IOR Australia Pty Ltd	10	0.6	5	0.5	0.7
Latrobe Health Services (VIC)	8	0.5	6	0.6	0.4
Lysaght.	1	0.1	1	0.1	0.2
Manchester Unity Friendly Society in NSW	34	1.9	18	1.9	1.0
Medibank Private	481	27.6	268	29.0	27.1
Medical Benefits Fund of Australia Pty Ltd	419	24.0	162	17.5	18.2
Mildura District Hospital Fund	1	0.1	0	-	0.3
National Mutual Health Insurance Pty Ltd	264	15.1	171	18.5	10.5
Naval Health Benefits Society	5	0.3	1	0.1	0.3
NIB Health Funds Ltd	84	4.8	56	6.1	4.6
NSW Teachers federation Health Society	23	1.3	15	1.6	1.5
Phoenix Welfare Association Ltd	2	0.1	2	0.2	0.2
Queensland Country Health	5	0.3	4	0.4	0.2
Queensland Teachers Union Health Society	2	0.1	1	0.1	0.4
Railway & Transport Employees Friendly	7	0.4	5	0.5	0.4
Reserve Bank Health Fun Friendly Society	0	-	0	-	0.1
SA police Employees Health Fund Inc	0	-	0	-	0.1
SGIO Health Pty Ltd	19	1.1	11	1.2	1.2
St Luke's Medical & Hospital Benefits	12	0.7	9	1.0	0.5
Transition Benefits Fund	1	0.1	1	0.1	0.2
Transport Friendly Society	3	0.2	1	0.1	0.1
United Ancient Order Of Druids Victoria	1	0.1	0	-	0.1
United Ancient Order of Druids Grand Lodge	0	-	0	-	0.1
Western District Health Fund Ltd	19	1.1	10	1.1	0.4
Yallourn medical & Hospital Society	1	0.1	0	-	0.1
Total for registered funds	**1745**	**100**	**925**	**100**	**100**

Source: Private Health Insurance Ombudsman

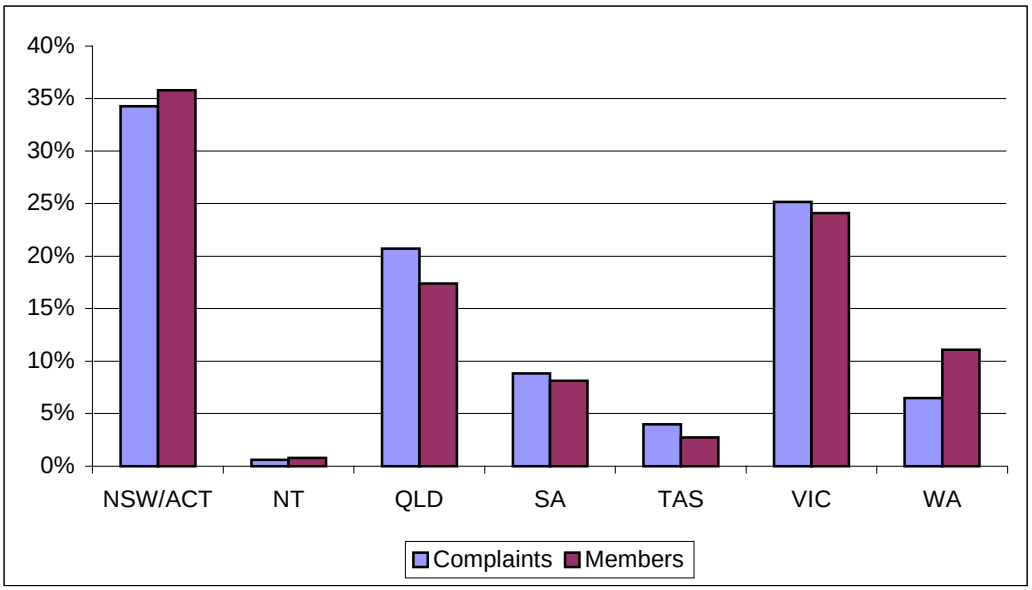
According to the Ombudsman, analysing the information in the 'dispute' category provides a more realistic picture of the way funds respond to their members' complaints in general and to the higher level issues included in the dispute category.[41] Medibank Private's share of disputes is slightly higher than its share of complaints and therefore its market share. MBF's share of disputes is significantly less than its share of complaints and slightly below its market share. AXA, however, has a greater share of disputes than of complaints, and this is significantly higher than its market share.

Of the other top six funds, HCF's and HBF's share of all complaints and disputes are significantly less than their respective market shares. NIB's share of all complaints is in line with its market share while its share of disputes is higher.

Care should be taken in drawing conclusions from these figures. The number of complaints received by the Ombudsman against each fund depends on many things, including positive aspects such as how well a fund advertises and promotes the services of the Ombudsman to its members, as well as negative factors associated with a fund's practices.

For instance, figure 9.3 suggests that the existence of the Ombudsman and the responsibilities of the office may not be as widely known in the West as on the Eastern Seaboard States.

Figure 9.3 Complaints and members by State and Territory



Source: Private Health Insurance Ombudsman and PHIAC

It should be noted that the Ombudsman only considers complaints, which have already been raised by the complainant with the fund and have not been resolved. Funds, which have set up effective complaints handling mechanisms, would therefore not be expected to have many complaints brought to the Ombudsman's attention.

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[41] Private Health Insurance Ombudsman, *Annual Report 1998/99*, p. 13.

The Ombudsman noted that overall a greater emphasis is being placed on dispute resolution within the individual funds, which leads to a lessening of the complaint load for his office.[42]

The Commission has long promoted to industries and individual organisations the adoption of effective complaints handling mechanisms. In the Commission's view, these should be based on the following principles:

- a consumer has a right to complain and to have the complaint handled;
- complaints provide feedback about a product or service experience; and
- complaints give an organisation the opportunity to maintain confidence in its products or services.

It is reasonable to assume that there will always be some consumer complaints about private health insurance products. However, the manner in which complaints are dealt with by health funds is important.

Health funds should not overlook the benefits which can flow from listening to and reacting to complaints. An effective complaints handling system can turn many disgruntled members into satisfied consumers and thereby increase member retention.

Standards Australia has a Standard on Complaints Handling (AS4269) which sets out the essential elements of effective complaints handling with a guide to their implementation.

The key points in this particular Standard are that:

- there should be a strong commitment from the top down to handling complaints, i.e. a 'your problem is our problem' philosophy throughout the whole company;
- the complaint handling process should be visible;
- access to the process should be easy; and
- there should be a systematic recording of complaints so that they can be classified and analysed for the identification and rectification of systemic and recurring problems.

9.3.2 Consumer information

Private health insurance products are becoming increasingly complex and diverse with a variety of features to choose from. Consumers need clear and simple information to understand all the different features of the product they choose, including any limit to the coverage it provides. They also need comparable information to be able to choose the product that best suits their needs. The ability of consumers to make informed decisions when purchasing health insurance products is an essential element for

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[42] Private Health Insurance Ombudsman, *Annual Report 1998/1999.*

effective competition in this market. However, consumers are still facing problems in that regard.

The Australian Consumers' Association notes that:

> Consumers are not infrequently dissatisfied with the level of hospital cover provided by their health insurance policy. This dissatisfaction is probably related to the fact that consumers are not well informed about the features of the policy they have purchased, but possibly they may not be aware of things such as waiting periods for some conditions and the pre-existing ailment rule. Some of this ignorance is no doubt due to failure on the consumers part to properly acquaint themselves with the details of their policy, particularly in cases where the details of the policy are complicated or change over time. However, health funds do bear some responsibility for not presenting product information in a simple way, which makes it difficult for consumers not only to understand what they are buying but also to make comparison between different health insurance policies.

Confusion about entitlements

The most critical concern of consumers is to know what they are purchasing, and when they change product or fund, what this means to them. However, confusion and uncertainty about entitlements remain major sources of consumer complaints to the Ombudsman. These complaints show that members were not aware of particular aspects of their cover. Many clearly relate to interpretation difficulties or lack of clarity in the communications between the fund and the member, oral or written.[43]

The Australian Private Hospitals Association (APHA) indicated that it has received numerous comments from its members about the lack of information provided by health insurance funds to their members. The APHA submission notes that:

> Hospitals often have the unenviable task of explaining to prospective patients that their insurance cover will not meet the full costs of hospital care and that an unexpected co-payment will be required.

Based on its members' experience, APHA is of the view that persons purchasing health insurance products clearly do not have adequate information on products and often do not understand the information they do receive from funds, such as the implications of exclusion clauses and front-end deductibles, pre-existing ailment rules and information on appeal rights.

Similarly the Australian Association of Surgeons notes:

> The difficulty that everyone (lay people and doctors) has in understanding exactly what are the patients' entitlements in the various schedules of health insurance offered by the various companies. Keeping tracks of the changes in those entitlements is even more difficult.

Although many people decide to join a health fund on the basis of a brochure or an advertisement, they often do not read such material carefully or understand it. The language used may be readily understood by the industry but not by consumers.

The result is that at the time of purchasing a health insurance product, or changing product or fund, consumers may not understand important points about their cover. In

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[43] Private Health Insurance Ombudsman, *Quarterly Bulletin*, No. 12, July to September 1999.

the Commission's experience this problem can often be created and compounded by the nature of health funds' promotional material.

As indicated in chapter 4, the Commission and the Private Health Insurance Ombudsman (the then Private Health Insurance Complaints Commissioner) published a guide to the Act for the promotion of private health insurance in April 1998. As highlighted in the guide, a major concern to consumers at the time, and a major source of complaints to the Commission and the Ombudsman, was the use by health insurers of such terms as '100 per cent hospital cover' and 'full cover' in their brochures and advertising.

Many consumers are not familiar with the terminology used by health professionals and in the health insurance industry. As a result, claims in advertising that members would have '100 per cent hospital cover' were taken at face value, meaning that all expenses associated with a particular hospital stay would be covered by the fund.

There was clearly a difference between what health funds meant by '100 per cent hospital cover' and what consumers understood that term to mean. The Commission therefore recommended that health funds avoid using this term, and to state exactly what members would get — for example '100 per cent hospital accommodation cover'. It should be noted that most health insurers have taken this advice on board and have amended their brochure and advertising accordingly. The Commission has had very few complaints on this issue since the release of the guide.

With the introduction of selective contracting of hospitals, i.e. where a fund does not offer a contract to all private hospitals in a given geographic area, members' entitlements will depend on whether the hospital of their choice has an agreement with their health fund. When there is no agreement between the two organisations, the member will face significantly higher out-of-pocket expenses for hospital accommodation than would apply with contracted hospitals. Consumers may not realise this fact and may not know which hospitals are contracted.

Members may have chosen a particular fund because it provided full cover for accommodation at their hospital of choice. However, arrangements between funds and hospitals change over time, without members necessarily being made aware of the fact. Members may only discover at the time they need treatment that their hospital of choice no longer has a contract with their fund, and that they will face out-of-pocket expenses unless they go to another hospital. Changing funds will often not provide a solution to this problem (see below).

APHA argues that a member's decision to go to a particular hospital is usually pre-determined by the admitting medical practitioner, who will both advise the member of the requirement for hospital admission and nominate those hospitals at which the practitioner is available to conduct the procedure or treatment. The trend by funds towards selective contracting of hospitals has increased the likelihood of an insured patient's chosen medical practitioner practising at a hospital that has no contract with that patient's health fund.

APHA notes that:

> The full financial consequences of selecting a non-contracted hospital are often only appreciated by the member during the pre-admission process, where the need for an unexpected co-payment from the member becomes apparent. Clearly, members would prefer to have this information at the time of selecting a specialist. However, unless a member has already been advised by their GP of the need for hospital treatment before visiting the specialist, the member is unlikely to seek this information from their fund. Indeed, a vast majority of health fund members, at the time of health insurance purchase or subsequently when facing imminent hospital admission, do not even consider the possibility that their health fund may not have a contract with the chosen hospital.

APHA believes that funds have an obligation to provide accurate and timely information to assist members to claim benefits. APHA notes that some funds already provide their members with the names of contracted hospitals on request. However, APHA argues that funds are also reluctant to provide information which could increase the costs of claims. For example, increased costs to funds could arise if members were to seek out contracted practitioners and hospitals in an attempt to minimise their out-of-pocket expenses.

APHA points out that health funds have access to a vast array of data that could be used to provide information about average hospital charges and likely patient expenses for any episode of care. By contrast, an individual hospital can only advise patients about their likely costs for that hospital and thus are not in a position to provide advice on services and costs at alternative hospitals. APHA therefore concludes that:

> The health fund's responsibility for providing members with relevant information on comparative costs of contracted versus non-contracted hospitals cannot be assigned to either hospitals or doctors.[…] The GP cannot provide 'financial advice, ie. to select on the basis of health funds' contract status, which combination of hospital and specialist would suit a particular fund member. In this regard, a member should be able to obtain this information from the relevant fund prior to GP referral to a specialist and again prior to hospital admission.

Waiting periods may apply to new members, members who have upgraded their cover in the year before the treatment and even members who have recently transferred from another fund. In particular, the waiting period for pre-existing ailment may apply to them. Many consumers do not seem to be aware of the reality of the provisions of the pre-existing ailment rule as set out in the National Health Act (see below).

Benefit limitation periods, in addition to the standard waiting periods, apply for entitlement to the full amount of benefits in private hospitals for specific treatments such as obstetrics, mental illness, plastic surgery or IVF. Although these are standard features of health insurance policies, funds should not assume consumers know about them. It is important that consumers fully understand these features of their policies, so that they can make an informed decision whether to purchase private health insurance in the first instance, and then whether to seek treatment at a private hospital.

Health funds have the discretion to reduce or waive waiting periods. Funds have used this discretion during membership drives by offering 'immediate cover' and 'waiver of waiting periods'. These practices were a major source of complaints, which gave rise to the need for the publication of the guide to the Act.

Complaints arise from the fact that it is invariably the general two-month waiting period which is waived. New members who join up on the basis of 'immediate cover' find that they are still subject to waiting periods for pre-existing ailments or obstetrics.

The Ombudsman notes that:

> It is difficult to be sure about what is achieved in waiving the two-month general waiting period; many illnesses in the first two months would be deemed to be pre-existing and accidents are usually covered immediately. So in effect, funds are not giving consumers any benefit in waiving the two-month general waiting period, but consumers are frequently misled into believing that a greater benefit is being conferred than is the case in reality. This very often results in claims being rejected under the pre-existing ailment provisions.

It is important that funds provide clear and concise detail of what is or is not included in the waiver of a waiting period, and draw attention to the other waiting periods that are still applying.

As described in chapter 5, an increasing proportion of health fund members have opted for front-end deductable (FED) products. These products involve a trade-off between lower premiums and higher out-of-pocket expenses when the member needs treatment. However, this implies that consumers are aware there is a trade-off and understand the future consequences of what they are purchasing now. That is, consumers must be in a position to make an informed choice about the trade-off which characterises these products.

Finally, members have to make sure that they have a policy that covers them for the treatment they need. There has been a trend towards exclusionary products in recent years. Such products are usually designed for younger people because they exclude such items as hip replacements, cardiac surgery and lens procedures that healthy young people are not expected to need.

It is important that funds point out **all** the exclusions of the product, and make sure consumers realise the consequences of purchasing such products.

In that regard, the Ombudsman notes that exclusionary products pose distinct problems for consumers who take out this type of cover in mid-life or later, or those who take it out in their youth and neglect to ensure it is still meeting their needs as they age. Funds need to be aware that the product they sell to a contributor has to be fit for the purpose.

The Ombudsman provided the following example which highlights the issue posed by exclusionary products.

> A long running and current case involves a $20,000 dispute for an 86 year old female who broke her hip and fell when alighting from a bus. Following an examination at the local public hospital, she was transferred to the private hospital as she has private insurance. Following examination it was determined she needed a hip replacement. The fund was not contacted as the husband had in his possession an old health fund card. The procedure was followed by several days recuperative care and then post operational rehabilitation. It was discovered when the account was presented to the fund by the hospital that the member had changed cover to a couple cover with exclusions. One of the exclusions was hip replacement. The question still left unanswered is how the fund could sell such a product to an elderly couple (the youngest was 84 on transfer to the exclusionary product). The couple was under the impression the product excluded obstetrics and other minor unnecessary items.

It should be noted that s. 74(2) of the Act requires services, including contracts of insurance, to be fit for the purpose for which they are supplied. In relation to health insurance, this means that a health insurance product must be suitable for any particular purposes the consumer, expressly or by implication, made known to the fund when arranging to purchase the product. Therefore, if an elderly couple is purchasing health insurance for themselves, it should be obvious that a product that excludes hip replacement would be unsuitable, and this fact should be drawn to the attention of consumers. If a product is sold to such consumers in these circumstances without the exclusions being drawn to their attention, then this may well constitute a breach of the Act.

The Commission cannot take action on behalf of consumers for breach of s. 74(2) of the Act. However, consumers may bring their own private action for damages in any court or tribunal of competent jurisdiction against the fund in question.

A clear message from the above discussion is that health funds need to provide to their members adequate information about the conditions of their membership — and in particular the benefits for which members are eligible. Failure to do so may, in certain circumstances, amount to a breach of the Act. The Commission will continue to examine allegations raising such issues.

The Ombudsman has published a document entitled *The 10 Golden Rules of Private Health Insurance*. This document outlines what consumers should be mindful of at the time of purchasing private health insurance and what they should bear in mind once they have purchased private health insurance. It provides important information and it would certainly be useful if consumers could be given a copy of this document before they decide on a particular product.

The Minister for Health and Aged Care has a responsibility under the National Health Act to publish the Private Patients' Hospital Charter to inform contributors of what they can reasonably require from health funds, medical practitioners, hospitals and day hospital facilities.[44] The charter also advises people on matters to consider in making decisions about becoming contributors of health funds.

The purpose of the charter is to empower private patients by providing general information on their entitlements, assist with obtaining information on what they can expect from health funds, doctors and hospitals, as well as informing patients about complaints mechanisms.

The first edition of the charter was published in 1996. The charter is currently being revised by the Department of Health and Aged Care.

In its submission to review the Private Patients' Hospital Charter, the Consumers Health Forum noted that:

> A major problem identified by consumer groups consulted in preparing this submission was that the Private Patients' Hospital Charter is not widely known. Consumer organisations support the need for the Charter, but are unsure about who endorses, promotes and distributes the Charter.

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[44] Section 73F of the *National Health Act 1953*.

> Some consumer organisations consulted as part of the preparation for this submission were aware of the Charter, but considered that more needs to be done to promote the Charter to consumers.[45]

The Department of Health and Aged care indicated that one of the aims of the second edition of the charter is to make it more accessible and comprehensive.

Under the National Health Act, the Private Health Industry Administration Council (PHIAC) is responsible for distributing the charter to registered organisations which, in turn, further distribute and display it. The charter is also available on the PHIAC and Ombudsman's websites. It is expected that the revised charter will be available from the Department's website as well. The Department of Health and Aged Care is responsible for distributing the charter to hospitals and other stakeholders such as consumer organisations.

Funds have several initiatives to better inform their members and prospective members about their products and answer any queries they may have.

Funds are upgrading and expanding their call centres, which are becoming a key point of contact with fund members. Funds have also set up Internet sites to provide existing and potential members with information about their products and services. Some funds' websites enable consumers to compare the funds' different products. Some also list the hospitals and day surgeries contracted with the fund, while others allow consumers to find out which hospitals or providers in their area have a contract with the fund.

Comparative information

Consumers' ability to make an informed choice when purchasing private health insurance is hampered not only by the complexity of the products offered by the various health funds, but also by the difficulty in comparing products.

As noted by Choice magazine, 'comparing a large range of health insurance policies, each with its own limitations and special features, can be as complicated as learning to tango. Not surprisingly, it seems many people aren't happy with the choice they made'.[46]

Comparing many different policies from the various funds to find a product that suits consumers' particular needs is complicated, overwhelming and time consuming for most consumers. This suggests that there is a role for brokerage services in the private health insurance sector which could evaluate the various products on offer from the funds and be able to assist consumers choosing the best cover. The Commission is aware of one such brokerage service currently operating.[47]

The Department of Health and Aged Care is currently involved in several projects, which aim to provide simplified and comparable product information.

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[45] Consumers Health Forum, *Revision of the Private Patients' Hospital Charter*, October 1999.

[46] 'Doing the health insurance tango — your guide to the right steps', *Choice*, August 1998, pp. 16 to 23.

[47] Health-link consultants.

The department has arranged for a contractor to develop, implement and evaluate a trial Health insurance telephone information service – the consumer hotline trial. The department indicated that:

> The purpose of the Consumer Hotline is to provide consumers with information about the variety of health insurance products available, which will enable consumers to make an informed choice and help them to select a product which is appropriate to their needs.

The hotline will not recommend a specific health fund or product.

The hotline trial is being conducted in the ACT from 1 February 2000 until 14 March 2000. It will serve to determine whether a phone line is the right tool to use nationally to help consumers wade through the myriad of information available about private health insurance.[48]

At the end of the trial a decision will be made whether or not to expand the service to ensure national access.

The Department of Health and Aged Care is also involved in developing a key features statement for private health insurance. The aim of the project is to empower consumers to select a private health insurance product which meets their needs, and to gain a clearer understanding of product benefits and entitlements. It is envisaged that a key features statement would appear in fund brochures, summarising agreed key features that consumers should focus on when choosing a policy. According to the Australian Consumers' Association, the key feature statement will be:

> An essential tool to enable better competition by enabling easier comparison of policies and informing consumers of the key features of the policy they are purchasing.

The project arose from a joint working party between the Australian Consumers' Association and the Australian Health Insurance Association. The department subsequently agreed to provide funding and participate in its development. The Australian Consumers' Association has contracted the services of a consultant who worked with a steering committee (comprising private health insurance funds, the Australian Consumers' Association and the Department of Health and Aged Care) to draft the key features statement and test it with consumers in Sydney, Melbourne and Perth. This work has now been completed.

The department indicated that the last stage of the project would require the development of key features statement guidelines to explain the purpose of the key features statement to industry members who are unfamiliar with the statement, to consult with the industry, to review and revise the statement based on industry feedback and to launch the key features statement. The department also envisages that the steering committee would need to be reconvened to review the implementation after one year and establish an ongoing process for monitoring the use of and updating the key features statement by the industry.

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[48] Dr Michael Wooldridge, Minister for Health and Aged Care, 'Canberra to test run landmark Private Health Insurance Hotline', Media release MW006/00, 1 February 2000.

Verification of entitlements

Both the Ombudsman and the health funds recommend that members check their entitlements with their fund before they are admitted to hospitals. The situation has become very complex, and all the above factors need to be taken into account before the level of a member's cover for treatment as a private patient can be ascertained.

However, problems still have occurred for members who had contacted their health funds and the hospitals of their choice, before admission, to check that the fund would pay benefits to cover planned treatment. Some people have had the unpleasant surprise to find that they were not covered at the time they were discharged from hospital.

The National Health Act requires, where a health fund has a purchaser provider agreement with a hospital, that this contract includes a clause obliging the hospital to advise the member of what their out-of-pocket expenses for hospital accommodation will be. To do so, hospital admission staff will contact the patient's health fund for advice on the patient's insurance status. Based on the advice received from the health fund before admission, hospitals bill the fund or patient on discharge.

The Ombudsman indicated that if the hospital fails to check or makes a mistake about the patient's cover, the legislative provision provides no remedy to the member, who is usually asked to pay any outstanding amount. According to the Ombudsman, the legal position seems to be that members have a responsibility themselves to check their level of cover with their fund before commencing treatment.

APHA pointed out that too frequently, and irrespective of any initial patient eligibility advice that may have been provided by a fund, claims are subsequently denied or only partly honoured. In such cases, hospitals have had no option but to invoice the patient for the amount unpaid by his/her health fund. For example, APHA notes:

> MBF requires that a hospital seek fund authorisation prior to treatment, wherever possible. Such a process should enable a fund to check that premiums are up to date, that pre-existing condition rules are not applicable and that the member has satisfied waiting periods. Despite this process, the [December 1999] MBF Queensland HPPA document clearly states that authorisation is indicative only and that MBF will not accept financial responsibility if erroneous or incomplete advice is given to a provider or member.[49]

The Ombudsman has received several complaints from people where the hospital attempted to check their level of cover with the fund, but the fund either could not or did not respond, or provided incorrect information.

Hospitals and health funds currently use several different methods to check members' cover, including telephone advice, fax and recorded information services.

In order to provide accurate information as to whether a particular procedure is covered by the fund, i.e. exclusions, waiting periods and other extended limitation periods do

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[49] MBF HPPA and Queensland private hospital request for tender documents, reported in APHA submission.

not apply, the hospital may need to provide advice about the treatment and in some cases the Medicare item numbers to be used. Even then, in a few cases, it is not possible for a health fund to determine conclusively whether an ailment is pre-existing until after surgery has been performed.

Particular problems can arise where a new partner has been added to an existing membership. The membership may appear to be a longstanding one, but the new partner may still be subject to waiting periods.

The Ombudsman is aware of several cases where a hospital attempted to check a member's cover with the fund, but was unable to obtain a response from the fund. The Ombudsman reported that in other cases the hospital had checked with the fund and been advised that benefits would not be payable because the member had not served the waiting period for pre-existing ailments. This information was passed on to the member, who then contacted her doctor and was told, incorrectly, that the condition was not pre-existing.

The Ombudsman's most notable outstanding case under these circumstances involves a patient with chest pain who went to a private hospital accident and emergency centre.

> The hospital faxed the fund for confirmation of membership entitlements, prior to exploratory procedures. The health fund did not respond within 24 hours and the hospital proceeded. When the fund was asked to address the contributor's complaint to this Office, they responded, "However there will be times when it is considered other work loads have a higher priority for the day to day functioning of this office and service to our members in general than the check of fax facilities". The contributor is some many hundreds of dollars out of pocket with nowhere to go but to proceed in the courts as the fund and hospital are not willing to budge.

The Ombudsman indicated that his Office has recently established private health reference groups in both NSW and Victoria, comprising senior executives of the health insurance and private hospital industry. Participants in these groups work in their own individual capacities to put forward suggestions to resolve fundamental issues. The issue of verification of membership entitlements is currently under review by the NSW reference group.

9.3.3 Pre-existing ailments

The test to be applied to pre-existing ailments is set out in the National Health Act. The rule requires that a medical practitioner, appointed by the health fund, must be satisfied that signs or symptoms of an ailment, illness or condition were in existence at any time in the six months before the member joined or upgraded their cover. Benefits are not payable for treatment in relation to this ailment, injury or condition for the first twelve months after joining or upgrading.

Application of the pre-existing ailment rule does not depend on the awareness of the ailment or on the need for treatment, but purely on the existence of signs or symptoms.

The principles governing the application of waiting periods for ailments, illnesses and conditions existing at the time a member joins a fund or upgrades his/her cover continue to be a major issue raised in complaints to the Ombudsman.

If a member is hospitalised before they have fully served their waiting periods, they may not be aware that they are not covered for the hospitalisation until they submit their bills to the health fund and benefits are denied on the basis of the pre-existing ailment rule. The Ombudsman indicates that there has recently been a tendency by some funds to also apply the pre-existing ailment rule to ancillary benefits, in particular dentistry, without being obvious as to the application of the rule to such procedures in either their advertising or brochures. The effect of this can mean the patient is left with sole responsibility for a bill which could be many thousands of dollars.

The Ombudsman notes that:

> Most funds adopt a responsible position in both their literature and their communication with members relating to this issue, but still it remains a problem. There is no universal application of the rule even though it is part of the legislation. Some funds do not apply it in a consistent manner, and this office would contend that others (although few in number) apply it incorrectly.[50]

The Ombudsman is of the view that, in the context of the relevant provisions of the National Health Act, there must be some manifestation of the ailment, illness or condition at some time in the preceding six months before a fund's medical adviser can say there was a sign or symptom. That is, there must have been something which would have prompted a reasonable person to seek medical advice or a reasonably competent GP to have detected an abnormality during a routine visit.[51]

In September 1999 a committee was set up by the Government to undertake an inquiry into the effect of current pre-existing ailment rules on health fund members.[52] More specifically, the inquiry is to examine:

- the extent of unresolved conflict or hardship caused by the current rules and their implementation, particularly in relation to psychiatric care, palliative care and rehabilitation;
- if the rules are adequate or need clarification, amendment or expansion; and
- if necessary, advise on appropriate changes or measures to improve their effective and fair operation.

The Ombudsman argues that even if there is universal application of the pre-existing ailment rules, there will still be problems because some medical practitioners do not understand how the rules operate.

The National Health Act places the final arbitration in the hands of a medical practitioner appointed by the fund to determine that signs or symptoms existed in the six months before the member joined or updated his/her cover.

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50 Private Health Industry Ombudsman, *Quarterly Bulletin*, No. 13, October to December 1999, p. 2.

51 See Private Health Insurance Ombudsman, *1999 Annual Report*, p. 18.

52 Dr Michael Wooldridge, Minister for Health and Aged Care, 'Pre-existing ailment rules for private health insurance members under scrutiny – committee members announced', Media release, MW 87/99, 27 September 1999.

The Ombudsman indicated that on many occasions patients would rely on the advice of their own medical practitioner as to whether the ailment or condition was pre-existing. The medical practitioner may not be conversant with the provisions of the National Health Act and may place himself or herself in jeopardy by offering such advice without being aware. Patients may be able to take legal action against their medical practitioner if they rely on his/her advice.

There is certainly a need for a campaign to inform all medical practitioners about the operation of the pre-existing ailment rules.

9.3.4 Transferability of cover

The right to transfer from a policy with one fund to a policy with another fund offering a comparable level of cover, with continuity of entitlements is a basic consumer protection measure which has been an accepted element of private health insurance for many years. This right has been recognised in the National Health Act, which entitles consumers to transfer from broadly comparable health insurance products without penalty.[53] The intention of this entitlement is to provide for the seamless transfer of memberships between health funds.

However, this right is no longer so clear cut in many situations. The reasons are complex.

First, there is an ever increasing divergence of policies and it is harder to be sure about the similarity of cover between policies of different funds. The Ombudsman considers that the portability provisions of the National Health Act were appropriate under earlier circumstances when the products of funds were similar, but are now no longer appropriate with the multitude of offerings from funds. In his submission, the Ombudsman notes that:

> As there are no like products to choose from, transferring members find themselves facing extended waiting periods for marginally differing products. This leads to unexpected out of pocket expenses and gives rise to considerable consumer complaint.

An increasingly important factor affecting portability of cover is the practice of selective contracting with hospitals and day surgeries. As contracts between hospitals and health funds come and go and vary over time, it is more difficult to conclude that different funds' hospital cover policies are comparable. A fund may require that waiting periods be served if the member's new cover is not exactly the same as the old one in terms of individual hospitals, even though they provide the same level of cover.

For example, fund A has a contract with hospital X but not fund B. A member who has full hospital accommodation cover with fund A would not incur out-of-pocket expenses at hospital X, while a member of fund B with a similar level of cover would. If such a member of fund B wants to transfer to fund A, fund A may well argue that the member's previous level of cover was not comparable because it included lower benefits at hospital X. The member may be required to serve a waiting period before receiving full benefits at hospital X.

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[53] *National Health Act 1953*, Schedule 1 — Conditions of registration of an organisation.

The Ombudsman indicated to the Commission that his office is intending to put the issue to the Victorian Reference Group early in the new year.

The Ombudsman also indicated that he has raised his concerns regarding the portability provisions contained in the National Health Act with the Department of Health and Aged Care.

The department indicated to the Commission that it has received minimal requests to investigate the portability provisions of individual health funds indicating that most funds are doing the right thing when accepting transferring members. However, the department informed the Commission that:

> The Department intends to review the conditions relating to transferring contributors as the diversity of products now offered by health funds has increased the complexity of transferring between health funds to a comparable benefit arrangement.

9.3.5 Changes to benefit entitlements

Health funds can change benefit entitlements at short notice. These changes can cause confusion for people who rely on information in the material they receive when first joining a fund.

Health funds need to be careful of how they advise members of changes to benefits or the extent of cover. For example, a fund may initially have a contract with several hospitals where members would have no out-of-pocket expenses for hospital accommodation. The fund may no longer have contracts with all the hospitals, which means that members would not be entitled to the same level of benefits.

Silence can clearly constitute misleading and deceptive conduct where there is a duty, in all the circumstances, to reveal particular facts or alternatively, where there is a reasonable expectation that if particular matters exist, they will be disclosed. In *Winterton Constructions Pty Ltd v Hambros Australia Pty Lyd*, Justice Hill said the following:

> If the circumstances are such that a person is entitled to believe that a relevant matter affecting him or her would, if it existed, be communicated, then the failure to communicate it may constitute conduct which is misleading or deceptive because the person who ultimately may act to his or her detriment is entitled to infer from the silence that no danger or detriment existed.[54]

How members are informed and in what detail would depend of the nature and extent of the changes and the contract members have with the fund.

The Australian Consumers' Association indicated that:

> Another practice which ACA regards as anti competitive is to change the details of a policy for example, changing a policy so that obstetrics are no longer covered and requiring a consumer to 'upgrade' if they want that particular service covered.

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[54] *Winterton Constructions Pty Ltd v Hambros Australia Pty Lyd* (1992) 39 FCR 97.

This type of change to health insurance cover is in effect a disguised price increase, as consumers must pay more if they want to keep the same level of cover. The Commission is of the view that this marketing practice may raise issues under the Act, in that consumers may not realise that they are no longer covered for services which were explicitly included in their policy at the time they purchased it. The Commission will take up this issue with health funds.

9.3.6 Choice of hospital

The Ombudsman notes that the introduction of selective contracting by health funds with hospitals and day surgeries, while being a means of keeping costs down for members, has also had the effect in some cases of limiting members' choice of hospital and increasing their out-of pocket expenses.

According to the Ombudsman these problems are compounded when a fund chooses to contract with a limited range of hospitals, restricting choice for their members, particularly those in regional and rural areas. Other problems arise when a member's chosen doctor does not have visiting rights at a hospital with which the fund has an agreement. In this case, the member is obliged to change doctors, or pay higher out of pocket costs to attend the hospital where his/her doctor has visiting rights.

The Ombudsman indicated that the number of complaints with respect to non-contracted hospitals is not high, but the process of selective contracting is in its infancy and has the potential to be quite a problem for the future.

In that regard, the Australian Association of Pathology Practices Inc (AAPP) has expressed serious concerns about the recent action of MBF (the MBF network tender process). The AAPP is of the view that:

> There is likely to be a reduction in choice of hospitals which can be accessed by patients, as losing an MBF tender will either price a hospital out of the range of many consumers or as a consequence, lead to its closure. As a result, hospitals which are likely to be attractive by way of location, services and in many cases just familiarity (there is much evidence of this with many patients electing to always return to the same institution), will no longer be available to be used by consumers.

As pointed out by the Ombudsman, this is one area where the greater good for the largest group of members by way of reduced overall costs may disadvantage a small number of consumers who want to use a particular facility or provider.

From the Commission's point of view, selective tendering raises consumer information issues. Indeed, it is even more relevant in that context that consumers be adequately informed at the time of purchase of which hospitals are contracted with the particular fund, and that this may change over time. Consumers need to be given a list of contracted hospitals and be informed of changes to this list.

9.3.7 Ancillary cover

A number of submissions by allied health practitioners and their associations have raised issues in relation to preferred provider schemes set up by health funds for the provision of ancillary services.

These submissions have alleged that the marketing and advertising of these schemes by health funds is misleading by promising no or known gaps for ancillary services at preferred providers. It is argued that funds cannot meet such a promise because of the small number of practitioners contracted and their sparse distribution. It has also been alleged that these schemes are misleading because of very little advertisement of the limited total amount claimable.

The Commission is concerned that the promotion of preferred provider schemes does not mislead or deceive the public and will take up this issue with the organisations concerned.

9.4 Compliance programs

Health funds' trade practices compliance risks may arise in their dealings with other health funds, hospitals, providers and their customers. It is therefore essential that health funds have effective trade practices compliance programs in place to reduce their risks of breaching the Act.

A good compliance program has two main benefits for individual health funds:

- It will help a health fund to avoid breaking the law and suffering the consequences. It should be noted that the Courts have taken the view that companies which have effective compliance programs should be rewarded by reduced penalties. However, companies that have compliance programs that are inadequate or poorly implemented have not been so rewarded.

- Instituting a good compliance program and generating a 'culture of compliance' within the organisation can also enhance a health fund's business operations and may be used for 'positive' business purposes, other than reactive risk-management.

The Australian Standard on Compliance Programs AS 3806 sets out the essential elements for establishing, implementing and managing an effective compliance program within an organisation and provides guidance in using these elements.

First, and perhaps most crucial to the success of any compliance program, is that there has to be total commitment throughout the organisation. Compliance must be driven from the top down.

Another essential element of compliance is a compliance policy. This means that a company should have a well defined, visible and 'up front' policy which all staff are aware of and observe.

The standard also recognises that management responsibility is an important element of effective compliance.

Obviously an organisation's compliance requirements need to be systematically identified and managed. Then, operating procedures and practices need to be designed and implemented.

The standard recognises that compliance is a dynamic process. It suggests that organisations should adopt a philosophy of continuous improvement in compliance performance.

10 Hospitals

10.1 Hospital gaps

The hospital gap is the difference, paid by the health fund member, between the hospital bill and the health insurance benefit after an episode of care requiring hospitalisation. However, some out-of-pocket expenses incurred by fund members for hospital accommodation would not generally be regarded as gap payments, as these are due to the member's choice of a particular cover.

Generally speaking, health fund members are benefiting from a regime of no/known gaps for hospital services provided they use a hospital that has a contract with their health fund. This result flows from the hospital purchaser provider agreements (HPPAs) that funds have negotiated with private hospitals. Details of the level of the gap and the trend in hospital gaps are outlined at chapter 8.

10.2 HPPA Contracting

10.2.1 Background

In 1995 Parliament passed legislation amending the National Health Act and allowing health funds to contract with hospitals for services required by their members. This legislation changed the dynamics of the health fund/hospital relationship. Prior to the amendment, health funds were generally passive price takers with hospitals and their associations requiring higher fee levels each year. There was limited price competition among hospitals, which may have resulted in higher levels of hospital charges than would be the norm in a more competitive environment.

The 1995 legislation changed these market relationships considerably, and in particular transformed health funds from passive price takers to active purchasers of services. As a result, hospitals were forced to look at the way they are managed with a focus on increasing cost efficiencies.

The contracting process between hospitals and health funds has not been without its problems.

10.2.2 Hospitals' position

The hospital sector has reacted strongly against the contracting framework claiming that the funds have the upper hand in the process and are using this to unfairly reduce rates paid to hospitals. The main areas of concern in the contracting process outlined in a submission to the Commission by the Australian Private Hospital Association (APHA) are:

- Lack of clear and transparent contracting processes.

  Hospitals are reporting that funds choosing to purchase hospital services on the basis of competitive tendering are often failing to implement transparent, fair and equitable processes.

- Delaying tactics — request for unreasonable amounts of information or confidential patient health information.

  Health funds relentlessly question the legitimacy of many hospital benefits claims for the provision of some levels or types of clinical care. In this regard, the amount of information required by funds of hospitals, together with the increasing level of scrutiny of the veracity of this information, has imposed an unreasonable administrative burden on private hospitals.

- Fund negotiator not given authority to negotiate and agree fees.

  Some hospitals have reported that some health fund negotiators have not had the authority to agree on benefits.

- Inaccurate information provided by fund as part of HPPA negotiations.

  Hospitals must often rely on the accuracy of information provided by health funds as part of a HPPA negotiation process to estimate the cost of providing hospital services under the HPPA.

- Abuse of market power.

  Hospitals are increasingly reporting instances of funds delaying payment under existing or roll – over (ie. Expired) HPPAs, while negotiations for new HPPAs are underway. Health funds also routinely use their market power, including the threat of no contract, to impose onerous, harsh and commercially unacceptable contract conditions on private hospitals.

- Requests for schedule of 'second tier default benefits' denied.

  Hospitals have sought to establish in advance of making a specific claim on behalf of a member, that they meet the eligibility criteria for the payment of 2nd tier default benefits. On this basis hospitals have sought an estimate of the likely benefits for specific treatments, so they can advise prospective patients of the likely benefit to be received and any out-of-pocket expenses. This information is difficult, if not impossible, to obtain from funds.

- Requests to examine specific facility HPPAs.

  Section 73ABC of the National Health Act 1953 specifies that health funds make available for scrutiny a copy of HPPAs that the fund has entered into. Health funds have made it extremely difficult, if not impossible, for hospitals to obtain copies of HPPAs struck with other hospitals.

- The imposition of discounting policies on hospitals, notwithstanding no clause in HPPAs.

APHA indicates that in 1998 a new hospital services product was proposed, aimed specifically at the self-insured market. Medibank Private responded to the hospital with the following:

> We do not have an issue with you treating self insured patients at Hospital 'x' as long as it is at the same rate that Medibank Private patients are charged at. I would therefore like to officially convey to you that if we become aware that self insured patients are being charged a lower rate than Medibank Private patients, we will treat this as a breach of our contract with the hospital and withdraw our contract.[55]

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[55] From consultant as reported in APHA submission.

- Inclusion of a 'no-discounting' clause in the HPPA: HCF's standard contract clause.

> HCF continues to include in new contracts a clause which restricts hospitals from offering a lower price to uninsured persons.[…] This practice limits hospitals' ability to set prices in response to market pressures and raises prices for uninsured patients if hospitals are intimidated by the threat by the fund.

- Capped volumes.

A NSW hospital reported to APHA that –

> Medibank Private has a policy of a 30 per cent reduction of benefits once the prior year revenue has been reached. Medibank's whole negotiation process is based upon acceptance of this condition.

APHA considers this approach unacceptable, as it effectively means that hospitals either refuse to admit patients once the revenue threshold is reached, or accept a 30 per cent reduction of benefits – thereby losing money on every Medibank Private patient admitted after the benefit reduction takes effect.

- Rejection of certificates as a method of avoiding payment

> Critical care certificates have become a joke. They are continually rejected by funds requesting more and more information to validate claims even though there is an agreed working party document.

APHA outlines criticism about the level of information provided by funds to members with the general claim that hospitals have to explain the implications to fund members of the type of cover they have, a time consuming and stressful occurrence given that these discussions are prompted by the need for the member to pay an unexpected gap to meet the full costs of the hospital care. This issue is examined in detail in chapter 9.

Jessie McPherson Private Hospital (JMPH) also raised some issues in relation to National Mutual Health Insurance (now AXA Australia Health Insurance) contracting practices. JMPH has been unsuccessful in negotiating a HPPA with AXA and was not successful in the fund's competitive tendering, because of the fund's "ideological opposition to dealing with a private hospital which is owned by a public body". JMPH argues that:

> [National Mutual's] pursuit of this line is anti-competitive, contrary to the interests of its members and an impediment to attracting new contributors to private health insurance.
>
> Through its strategy of excluding several hospitals from its 'participating agreements', National Mutual has effectively inflicted a financial penalty on its members electing admission to those hospitals not recognised under National Mutual's new arrangements. We believe this to be discriminatory behaviour.

10.2.3 Practitioners' position

The Australian Association of Surgeons has expressed its concerns about selective tendering of hospitals by National Mutual/HBA and MBF. It stated that:

> The evil we see in this practice is that private hospitals may be forced into ultra-competitive quoting with private health insurer. Already there is anecdotal evidence (but no formal surveys, so far as I am aware) that this has led in some instances to unsustainable cost-cutting. […]
>
> We believe that MBF in Queensland have taken this a step further by demanding that tendering private hospitals "roll up" radiology and pathology fees with the hospital fees, thus limiting MBF's exposure and increasing the private hospitals' exposure even further. The medical profession believes this is a most dangerous development with respect to the standard of patient care

The Australian Association of Pathology Practices (AAPP) also expressed concerns in relation to the MBF network tender process. The AAPP was of the view that:

> The recent action by MBF may well lead to the situation where competition is reduced, choice is restricted, the extent of health cover is diminished for some consumers and out-of-pocket medical/hospital expenses are increased

The AAPP points to possible consequences of hospitals losing on MBF tender. These include:

- increase in out-of-pocket expenses for hospital treatment at these hospitals and possible increase in medical expenses because the MBF schedule of fees will not be available for use by medical practitioners who treat MBF members at these hospitals;
- reduced choice for consumers as these hospitals become too expensive for consumers, and some may close; and
- this could lead to significant financial loss for practitioners who have invested in accommodation and equipment in association with these hospitals (for example pathology laboratories).

10.2.4 Health funds' position

Health funds are well aware of the various criticisms levelled by hospitals concerning the contracting process. As expected these are soundly rejected.

The Australian Health Insurance Association indicated that:

> Health funds have adapted to this change much more quickly than many hospitals, who see it as providing insurers with 'excessive market power'. I think more accurately one should see it as more of a levelling of the playing field. Hospitals, who used to say 'this is my price and you must match it' are now forced into a much more competitive relationship with one another with health funds able to come to a better deal with one hospital than another, and in return provide the hospital with patient volumes. Unfortunately the hospitals interpret this as 'unfair competition' from health funds. In fact they are yet to concede the market now encourages competition between providers.

Medibank Private provided the following comments**:**

> There have been media reports from private hospitals foreshadowing renewed demands for increased benefit payments on the basis that some hospitals may go out of business unless they are treated more generously by health funds. Health funds are at the same time accused of using an imbalance of bargaining power to restrict hospitals to unrealistically low benefit increases. The experience and view of Medibank Private is that many private hospitals are simply not operated on a commercial, business-like basis and have become used to raising 'cost plus' charges without pursuing business efficiencies. The 1995 Lawrence reforms are now starting to bite, in that funds

have become much more business-like in their approach to negotiating with hospitals. Nevertheless, funds like Medibank Private have been able to negotiate with hospitals to produce workable agreements that benefit both parties.

However, inefficient private hospitals do not have an intrinsic right to a continued existence and should not be supported by unrealistic benefit levels.

HCF indicated that:

HCF believes its approach to business and contracting is professional and ethical. We are concerned about unsubstantiated allegations made by private hospitals and their lobby groups about private health fund practice generally.

The private hospitals' lobby group has been successful in having:

- the Second Tier Default Benefits introduced, significantly in response to AXA's tendering process in South Australia;
- a Ministerial round table discussion on the development of a code of conduct;
- Department of Health and Aged Care (DHAC) meetings on HPPAs and their standardisation;
- ACCC inquiries into contracting conditions and allegations of unconscionable conduct;
- Industry sponsored meetings on case payments, standardisation of payment systems and HPPA terms and conditions.

HCF also pointed out the following:

HCF analysed the revenue and cost trends for the delivery of hospital services in the private sector for the period 1992–1998. The key conclusions reached from our analysis were that there are many factors beside health fund charge agreements affecting the performance of the private hospital industry and individual operators within it. Some of the most important factors are:

- an over supply of beds;
- low occupancy rates;
- increased competition;
- relative overstaffing and inefficient use of resources;
- start up and Commissioning costs for new hospitals;
- sub-optimal patient mix in high acuity private hospitals;
- the lead time required to bring newer, under-performing hospitals to full operation;
- over capitalisation of some hospitals;
- level of debt;
- unrealistic assumptions used by some operators when projecting revenue growth;
- poor investment decisions which have led to write downs of valuations, rationalisations and closures;
- unprofitable contracts with state governments; and
- the extent of cross subsidisation between payer categories resulting from differential pricing.

10.2.5 Commission's Position

The Commission has continually monitored the health funds–hospitals contracting environment. Several investigations have been conducted into allegations raised by the

hospital sector of health fund conduct that is claimed to contravene the misuse of market power and/or the unconscionable conduct provisions of the Act.

The general view of the hospital sector is that the conduct of the health funds is unfair and oppressive. The Act is a competition instrument and has no provisions that outlaw unfair or oppressive conduct generally. It is important to note that the purpose of competition laws, and in particular the Act, is not to protect the survival of every single business. Business failure is also part of the competitive process. The purpose of the Act is to protect consumer welfare by prohibiting certain anti-competitive conduct as well as unconscionable conduct in business dealings.

Similarly, nothing in the Act requires funds to provide a contract to every hospital. A failure to receive a contract does not constitute a breach of the Act by itself, but would do so only if the fund acted in such a way as to contravene one of the sections of the Act outlined below.

Section 46, the misuse of market power provision, prohibits any business that has a substantial degree of power in a market from taking advantage of that power for the **purpose** of:

- eliminating or substantially damaging a competitor;
- deterring or preventing a person from engaging in competitive conduct in any market; or
- preventing the entry of a person into any market.

While some conduct of health funds may have the **effect** of one of the above prohibitions, the Commission has found no evidence to date to support a claim that the conduct of the health funds is done for that **purpose**.

The Commission has also dealt with complaints from individual hospitals concerning allegations of unconscionable conduct by health funds in the contracting process. Some of these complaints are outlined in APHA's submission.

The Commission has formed the view, after seeking advice, that the conduct outlined in most of these complaints would not be considered by the court as being unconscionable conduct.

As indicated in APHA submission, the Commission has also investigated a complaint alleging a large health insurer had acted unconscionably by inserting a 'no-discounting' clause in its contract with a hospital (see chapter 4 for details). The Commission investigated the matter and came to the view that this clause could amount to unconscionable conduct. The health insurer in question, however, changed the clause before the Commission took further action.

As indicated in chapter 4, the Commission has also investigated allegations of misuse of market power, exclusive dealing and unconscionable conduct by MBF in its tendering for MBF network in Queensland, following a complaint from the Private Hospital Association of Queensland (PHAQ). The Commission was particularly

concerned about the tight timeframe in which hospitals were required to respond to the tender and the high level of misunderstanding between the parties.

The Commission immediately met with MBF to raise the concerns of PHAQ. Subsequently, MBF twice extended the deadline and addressed several PHAQ concerns.

The Commission is currently investigating a further complaint of unconscionable conduct by a major health fund.

The Commission will continue to examine any allegation of breaches of the Act raised in relation with the contracting process, and will further investigate any such matters that raise trade practices issues.

It should be noted that, in some instances, parties have been unwilling to speak out to the Commission in specific terms about particular health funds and alleged conduct because of an apparent fear of future commercial retribution by health funds towards the hospital for speaking out to the Commission.

10.3 Code of conduct and other industry initiatives

In an attempt to overcome the perceived unfairness in the contracting process, the private hospital and health insurance sectors are currently developing a code of conduct. It is expected that adoption of the code and genuine adherence to its requirements will be a key element in changing the level of distrust between the two sectors. By laying a foundation of greater certainty in the nature of the negotiation process, it is anticipated that the code will achieve improved confidence and a better recognition of the mutual interests and interdependency between the two sectors.

The code aims to detail an acceptable framework for minimising disputes between health insurers and hospitals during contract negotiations by introducing a system based on principles of fairness and reasonableness. Where such disputes do eventuate, the code provides a quick and inexpensive means of resolution.

The negotiation framework set out in the code would only deal with procedural issues arising in contract negotiations and is not there to determine substantive outcomes.

The Commission understands progress has been made in developing the code and is very supportive of this initiative. It believes that an effective code of conduct between health funds and hospitals has the potential to address the procedural concerns raised by hospitals about the contracting process.

However, it is important to bear in mind that such a voluntary code of conduct can only be effective if it has a commitment from all participants in the industry, both hospitals and health funds. This in turn requires recognition by all industry participants that there are several problems that need to be addressed, and that a code is a way to address those problems with the minimum government intervention. In addition, such a code also needs to be properly set up in order to be effective. In particular, this includes clearly articulating what the code wants to achieve so that it can be evaluated later on to see whether it has achieved its objectives.

Finally, industry participants should bear in mind that codes of conduct are not meant to serve anti-competitive purposes. A code that restricts competition would be at risk of breaching the Act and would require the industry to apply to have the conduct authorised by the Commission if there are net demonstrable public benefits.

In addition to developing a code of conduct, the Department of Health and Aged Care indicated that, at a Round Table meeting held under the auspices of the Minister for Health and Aged Care, representatives of the health funds agreed to work with hospital representatives on several other issues. These are:

- the development of standard data set for exchanging information between health funds and hospitals;
- agreement on patient classification systems to be used in the industry;
- agreement on standard payment systems to be used in the industry;
- development of a standard hospital purchaser provider agreement or contract;
- agreement on the nature and interpretation of quality indicators in the private health sector;
- development of an automated system for rules and billing; and
- funding arrangement for pharmaceutical products in the provision of private health care.

With regard to these initiatives, the Department of Health and Aged Care noted that:

> None of the above initiatives will ensure that hospitals will receive sufficient remuneration from health funds to prevent closures or the requirement to introduce out-of-pocket charging to insured patients. It is possible that these may occur at any time as the result of the fair and efficient operation of the market: for example, where there is an oversupply of hospital beds in a certain locality. However, such outcomes would be of far more concern to the Government where they would deprive health fund members of ready access to appropriate care without facing undue waiting time and/or gap payments.

HCF also indicated in its submission that, at State level, the Private Hospital Association NSW and the NSW Health Funds Association have several joint working parties to address industry wide issues. The current working parties cover issues such as case payment structure, critical care, pharmacy and exceptional drugs, psychiatry and rehabilitation. HCF further argues that:

> The existing joint working parties have a successful record of addressing industry issues over several years. If there are specific industry issues, then HCF believes there is already an avenue available to address these matters. HCF is unaware of any impediment to establish other joint working parties to examine issues of mutual interest and priority.

10.4 Joint negotiation — authorisation applications

Another avenue followed by hospitals in order to address their concerns about the contracting process has been to seek authorisation under the Act for conduct which would allow applicant hospitals to share information and/or jointly negotiate contracts with health funds.

The Commission must, in considering whether to grant authorisation, apply the statutory test pursuant to s. 90(6) of the Act. Section 90(6) provides that in considering an application for authorisation the Commission shall not make a determination granting an authorisation unless it is satisfied that, in all the circumstances, the proposed conduct would result, or be likely to result, in a benefit to the public and that the benefit would outweigh the detriment to the public constituted by any resulting lessening of competition.

As indicated in chapter 4, the Commission authorised the first application from a group of Queensland hospitals with certain conditions. However in the draft determination issued in respect of the application from three Sydney hospitals, the Commission has indicated that it does not intend to authorise the conduct. In its draft the Commission said that:

> The Commission is also of the view that the proposed conduct would result in an anti-competitive detriment in the private hospital – health insurance market through the impact of agreements on prices and increases in prices. The detriment would in particular be reflected by:
>
> Increased costs to health funds, potentially impacting on health insurance premiums and membership levels; and
>
> the easing of competitive pressures on the Applicants to improve the quality and efficiency of operations and services as a result of their being given an opportunity to pass on cost increases, pursuant to a 'cost plus' mentality 'whereby negotiations are to relate to the level of reimbursement to be received by Hospitals to reflect their ever increasing costs of operations'.
>
> As to public benefits, the applicants claimed that the Proposed Arrangement would give them countervailing power against the health funds. The Commission considers that this has been sought in order to achieve higher reimbursement levels from health funds than would be obtained if the Applicants negotiated individually. Noting that higher reimbursement levels in themselves do not constitute a public benefit, the Commission has examined the ramifications of higher reimbursement levels in light of the other public benefits claimed. The Commission was not convinced that the higher reimbursement levels sought from collective negotiation are essential to the Applicants' viability or to the continuation of community services.

The Commission is currently examining a further application from a group of twelve smaller hospitals in New South Wales, located in both urban and rural areas.

It is important to note that the Commission examines each authorisation application on its own merit, taking into account the particular circumstances of each individual case.

In a recent report the Productivity Commission points to the differential impact of the Act across ownership structures.[56] The Productivity Commission argues that group

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[56] Productivity Commission, 'Private Hospitals in Australia', Commission research paper, December 1999, pp. 88-89.

hospital networks have a significant advantage over stand-alone private hospitals because their integrated ownership means they can share information (including rates) in their dealings with health funds without any trade practices concerns, while stand-alone hospitals cannot.

There is no doubt that the Act affects hospitals differently based on their business structure. However, it is important to note that the Act is concerned by, and applies to, the conduct of separate legal entities, which are considered competitors under the Act.

Each corporation forms one legal entity and thus hospitals, which are part of one group, are not considered competitors under the Act. Therefore, the Act does not apply to the individual hospitals but to the group. Individual hospitals in this case can jointly negotiate and agree on their charges (i.e. one corporation sets the fees to be charged by its different facilities). Stand-alone hospitals, on the other hand, constitute one legal entity and as such are competitors under the Act. They cannot jointly negotiate with health funds unless authorised by the Commission.

The Commission has also received complaints regarding the differential treatment applied to joint negotiations by health funds and hospitals.

Suppliers of goods and services, in this case hospitals, cannot jointly negotiate as this conduct would be caught by s. 45A of the Act and would constitute a per se contravention. Conduct of health funds, the **acquirers** of goods and services, if they jointly negotiate, falls within the 'collective acquisition' exception to s.45(A) provided in s.45A (4)(a) and thus comes under consideration in the general s. 45 anti-competitive agreements section. That is, health funds are able to jointly negotiate with hospitals provided such conduct does not substantially lessen competition. Thus the Australian Health Service Alliance Ltd (Alliance), a group of some 30 small funds, is able to operate. This operation has come under question recently and is a matter kept under review by the Commission.

10.5 Hospital mergers

Hospitals may also seek to merge to address some of the problems they currently face.

Section 50 of the Act prohibits acquisitions which have the effect, or likely effect, of substantially lessening competition in a substantial market. To determine whether any particular acquisition breaches s. 50 requires an assessment of the following matters:

- what is the relevant market;
- is that market substantial; and
- will the acquisition be likely to substantially lessen competition?

The Commission would examine each proposed merger between hospitals on its merit, taking into account all the relevant factors of the particular proposal, in accordance with the its merger guidelines.

As indicated in chapter 4, the Commission has examined the proposed acquisition of the St Andrews War Memorial Hospital in Brisbane by the Uniting Church of Australia Property Trust, which manages the Westley Hospital and Turrawan Private Hospital in Brisbane, St Stephen's Private Hospital in Maryborough and Westley Park Haven Private Hospital in Townsville. The Commission has decided not to intervene in this proposed acquisition.

10.6 Other issues

10.6.1 Rehabilitation hospitals

The National Health Act requires all funds to cover rehabilitation care, at least at the level of the default benefit, in all hospital insurance tables. The National Private Rehabilitation Group (NPRG) indicated that, under the contractual arrangements between health funds and private hospitals, funds in most cases pay above the required minimum default level.

The NPRG contends that:

> Over the last two years, health funds have introduced a range of practices as disincentives to the funding of rehabilitation episodes which have acted to circumvent the legislation and disenfranchise health fund members.[57]

The NPRG provides examples of cases experienced by some of its members where, it argues:

> Funds have either attempted to or successfully achieved the introduction of payment practices which have breached the intent of the legislation and in so doing risked transgressing the Government's intention of increasing the attractiveness of private health insurance to consumers and risked increasing the pressure on the public sector through cost transfers.

The cases presented fall into the following categories:

- funds redefining certain rehabilitation classes as not being rehabilitation;
- funds penalising transfer of patients to rehabilitation hospitals by reducing payments;
- funds limiting payments within step-down model;
- funds introducing episode-of-illness payments; and
- funds withholding fees or threatening disengagement during negotiations.

The Australian Association of Surgeons also indicates that:

> National Mutual/HBA pioneered the tendering for rehabilitation services and reduced the number of rehabilitation institutions with which it contracted in Victoria and South Australia. Furthermore, it introduced prompt step down provisions for its clients when they were in-patients of rehabilitation

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[57] Report by the National Private Rehabilitation Group attached to APHA submission.

> institutions. The clear intention was to limit the supply of rehabilitation services by imposing financial restrictions.

The Commission understands that some of these issues are currently being considered by the NPRG, a group with representation from health funds, hospitals and government. The Commission has examined complaints by rehabilitation hospitals with regard to conduct by health funds. It did not find evidence in those cases that the conduct of health funds contravened s. 46 or s. 51AC of the Act.

The issue has also been raised with the Commission that changes to contracting arrangements between health funds and rehabilitation hospitals, resulting in a lesser range of rehabilitation classes being covered by health insurance, were not adequately disclosed to consumers. The Commission is concerned that consumers are well informed about changes affecting the extent of their insurance cover. As indicated in chapter 9, it may be misleading by silence not to inform consumers of such changes.

10.6.2 Non-PBS drugs

APHA raised the issue of benefits for non-PBS drugs. APHA states that:

> A serious problem arises when a patient's insurance includes cover for non-PBS drugs and where the hospital's HPPA allows for the separate charging of drugs. As each fund determines pharmaceutical benefits on a patient –by – patient basis, there is little guidance to a member and the hospital as to whether or not cover for certain drugs is included in any particular insurance product.

APHA recommends the establishment of a standard schedule of benefits payable by health insurers for high cost drugs not listed on the Pharmaceutical Benefits Scheme.

This proposal, however, would be likely to breach the price fixing provisions of the Act, if it involves funds agreeing on the price to be paid for non-PBS drugs.

10.6.3 Front-end deductibles (FED)

APHA points out that the responsibility for collecting payment for front-end deductibles (FEDs) rests with the hospital. The hospital is responsible for administering a health fund marketing initiative and is solely responsible for any ensuing bad debts. A health fund cannot deduct FEDs from amounts payable by the fund relating to an in-patient medical claim.

APHA indicated that:

> APHA will be seeking to have the determination amended to reflect recent changes to insurance products that allow above Commonwealth Medical Benefits Schedule payments to be made to medical practitioners. Under these new arrangements it is unreasonable to expect that hospitals should continue to be solely responsible for collecting FEDs from patients and/or face the cost of increasing bad debts arising from unrecoverable FED payments.

10.7 Compliance programs

Effective compliance programs are also important for the hospital sector. A good compliance program reduces hospitals' risk of breaking the law.

The Australian Standard on Compliance Programs AS 3806 provides some useful benchmarks in achieving effective compliance. The standard sets down performance criteria for the operation, structure and maintenance of an effective compliance system, and gives guidance on how to achieve this. The standard also recognises that the application of the basic concepts will be different for small businesses.

11 Medical practitioners

11.1 Contracting with health funds

11.1.1 The medical gap

The medical gap is the difference between fees charged by medical practitioners for in-hospital medical services and the combined benefits from health insurance and Medicare.

The Council of Procedural Specialists provides the following statement in its submission to explain the existence of the medical gap:

> Doctors charge fees which they believe accurately reflects the value of their service, and each individual doctor must determine his/her fee with the patient.
>
> A 'gap' may occur when an insurer either deliberately or through lack of knowledge of the real value of the service seeks to under reimburse a patient, hence causing the patient to meet the difference from their own pocket. This has been the case with Medicare over several years, as patients' rebates have not kept pace with movements in the consumer price index or more relevantly, movements in average weekly earnings.

Medical practitioners, as with all businesses, are free to set their own level of fee. However, medical practitioners, particularly specialists, operate in a market with considerable barriers to entry, in particular restrictions on training numbers, and limited information available to consumers. These elements restrict competition and are likely to result in higher fee levels than would otherwise be attainable in a more competitive environment (see s. 11.2 below).

11.1.2 The medical gap and private health insurance participation rates

Member surveys conducted by health funds and included in submissions have clearly indicated that the medical gap is a major consumer concern and a key reason for public dissatisfaction and subsequent decline in the private health insurance sector.

HCF in their submission at p. 7 state:

> Research has established a clear link between the medical gap and the decline in the number of people with private health insurance. It has a major effect on both the take up and retention of health insurance and as a consequence, the demand for private hospital and other private health care services.

HCF quote the following from an Industry Commission Report:

> The attractiveness of private health insurance has been diminished by unpredictable out of pocket expenses….and is compounded by the uncoordinated proliferation of doctors bills.

HCF further quote from TGA research — 'Health Care and Insurance Australia', October 1999 as follows,

> The gap problem has become significantly greater over the last two years….out-of-pocket expenses were perceived to be predominantly due to doctors/specialists bills (87 per cent) followed by hospital accommodation (17 per cent).

Complaints to State and Territory health complaints bodies also show that consumers are concerned about medical gap payments.

The Queensland Health Rights Commission indicated that:

> Nine to ten calls received by this Commission concerning the cost of treatment are by complainants annoyed at having out of pocket expenses for private treatment. In many cases, the complainant has received a bill that is well above the scheduled fee. Even though the complainant may have top level private health insurance, they are still required to pay a large gap between the scheduled and charged fee.

Similarly, the WA Office of Health Review stated that:

> Of the cost-related complaints dealt with by this Office, where private health matters arise as part of the issue, it is plain that the Gap payment is of major concern to consumers.

Finally, the Private Health Insurance Ombudsman indicated that one of the major areas of complaints to his office against the current system relates to the apparent failure of health funds to be able to provide medical gap insurance for in-hospital episodes.

A more detailed analysis of the quantum of the gap is at chapter 8 of this report.

11.1.3 *Private Health Insurance Incentives Act 1998* (PHIIA)

As part of the measures to increase the participation rate in private health care, the Parliament passed the Private Health Insurance Incentives Act. This legislation provided for the 30 per cent rebate on private health insurance. It also required all health insurers who wished to offer the rebate as a premium reduction to have established no/known gap products by 1 July 2000.

Medibank Private stated in its submission that:

> The PHIIA has, by its mandatory overtone, essentially put providers into a position of increased bargaining power, almost to the level of extortion, when in fact it is the providers who have presented the greatest obstacles to the introduction of such products. For the negotiation regime to be effective there needs to be a balance between funds and providers. The imbalance needs to be addressed (possibly through legislation) to the extent that it is preventing the objectives of the Harridine Amendment from being met.

The Australian Health Insurance Association at p. 2 of their submission state:

> One of the difficulties facing the Parliament and the industry on this issue is the fact that Commonwealth powers over medical matters are largely confined to control of insurance. This means that while Parliament can legislate to force health funds to take certain action, it is less able to force medical practitioners to act. […]In the current environment health funds are to be punished if they do not provide products, but no punishment or threat is made against those who determine the level of gaps: medical practitioners.

11.1.4 Medical practitioners' opposition to contracts

Many doctors are, in principle, firmly opposed to the entering of contractual arrangements with a third party in relation to services they provide to patients. Despite safeguards, they fear there is a risk that the fund will interfere in the doctor/patient relationship, eventually leading to the fund directing the types of treatment to be provided to patients.

The AMA has been totally opposed to health funds contracting doctors and private hospitals, claiming that contracting would lead to US-style managed care. The AMA in its submission states:

> The AMA has supported gap insurance although it has opposed its provision through individual Lawrence style contracts.[58]

The Commission notes, however, that the Australian Society of Anaesthetists (ASA) does not appear to have the same philosophical objection to contracting as other sections of the medical profession. In its application for authorisation, the ASA submitted that anaesthetists are currently unwilling to negotiate MPPAs with health funds because of the perceived inequity in negotiating positions. In addition, at the pre-decision conference held following the release of the Commission's draft determination, representatives of the ASA stated that they are not implacably opposed to such contracts.[59]

It should also be noted that over 1600 providers in South Australia and Victoria are now using AXA's Ezyclaim. This scheme is successfully delivering no-gap cover to over 9000 patients a month. The Commission is not aware of any concern by doctors participating in this scheme about actual or potential interference with their clinical independence.

The AMA's opposition to contracts has been actively promoted to AMA members. In its submission, Medibank Private makes the following comment on the issue:

> It is a matter of substantial concern to Medibank Private that trusted and influential bodies such as the AMA can engage in conduct which, in a literal sense, may be viewed as misleading and deceptive. Under the current regimes for entering into HPPAs and MPPAs, it is mandatory that providers have clinical independence, which is the antithesis of Managed Care.

MBF indicated that:

> In the early stages of the tender process, the Australian Medical Association Queensland Branch waged a strong public campaign against MBF in the media and via some providers in their rooms using an emotive poster and other literature.
>
> While the MBF Network tender was ostensibly the target of this campaign its real focus was the tender's link to the establishment of medical gap cover arrangements. This was inaccurately portrayed by AMAQ as an example of US-style managed care, the catch-all slogan developed to resist change within the private health system.

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[58] That is, medical purchaser-provider agreement (MPPA), as set out in the *National Health Act*.

[59] ACCC, *Application for Authorisation, Australian Society of Anaesthetists*, 8 October 1999, p. 27 and Australian Society of Anaesthetists (2000) ATPR (Com) 50-278 at p. 53,408.

MBF also made the following comments in relation to providers generally:

> It is not surprising that MBF has encountered very strong resistance from some quarters as the fund has moved to become a discerning purchaser of quality health services on behalf of its members and to be able to offer members the financial certainty of medical gap cover.
>
> Those who have opposed these desired changes are unlikely to view their positions as being anti-competitive in nature. They would more likely regard their actions as defending the status quo, their own positions in the system and the tired practices of more than half a century.

The Commission has received a complaint that the information given by the AMA to doctors that 'contracting equates with the introduction of managed care' is misleading and deceptive and is a breach of s. 52 of Act. The Commission took legal advice from senior counsel on the complaint and was advised that the AMA was not in breach of the Act in its actions. However, the Commission would examine any such complaint on a case-by-case basis.

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. The Commission is unaware of any such action. Competing doctors for their part are able to make a unilateral decision not to enter into contracts. Competing doctors are not permitted under the Act to collectively **agree** not to sign contracts. The Commission is not aware of any collective agreements among doctors not to sign contracts.

The claim that contracting would lead to managed care has been persistently made by medical practitioners and their associations despite the legislative requirement that contracts contain a clause ensuring clinical independence. The Department of Health and Aged Care in its submission stated:

> Health Funds are currently working hard to introduce no/known gap schemes to meet this requirement. A major problem has been opposition from the official representatives of doctors to the idea of practitioner agreements with funds and hospitals, who claim that such agreements threaten the clinical independence of doctors. In response to these concerns, legislative changes were made in April 1998 to ensure that clinical freedom is maintained at all times during the agreement process.

Under the National Health Act, a medical purchaser provider agreement (MPPA) must require the health fund 'to maintain the medical practitioner's professional freedom, within the scope of accepted clinical practice, to identify appropriate treatments in the rendering of professional services to which the agreement applies.'[60] A similar requirement exists in relation to practitioner agreements.[61]

In line with this requirement, health funds have also indicated to the Commission that their contracts expressly include a clause regarding the clinical independence of medical practitioners.

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[60] Section 75BDA of the National Health Act.

[61] Section 73BDAA of the National Health Act.

Other submissions also suggest that some form of contracting between health funds and medical practitioners would not necessarily lead to managed care or be detrimental to consumers.

For instance, the Health Rights Commission notes that:

> Whilst the proposal of health funds to dictate terms through managed care could be perceived as anti-competitive behaviour, it is our experience that most members of private health funds appear to favour a no-gap form of insurance.

The Ombudsman notes the medical practitioners' public position that contracting must ultimately lead to professional judgements being taken away from practitioners and placed in the hands of the health funds. However, the Ombudsman also stresses that:

> This is clearly not envisaged by the legislation nor sanctioned in any way. This office would campaign on behalf of consumers to ensure this situation did not arise.[62]

The Ombudsman suggests a possible solution to address medical practitioners' concern with regard to contracting:

> It would seem to be a short step to have the medical fraternity agree on a set of words which enshrined safeguards into the pre-amble of a contract which provides for the absolute medical discretion within college acceptable standards.

The Commission is of the view that this proposal has merit worth pursuing.

At the pre-decision conference held following the release of the Commission's draft determination on the Australian Society of Anaesthetists (ASA), the Ombudsman also submitted that the ASA could send its members information relating to matters which need to be considered when negotiating a MPPA.[63]

The Commission agrees that associations could provide guidance on the negotiation process to their members to ensure they consider all the relevant issues pertaining to contracts, including clinical independence.

11.1.5 Health Legislation Amendment (Service Delivery Schemes) Bill

The Government has introduced the Health Legislation Amendment (Service Delivery Schemes) Bill in the Autumn Session of Parliament. This Bill effectively allows health funds to insure the gap without a contract with the provider in place, the preferred AMA position. Currently the gap may be covered by a health fund only where the provider of the service has a formal contract with the fund.

The Bill provides an alternative non-contract option to the existing contract option and will give funds scope to devise schemes that may be more acceptable to both the AMA and individual doctors as it overcomes the AMA opposition to contracting.

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62 Private Health Insurance Ombudsman, *Quarterly Bulletin*, No. 13, October to December 1999.

63 Australian Society of Anaesthetists (2000) ATPR (Com) ¶50-278 at p. 53,412.

The Bill expressly provides that the Act applies to gap cover schemes. In putting these schemes together, health funds, competing hospitals, competing providers and their associations will therefore need to be mindful that their conduct is in compliance with the requirements of the Act.

A health fund can hold discussions or consult on an industry wide or group basis and then make its own independent decisions about the terms and conditions of its gap cover schemes. However, the parties with whom the health fund consults or holds discussions must ensure that they do not reach a collective agreement with each other on matters which may be anti-competitive including the fees for the services they provide to the members of the health fund.

11.2 Competition in the medical sector

In the Commission's view there have been several areas which have generally raised competition concerns for professionals and their associations.

Many of the restrictions applying to the professions have inhibited competition in two ways: through their effects on the structure of the relevant professional sector and on the conduct of professional practitioners.

Structural restrictions of professional sectors include those which:

- regulate entry into the sector;
- define the field of activity reserved for licensed or certified professional practitioners;
- separate the sector into functionally discrete professional activities (including those performed by accredited specialists); and
- impose restrictions on the ownership and organisation of professional practices.

Conduct restrictions include those which:

- set a price floor for the fees professionals may charge or require the application of recommended fee scales for particular professional services;
- prohibit certain kinds of advertising or other promotional activities by professional practitioners; and
- specify or use professional and ethical standards to be observed by, and disciplinary procedures to apply to, professional practitioners in an anti-competitive way.

These restrictions may constrain the commercial and competitive conduct of professionals and limit the choices available to consumers. Where such restrictions are imposed by the self-regulation arrangements of professional associations, contraventions of the Act may be involved in some cases.

However, the Act recognises that competition may not always deliver greater consumer welfare, and that certain conduct restricting competition may have net benefits to the public. For this reason, the Act allows the Commission to authorise some form of anti-competitive conduct, where the total public benefits of the conduct outweigh the detriment caused by the anti-competitive process.

The Commission considers that the concept of public benefit is capable of wide interpretation. Many of the benefits the Commission has accepted over the years relate to increased efficiency of operation, and can be regarded as broadly economic benefits. However, the Commission has also accepted a range of non-economic benefits such as improvement in health and safety, avoiding conflicts of interest and provision of equitable dealings. In a sense, such benefits are less tangible than economic benefits and seem less easily demonstrated. Nevertheless they are real benefits and, in the appropriate circumstances, are no less important in the authorisation process than economic benefits.[64]

The Commission is certainly willing to work constructively with professional associations generally, and in particular those in the health sector, to deal with such issues.

As mentioned earlier, the specialist medical sector is characterised by high barriers to entry and limited information available to consumers, which restrict the extent of competition in this sector.

11.2.1 Barriers to entry

There are high barriers to entry into the markets for the provision of specialist medical services. Because of public health and safety issues, the markets for the provision of specialist medical services are naturally not open to anyone — there are qualification and training requirements placed on these providers and registration requirements imposed by State and Territory Medical Boards. It should be noted that with the adoption of the competition principles agreement, States and Territories have undertaken reviews of anti-competitive restriction in their legislation, including registration of medical practitioners. The Commission has no formal role to play in this legislative review process.

However, restrictions to competition go beyond this. Indeed, entry into medical specialties is further restricted by the fact that some of the specialist colleges, who have responsibility for medical specialist training in Australia, are only providing a limited number of advanced training positions in each specialty.

The Productivity Commission notes that:

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[64] A discussion of 'public benefits' under the Act and in particular what the ACCC has accepted as constituting non-economic public benefits can be found in Sitesh Bhojani, "Public Benefits under the Trade Practices Act" in *Can the professions survive under a national competition policy?*, proceedings of a joint conference on competition law and the professions, Perth, April 1997.

> The colleges set numbers of places having regard to such things as indicative specialist to population ratios and the availability of training places in teaching hospitals. There are also restrictions on the accreditation of specialists trained in other countries.
>
> There are several rationales for these controls on supply, including to*:*
>
> - Ensure that specialists are appropriately qualified and trained;
> - Balance the number of trainees with the capacity of teaching hospitals to provide the necessary practical training; and
> - Guard against problems with over-servicing of patients, or so called supplier-induced demand.[65]

The Productivity Commission further reported that there have been longstanding concerns that some of the colleges have unduly restricted supply to increase specialists' incomes and general bargaining power.[66]

HCF indicated that it shares these concerns about colleges unduly restricting the supply of specialists.

The Productivity Commission concluded that:

> From a policy perspective, more research on supplier-induced demand seems particularly important. As well as providing a major rationale for arrangements that have the potential to indirectly increase the cost of hospital services, the theory of supplier induced demand influences policies in a number of other health care areas.[67]

The Commission is currently investigating the Royal Australasian College of Surgeons (RACS) and the Australian Orthopaedic Association (AOA) to establish whether their conduct in determining the number of training positions available for specialist training in orthopaedic surgery is in breach of s. 45 and/or s. 46 of the Act.

As indicated in chapter 4, the Commission appreciates that the issue of restrictions placed on trainee numbers is complicated by government funding constraints, the availability of suitable hospital posts and government medical workforce planning policies.

Indeed, the Australian Health Ministers Advisory Council (AHMAC) established the Australian Medical Workforce Advisory Committee (AMWAC) in 1995 to advise on national medical workforce matters including workforce supply, distribution and future requirements. AMWAC has been given terms of reference to review the medical specialties where there are current or expected shortages of supply and to make recommendations to AHMAC to address those shortages.

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65 Productivity Commission, *Private Hospitals in Australia*, December 1999, pp. 115 and 116.

66 ibid.

67 ibid.

Over the period April 1995 to August 1999, AMWAC has completed 13 specialist workforce reviews. These reviews have shown a diverse range of trends across disciplines, but the overall trend has been a need for more specialists.[68]

The Commission understands that many colleges reviewed by AMWAC have increased the numbers of trainee positions by at least the quantum recommended by AMWAC, while other colleges' implementation of AMWAC recommended increases in training numbers has been more limited.[69]

It is important to note that irrespective of any AMWAC recommendation, colleges may be in breach of the Act if they are limiting trainee numbers for anti-competitive purposes or their conduct has anti-competitive effects.

As indicated in chapter 4, some colleges have argued that there are some public benefits in imposing restrictions on entry to advanced medical and surgical training. This may well be the case; however, this is not relevant when determining whether a college may be in breach of the Act, absent authorisation. It is only through the authorisation process that the public benefit can be taken into account by the Commission. The authorisation process involves a public process of assessment. Conduct would be authorised if the Commission is satisfied that the public benefits outweigh any anti-competitive effect.

Overseas trained specialists also face great difficulties in having their qualifications and experience recognised. Over the last few years, the Commission has received a large number of complaints from overseas-trained specialists whose specialist training, qualifications and/or experience have not been recognised by the relevant college, and therefore are unable to practice in their chosen specialty in Australia.

As indicated in chapter 4, the Commission is investigating whether the conduct of the Royal Australasian College of Surgeons (RACS), in failing to recognise qualifications, training and experience of particular overseas-trained surgeons, could constitute a breach of the Act.

11.2.2 Access to hospitals

In its submission HCF notes that:

> In the medical community, medical specialists are generally appointed to more than one facility and a significant concentration of power may occur in particular specialties such as cardiothoracic surgery, orthopaedic and neurosurgery.

HCF indicated that specialist appointments to three Sydney hospitals, St Vincent Private, Mater Misericordiae and the Sydney Adventist Hospital, significantly dominate these specialties in the Sydney Basin market. HCF analysis further revealed that:

- around 15 per cent of doctors in any specialty actively admit patients to two or more of these hospitals; and

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[68] Australian Medical Workforce Advisory Committee, *Annual Report 1998-99.*

[69] ibid.

- the cross appointments of these specialists with other private hospitals means these doctors provide 40 per cent to 100 per cent of the total services funded by HCF in NSW for these specialties.[70]

HCF believes that this market concentration vests a dominant market position in this group of doctors. HCF is also of the view that:

> Through their University teaching roles and appointments to Colleges and Associations a small number of doctors may wield a significant power within the industry.

As mentioned earlier, s. 46 of the Act does not prohibit market power, but rather taking advantage of that power for one of the proscribed anti-competitive purposes, which are:

- eliminating or substantially damaging a competitor;
- preventing the entry of a person in any market; or
- deterring or preventing a person from engaging in competitive conduct in any market.

Section 45 of the Act also prohibits agreements that have the purpose or effect of substantially lessening competition in a market, as well as agreements containing an exclusionary provision (primary boycott).

The Commission has investigated several complaints by medical specialists alleging that a group of competing specialists in hospitals are denying them access to these hospitals in breach of one or more of the above sections of the Act. The Commission has not found sufficient evidence to date to take the matters to court. However, this is a matter of importance and the Commission will give priority to the investigation of any such complaints.

Some specialists have also alleged that they were denied appointment to hospitals due to their non-membership of the relevant college and/or society. As mentioned in chapter 4, the imposition of either criterion may constitute third line forcing.[71] Following an investigation, the Commission obtained changes to the advertisement of hospital positions from a requirement for applicants to be Fellows to the use of the phrase 'Fellows or equivalent'.

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[70] HCF indicated that its analysis was based on fees charged by doctors to private hospital patients in NSW and the ACT for the 12 months to October 1998. The four high cost specialties reviewed were cardiothoracic surgery, obstetrics, orthopaedics and neurosurgery. HCF also considered renal dialysis.

[71] Third line forcing involves the supply of goods or services on the condition that the purchaser acquire goods or services from a particular third party, or refusal to supply goods or services because the purchaser will not agree to that condition.

11.2.3 Consumer information

In order for consumers to make an informed choice 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. However, information to allow informed choice on quality and price is not readily available to consumers.

In that regard, HBF notes that:

> With respect to fees members have expressed surprise and concern at the idea that a doctor will charge different patients different amounts for the same procedure. Patients are frustrated that there is no information against which they can judge whether the fee is reasonable or how it compares with fees charged by other doctors.
>
> Similarly with respect to qualifications, experience or quality of outcomes there is no information generally available other than "reputation". It would appear that this lack of information does indicate that the health area does not operate as with many other industries. In particular consumers are very often poorly informed. This lack of information does make resolutions of the medical gap particularly difficult to implement.

The ability of consumers to make informed choices about treatment options and providers is one of the most effective ways of enhancing competition and consumer welfare in the health care sector. For this however, consumers need comparative information on price and quality of a range of practitioners. In particular, consumers are disadvantaged by the lack of pricing information.

Historically, professional associations have contributed to the lack of pricing information by imposing restrictions on advertising by their members. Some practitioners had even been threatened with disciplinary action by their professional associations for 'unprofessional conduct' for simply advertising the fees they charged. This attitude regarding disclosure of fee information was not restricted to the health professions, but was widespread across all professions.

However, the environment in which professionals operate has changed. In many professions, disclosure of fee information to consumers has become a requirement of all ethical professionals. For instance, much State and Territory legislation regulating the legal profession requires legal practitioners to disclose costs to consumers, and failure to do so could be categorised as professional misconduct.[72]

More particularly, the whole debate about community dissatisfaction with unexpected medical gaps and the need for no or 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.

Advertising

The Commission is of the view that advertising can be a way of providing some quality and price information about medical services and providers needed by consumers,

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[72] See for example the NSW *Legal Profession Act 1987*.

although it is not necessarily always the only or most effective vehicle. However, advertising that is inaccurate, misleading or deceptive does not assist consumers in making informed decisions. While the Commission is keen to see factual information provided to consumers, it is of course imperative that the information provided is honest, accurate and complete. That is, advertising of medical services must comply with the provisions of the Act and the State and Territory Fair Trading Acts.

Each State and Territory has legislation to regulate the health sector and the conduct of medical practitioners in that sector. Traditionally, regulation of the medical profession has included strict controls on advertising and promoting medical services. However, as part of the implementation of the National Competition Policy, State and Territory Governments have reviewed, or are reviewing, these and other restrictions for anti-competitive effects. Where anti-competitive effects do not have countervailing public benefits, National Competition Policy requires the restrictions to be phased out. The Commission has no formal role in this process. Its only involvement has been to provide submissions to assist particular governments when requested to do so.

In many States recent changes to the law have relaxed some of the previous restrictions, giving professionals much wider opportunities to advertise their services. The transition to this new environment appears to have created some problems, and members of the community, regulators and medical professionals have raised concerns.

The Commission is aware of some renewed pressure to strictly re-regulate advertising in the medical sector. However, the Commission has some genuine concerns about restrictions on advertising that extend beyond the restrictions contained in the Act and the State and Territory Fair Trading Acts.

Restrictions on advertising have often required the application of subjective criteria, which in practice may be used to, or have the effect of, inhibiting information promotion by medical practitioners and become an anti-competitive tool. Typical restrictions would include that advertising should not:

- be vulgar or sensational;
- claim or imply that any particular medical practitioner is superior to another or other medical practitioners; or
- be unprofessional or likely to bring the profession into disrepute.

Three interpretation problems are common with such restrictions. First, there may not be an accepted community understanding of what amounts to a contravention of these restrictions. Secondly, there is no guarantee that the profession's interpretation of such requirements is the same as the community interpretation. Thirdly, there is no guarantee that there will be a consistent understanding among a profession about what the restrictions mean.

The vagueness of subjective advertising restrictions also makes consistent and fair enforcement difficult. Such restrictions and their application need to be interpreted to particular examples. It will often be the relevant industry association which will assess compliance. In that case, the subjective criteria may act as barriers to competition,

particularly as established medical professionals may not welcome the introduction of other practitioners with a different approach to promoting or marketing their services.

In addition, restrictions on advertising have often been very prescriptive. In some States, medical rules have required advertisements to be of a particular size, using particular typeface, and including only certain information. The Commission is of the view that such restrictions are very costly to enforce without providing benefits to consumers proportionate to those costs.

Restrictions have also applied to the medium by which advertisements for medical services could be made, for example prohibiting medical practitioners to advertise their services by television or radio.

Restrictions on the form and content of advertising material beyond the prohibitions in the Act may prevent consumers from receiving useful information about particular health services and practices. Such restrictions also make an unnecessary paternalistic assumption that everyone in the community effectively receives and understands information from the same form or medium of advertising.

Misleading or deceptive conduct can be far broader than just advertising. Even if advertising for medical services was restricted, there would still be problems with misleading or deceptive oral representations (for example, during a consultation).

Restricting advertising does not prevent misleading or deceptive conduct by unethical practitioners, but it does prevent ethical practitioners informing consumers about their services and others from informing consumers about medical services and practitioners.

Finally, health services are now widely advertised over the Internet. Even if restrictions on advertising of medical services were imposed in one State, this would not prevent consumers from viewing advertising, from practitioners based in another State. Authorities in the former State will have little control over this advertising.

As mentioned above, historically, professional associations have also imposed restrictions on advertising by their members in codes of conduct and other by-laws. Codes of conduct which impose restrictions on advertising, may be at risk of breaching s. 45 of the Act. The Commission has had discussions with many medical practitioners' associations or societies on this and other aspects of their codes. The Commission has investigated, and will continue to investigate, any complaint by medical practitioners about restrictions imposed by professional associations on their ability to advertise.

Role of health funds

From their claim records, health funds have extensive information about the charging practices of a range of practitioners. However, most health funds choose not to provide it to members.

HCF, however, has published the *HCF Medical Charges Survey 1998*, to inform its members, service providers and industry bodies about the level of medical gaps that a patient is asked to pay. HCF states that:

> While price alone does not give an indication of quality, we hope this report helps members make informed decisions about all aspects of their treatment, including cost.[73]

However, consumers also need information on the charges of individual specialists before they organise for a consultation. Health funds may be able to provide that information by setting up a database of specialists' fees for their members to access. In doing so, funds would also indicate with which specialists they have no-gap arrangements. Funds may also be able to indicate to consumers at which hospitals individual specialists are able to practice. Conversely, funds could indicate to consumers which specialists practice at a particular hospital and provide information on their charges.

The Australian Health Insurance Association (AHIA) notes in relation to AXA's Ezyclaim that:

> The success of this arrangement will largely depend on consumer and GP education. The more consumers ask, when making an appointment, whether a specialist will accept the health fund gap cover the more likely specialists will be subject to competitive forces.

AHIA further adds that the Commission and Parliament could assist health funds educate consumers to ask at the time of referral whether the doctor will accept a health fund's gap cover proposal.

The Commission agrees that there is a need for consumers to be educated about the existence and benefit of gap cover for medical services. However, the primary responsibility rests with the health funds to inform their members about the availability of their own schemes and provide lists of medical practitioners that are part of those schemes.

Role of professional associations

Professional associations could take a leadership role in helping the community to better understand the services their members provide and how to select appropriate professionals to provide these services.

This could include advertising or other information to general practitioners and/or consumers on what factors to consider when selecting a specialist.

This could also include regularly publishing directories of their members, and including, where individual specialists choose to do so, the fees they charge.This is common in other professional sectors such as the legal profession, where a number of directories of barristers are available for solicitors and even the general public to consult.

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[73] HCF, *The HCF Medical Charges Survey 1998*, November 1999.

11.3 General practitioners

The Royal Australian College of General Practitioners indicated that:

> The College is also concerned that the inability of health funds to offer gap insurance for GP fees is also reducing the attractiveness of health insurance to a large proportion of the community. Whilst it is accepted that the gap for each GP consultation is likely to be only small, those patients with chronic illnesses are likely to require a higher number of services and the inability to insure for the gap is of concern to that section of the community.

The Commission understands that funding was made available in the 1999/2000 Federal Budget to support the establishment of private sector coordinated care trials. The Department of Health and Aged Care indicated that these trials are currently at the approval stage. Some of these trials will involve GPs in the provision of care for elderly and chronically ill private patients. The department indicated that if the outcomes of the trials are positive, it is possible that legislation could be amended to encourage health funds to fund GP services in certain circumstances.

11.4 Compliance programs

Now that medical practitioners and their associations understand that the Act applies to their activities, they must focus on understanding their compliance risks. Professional medical associations can help their members and themselves by putting systems in place to ensure compliance with the Act.

Australian courts have consistently stated that they will take into account the effectiveness of trade practices compliance programs in assessing penalty for breaches of the Act.

One of the best starting points for achieving effective compliance is to refer to the Australian Standard on Compliance Program (AS 3806 – 1998). The standard sets down performance criteria for the operation, structure and maintenance of an effective compliance system, and gives guidance on how to achieve this.

The standard also provides guidance for small business. It recognises that, while some of the basic concepts of compliance are fundamental to any organisation regardless of their size, the method of their application will vary. This may be particularly important given the structure of some professions in the Australian economy.

The Commission has also released a publication, *Corporate trade practices compliance programs*, to assist Australian businesses including those in the medical sector, to achieve effective compliance. The Commission is happy to discuss any trade practices compliance matters with medical practitioners and/or professional medical associations, and to refer them to appropriate sources for specific advice.

12 Allied health practitioners

12.1 Preferred provider arrangements

As indicated in chapter 8, several health funds have introduced preferred provider arrangements with allied health practitioners, which seek to ensure that members have no or known out-of-pocket expenses for ancillary services.

Many allied health practitioners and their associations have expressed concerns that 'preferred providers' or 'participating providers' schemes being developed and introduced by health funds may place restrictions on the treatment to be offered to a patient and therefore may lead to the fund interfering in the clinical decision making of the practitioner.

The Australian Dental Association indicated that:

> Few providers have been attracted to such contract schemes because of restrictions placed on the treatment able to be offered to a patient. There is considerable experience overseas with such schemes and the 'managed care' approach has been heavily criticised. […] Ethical dental practitioners would have some difficulty in participating in an arrangement which encouraged them to deliver less than optimum care for their patient.

The Australian Physiotherapy Association (APA) indicates concerns about the implications of preferred provider arrangements. In particular, the APA is opposed to:

> Agreements between health funds and individual health care providers and/or private hospitals in this country leading to the introduction of managed care arrangements similar to those that apply in the USA where financial imperatives can override access to the best available or most appropriate care.

The Australian Osteopathic Association (AOA) is critical of the introduction by Medibank Private of its preferred provider scheme, Members' Choice. The AOA considers that:

> This product attempts to intercede in the relationship between practitioner and patient. The Association believes that as the purchaser of osteopathic treatment, the patient has the absolute right to choose who should provide that service, where the service is to be provided and how much they are prepared to pay for it.

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.

In that regard, the Australian Physiotherapy Association indicated that:

> We believe that price capping of the kind being promoted by several health funds will work to drive prices below sustainable levels and will affect the livelihood of many of our members. More importantly, we believe that if the price is fixed the number of consultations must be increased to meet the increased costs of running a practice. This would lead to shorter consultation times and less time is permitted to maintain quality of care.

Speech Pathology Australia notes:

> There is little incentive for providers to involve themselves with these types of contractual arrangements due to the set fees not reflecting varying practice costs.

Similarly, the Dietitians Association of Australia indicated that:

> [many DAA members] believe Medibank Private's' recognised fee' significantly undervalues their services and could result in a reduction in the quality of service provided to Medibank Private clients.

In addition, some allied health practitioners and their associations have also expressed concerns about the following aspects of some preferred provider schemes:

- insufficient safeguards provided to protect the confidentiality of sensitive clinical records;
- funds establishing their own disciplinary procedures with regard to inappropriate practice or over-servicing;
- lack of flexibility in charging arrangements for complex or specialty consultation.

A number of individual allied health practitioners and their associations have raised concerns in complaints to the Commission that preferred provider arrangements may breach the Act. It has been alleged that by providing for payment to fund members of a higher level of benefits if members use the fund's preferred providers, these arrangements may contravene the third line forcing provisions of the Act. Some complaints have also raised concerns about possible misuse of market power and/or unconscionable conduct by the funds in putting pressure on individual practitioners to join preferred provider schemes.

In that regard, the Australian Dental Association notes in its submission that:

> Health funds are in a substantial position of strength with respect to their market power. In South Australia, for instance, the health insurance market is almost entirely occupied by two companies, AXA (through Mutual Community) and Medibank Private. It is not surprising that the current attempts to establish preferred provider contract schemes had their genesis in this State.

Finally, several complaints and submissions to the Commission raised the issue that the imposition of a fee for service as part of these schemes may breach the price fixing provisions of the Act.

For example, the Australian Dental Association stated that:

> In reaching agreement with dentists to accept contracts for the provision of services, health funds have conducted meetings with these providers at which the fee levels have been discussed. Given that a set fee level is used in these contracts, it would seem that this could be in breach of the provisions for price fixing under section 45A of the Trade Practices Act.

Section 45A of the Act prohibits agreements between competitors that fix prices. Such agreements are deemed to substantially lessen competition. Collective acquisition of goods or services is exempted from this provision. However, collective acquisition that substantially lessens competition would still be likely to breach s. 45 of the Act.

Based on the information provided to the Commission on existing preferred provider schemes, the funds have not negotiated the maximum fees to be charged with groups of

practitioners. In that regard, a fund can consult practitioners and their associations about the scheme in general, including the fees to be charged to get feedback, as long as the final decision is an independent decision of the fund itself and not an agreement with a group of competing practitioners.

It is important that there is no negotiation between a fund and a group of practitioners as this would be likely to conclude in an agreement between both parties, which would be likely to breach the Act. Practitioners and their associations need to be aware that there is a fine line between discussing or consulting on the one hand and negotiating on the other. Even in respect of discussions or consultations, the group of practitioners with whom the health fund is consulting or holding discussions must ensure that they do not reach a collective agreement with each other on matters which may be anti-competitive such as the fees for the services they provide.

In the schemes brought to the attention of the Commission, the fees set by funds are capped, not fixed. That is, practitioners are free to charge less if they wish. The funds are unilaterally signing up practitioners and even if the contracts are similar for each practitioner, there is no indication of collusion or agreement between the practitioners involved. Individual contracts, even if similar, do not breach the Act if those supplying the services do not collude or agree on the terms of supply.

The Commission has formed the view that the preferred provider schemes it has examined are not caught by the misuse of market power provision of the Act, because the schemes do not have any of the **proscribed anti-competitive purposes** set out in s. 46, which are:

- eliminating or substantially damaging a competitor;
- preventing the entry of a person in any market; or
- deterring or preventing a person from engaging in competitive conduct in any market.

With regard to allegations of unconscionable conduct, the Commission has indicated to complainants that it would look more closely at such allegations, but would require documented case histories from individual practitioners to be able to do so. The Commission was provided with copies of the documentations that a fund had sent to practitioners inviting them to participate in the fund's preferred provider scheme. The Commission did not consider the 'Invitation to Participate' in this particular scheme as being unconscionable conduct in itself.

The Commission sought legal advice on the potential application of the third line forcing provisions of the Act to this issue. Third line forcing involves the supply of goods or services on the condition that the purchaser acquire goods or services from a particular third party, or refusal to supply goods or services because the purchaser will not agree to that condition.

The advice received by the Commission concluded that the arrangements did not contravene the Act. In the Commission's view, the essential reason is that health funds are not offering to provide health insurance contracts to members on condition that members use a preferred provider. Members simply get a higher rebate if they use a

preferred provider. In other words, the degree of compulsion required by ss 47(6) and (7) of the Act is absent because members are free to acquire the services of a preferred provider or a non-preferred provider.

Funds have indicated to the Commission that they are in no way interfering with the professional judgement of the practitioners who participate in preferred provider schemes. Preferred providers are only required to agree not to exceed the maximum fees set out in the funds' fee schedules. In return, the funds provide a higher benefit per service to members, who therefore incur no or less out-of-pocket expenses.

The Commission is of the view that 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 therefore enable consumers to benefit from reduced out-of-pocket expenses. With the introduction of preferred provider schemes, consumers can still access any practitioner, but some practitioners are more competitively priced. The Commission is not aware of any reduction in service quality as a result of the introduction of preferred provider schemes.

During consultations for the preparation of this report, the conduct of the Coalition of Health Professionals was brought to the Commission's attention. The Coalition of Health Professionals was formed in NSW by ancillary health professionals in response to the introduction of Members' Choice by Medibank. In June 1999, the Coalition issued an open letter to all health professionals, indicating that it had passed the following motion in relation to preferred provider agreements:

> The Coalition of Health Professionals is opposed to the policy of development or implementation of 'Preferred Provider' agreements with third party organisations because such agreements seriously threaten the relationship between health professionals and their patients, and as a consequence would seek to reduce the quality of care which is provided.[74]

Medibank Private noted in its submission that:

> There have been trenchant criticisms of our Members' Choice arrangements (and similar schemes of other funds) by certain associations representing ancillary providers, which we believe have no factual basis whatsoever. The associations in question have produced no evidence of the claims they have made, but have persisted with their viewpoints in communications with their members.

The issue has been raised with the Commission as to whether statements and other representations made by associations of allied health practitioners about preferred provider schemes may be misleading or deceptive in breach of s. 52 of the Act. It is a requirement of s. 52 that conduct be engaged in 'in trade or commerce' for a breach of

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[74] Published in Australian Dental Association (NSW branch) Ltd Newsletter, October 1999. The Coalition of Health Professionals includes the Australian Podiatry Association (NSW), Optometrists' Association of Australia (NSW), Australian Dental Association (NSW), Australian Physiotherapy Association (NSW), Private Speech Pathologists Association (NSW), Orthoptic Association of Australia (NSW), Pharmacy Guild of Australia (NSW), Sports Medicine Australia (NSW), Australian Osteopathic Association (NSW), Speech Pathology Australia (NSW).

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. Professional associations need to be mindful of the issue when commenting on a particular scheme or any other commercial product offered by a health fund.

In addition, allied health practitioners and their associations should bear in mind that any agreement between competing providers not to participate in preferred provider schemes would be likely to constitute a breach of the primary boycott provisions of the Act. This means that associations can inform, advise and make recommendations to their members about particular preferred provider schemes offered by health funds, as long as there is no contract, arrangement or understanding between competing providers having the purpose of preventing, restricting or limiting the supply of their services, and no enforcement or disciplinary action to force members to comply with any recommendation made by the association. Practitioners are free to unilaterally decide not to join a preferred provider scheme.

12.2 Registration by health funds

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.

The Dietitians Association of Australia expressed concerns that:

> Health funds often will not allow dietitians who are employed by government or private hospitals part-time or who operate from private rooms attached to a hospital to obtain a provider number.

The Commission has received some complaints about this very issue. However, there is nothing in the Act which requires a fund to register every practitioner. Even if a fund has a substantial market share, s. 46 of the Act (misuse of market power) would only apply to non-registration by a fund, if the conduct had any of the proscribed anti-competitive purposes set out in the provision (as for preferred provider schemes described above).

Funds are concerned that practitioners, who provide health services to their members, meet minimum quality/proficiency standards, and most funds set registration criteria to that effect. Some allied health practitioners, such as physiotherapists or chiropractors, are required under State legislation to be registered with the appropriate board and registration by these boards demonstrate required standards of proficiency. A fund would generally require a practitioner to be registered with the appropriate board in order to be registered with the fund for the payment of benefits.

However, other allied health practitioners, in particular in the complementary health care sector, operate with only limited government regulation or intervention. When there is no registration by State boards to demonstrate a practitioner's standard of proficiency, funds have to set up other recognition criteria to ensure practitioners meet minimum quality/proficiency standards.

For example, in 1998 AXA indicated that it expanded the services available under its naturopathy ancillary benefit. AXA indicated that:

> The introduction of these benefits caused an issue with provider recognition, given that there were no government regulatory controls to use as a guide for such recognition. AXA liaised with recognised industry bodies and Government departments to enable criteria to be set for appropriate provider recognition. These criteria include educational qualifications, course recognition and training levels.

Funds have to ensure that they do not risk contravening the Act when setting up recognition criteria. The Commission has had discussions with several funds regarding their proposal to set up recognition criteria for some allied health practitioners. In that regard, the Commission has indicated to health funds that a requirement for a practitioner to belong to a particular professional association as a criteria for registration by a fund is likely to constitute third line forcing in breach of ss 47(6) and (7) of the Act.

Indeed, a particular association may well require proficiency criteria as a condition of membership. The Commission is certainly very supportive of such quality and proficiency criteria. However, its major concern is that an association would be in a position to control entry to the market, and thus restrict entry for anti-competitive reasons in order to protect the income of its members. In addition, quality practitioners outside the particular association would be forced to become members of that association. The Commission would need to be convinced that the public benefit from such conduct outweighs any anti-competitive detriment to authorise the conduct. To address this issue, funds need to set up proficiency criteria without reference to a particular association.

Practitioners themselves may also seek to address this issue by setting up accreditation boards to evaluate each practitioner in terms of proficiency level. By their nature, such accreditation boards would have the ability to deny accreditation to some practitioners, therefore restricting the ability of those practitioners to compete and risking a contraventions of s. 45 of the Act.

Such accreditation boards may have some public benefits in terms of guaranteeing the practitioners' proficiency; however, the Commission is not entitled to take those benefits into consideration in an investigation or enforcement action. It is only entitled to do so in its adjudication role through the authorisation process. Authorisation provides protection from action by the Commission or any other party for potential breaches of the Act.

Authorisation would only be granted, following a public process of assessment, if the benefit to the public outweighs any anti-competitive detriment. Certainly, accreditation boards could be set up in such a way as to minimise their impact on competition, by including elements such as low cost, transparency of the process, clear and objective proficiency criteria, process outside the control of any one association, and/or an independent appeal process.

The Commission would encourage any group of practitioners and/or their associations considering lodging an application for authorisation of an accreditation board to have

prior discussion with the Commission. It has already had preliminary discussions in that regard with a group of allied health practitioners.

If health funds then only recognised practitioners accredited by such independent boards, it might raise third line forcing issue. However, because of the safeguards discussed above, the conduct would more likely produce net public benefit and therefore be authorised by the Commission.

12.3 Price issues

12.3.1 Practitioners' fees

Many submissions have stressed that practitioners now operate in a free marketplace where fees are set by individual practitioners.

However, the Chiropractors' Association of Australia (National) Limited considers it unreasonable to condemn and restrict the extension of recommended fee schedules as a guide to consumers and all third party payees. The association believes that:

> There is a value of guidance as to cost and fair remuneration. Uncontrolled competition in health care encourages poor practice procedures, discounting and even over servicing because of the need to sustain viable income return.

The Commission has consistently taken a strong stance against 'recommended fee schedules', usually implemented by the circulation of a list of recommended fees, often under the auspices of a trade or professional association.

Many such fee schedule agreements have come before the Commission, and its predecessor, the Trade Practices Commission, for 'authorisation' or informal approval and in the main these have been refused. These refusals are based on the fact that few public benefits flow from such agreements. The Commission considers that one of the inevitable purposes of the issuing of recommended fee scales by an association is that the association expects many of its members, if not all, to follow the recommendation.

In the Commission's experience:

- recommended fee schedules generally cover a substantial number of members who are competitors for the purposes of the Act, and
- recommended fee schedules operating in local geographic areas significantly effect prices in such areas.

The Commission considers that recommended fee schedules are likely to result in a substantial lessening of competition, notwithstanding that:

- the fee agreement consists of 'recommended' or guideline fees only,
- there is no obligation or undertaking to comply with the recommendations made,
- there is no attempt to police or follow up the recommendations made,

- the fees are recommended by an association and some individual members have no direct hand in the calculation of the recommended fees, or

- the prices are recommended by an association on the basis of costing or other calculations by an outside party.

However, associations can assist their members to set their fees independently by publishing costing information and formulas which allow individual members to determine and set their own fee levels, having regard to their actual individual costs and expected level of profit from their individual practice or business.

In addition, associations should assist the public to better understand the nature and value of the services their members provide. This would include providing information on what factors members of the public should consider when selecting an appropriate practitioner to provide services.

The Commission acknowledges that the AMA publishes a recommended fee schedule. However, the evidence to date has shown that this fee schedule is not adhered to by members. However, if this were to change in the future, the Commission would investigate the matter.

12.3.2 Funds' fee schedule and rebates

Several submissions have expressed concerns that fee schedules and rebates offered to consumers are too low.

For example, the Australian Osteopathic Association is concerned that:

> The amount refunded to patients have not kept up with inflation and in no way bear resemblance to the market fees of today…Therefore the patient is severely disadvantaged and all other allied health professional organisations would concur that rebates have not been substantially reviewed in line with CPI for a number of years.

Each fund is free to set its fee schedule, to be used as a reference to calculate rebates at the level it wishes.

With regard to the level of rebates, it is important to note that an increase in the level of rebates may not necessarily benefit consumers, as the provider may also adjust his/her price in line with the change in the rebate level. A fund provided the following example:

> Some years ago we increased our benefit on physiotherapy by $15 per service as this was the gap being paid by members for physiotherapy treatment. Within a short period physiotherapy charges increased by $15. Presumably the physiotherapists were aware that consumers were prepared to pay $15 for the treatment and consequently raised their fees to a level which meant there was a $15 gap.

To ensure funds do not breach the Act, they should unilaterally set up the prices at which they will acquire services from allied health practitioners. If a fund were to negotiate and agree its schedule of fees with a group of practitioners and or their associations, the latter would be likely to contravene the price fixing provisions (s. 45A) of the Act, and the fund would be at risk of having induced that contravention

or being knowingly concerned in that contravention. This would also expose the fund to serious liability under the Act.

A fund may also be at risk of contravening the Act if it agrees on its fee schedule with other funds. However, particular collective arrangements by health funds may, in some limited circumstances, be exempt from the per se price fixing provision (s. 45A) of the Act. Indeed, the conduct of health funds, the **acquirers** of goods and services, if they jointly negotiate, falls within the 'collective acquisition' exception to s. 45 (A) provided in s. 45A (4)(a), but still comes under consideration in the general s. 45 anti-competitive agreements section. Therefore, a significant number of health funds attempting to effect such a collective acquisition of ancillary services would be likely to breach the Act.

In that regard, the Australian Dental Association expressed concerns that:

> There might be a significant grouping of health insurance funds in setting both their fee scales and their level of rebates, rather than these being set "in the market place", as are dental fees in general. The Australian Health Insurance Association (AHIA) is a significant and influential group which includes some of the larger companies. While we do not have evidence of collective agreements in this regard by the AHIA, it is important that this area be monitored.

To date, the Commission has received very few complaints about this issue and has not found any evidence of such agreements between funds. However, this issue is one that will continue to be monitored.

An issue has been raised with the Commission regarding some funds still referring to practitioners' 'recommended fee schedules'.

Speech Pathology Australia indicated that:

> Speech pathologists are no longer able to produce recommended schedule fees however clients report health fund counter staff suggest speech pathologists are charging 'above recommended schedule fee' – whose schedule is being referred to?

Funds are free to set their schedule of fees on whatever basis, provided they do not agree with other funds or with groups of providers. If a fund bases its fees on an old recommended fee schedule which is no longer used by the practitioners because the prices do not reflect the current level of remuneration, then there is no agreement between competitors on prices. Rather, the fund has decided unilaterally to use an old price list on which to base its current fees.

Even though several funds use the same old fee schedule, there would not be a breach of the Act unless the funds agree to use that particular fee schedule.

12.4 Competition between providers

The Act prohibits competitors from colluding or taking joint actions that are anti-competitive, in particular the Act prohibits a group of practitioners agreeing not to deal with other practitioners or group of practitioners.

A few years ago the Commission investigated allegations of a boycott of chiropractors by the Australian Medical Association (AMA) after receiving many complaints on that issue. In essence, it was alleged that the AMA sought to stop its members associating in any way with chiropractors. In particular, these complaints alleged that AMA policy prohibited:[75]

- medical practitioners who are members of the AMA referring patients to chiropractors;
- medical practitioners who are members of the AMA sharing premises or practices with chiropractors;
- medical practitioners who are members of the AMA working alongside chiropractors in hospitals or other institutions where workplaces are shared by varied medical disciplines; and
- medical practitioners who are members of the AMA engaging in research work with chiropractors.

The Commission contacted the Federal, State and Territory branches of the AMA to ascertain whether any of those bodies still had policies or engaged in practices that would have the above effect. All branches advised the Commission that they had no policy prohibiting or discouraging members from dealing with chiropractors. According to the AMA branches, individual members were free to decide whether or not they form a professional association or alliance with chiropractors.

The Commission was concerned that many medical practitioners may not be aware of the AMA's actual position on this issue. The Commission therefore published an article in the *ACCC Journal*, to help educate the medical sector in that regard.[76] The Commission would examine any allegation of boycott activity that comes to its attention.

Some allied health practitioners have expressed concerns about the way products are designed, including limits on benefits to be paid for particular services, and that it may place some practitioners at a competitive disadvantage.

The Chiropractors' Association of Australia indicated that:

> Considerable disparity exists in the level or percentage benefit received by consumers for the same or for similar services performed by different health care professions. […] A particular fund's right to vary its insurance product as a legitimate competitive ploy is appreciated. However, when this freedom creates significant variation between like or competitive health services, such as chiropractic and physiotherapy, it then creates a distinct competitive advantage to one particular profession.

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[75] The background to this issue, including AMA policy, can be found in 'The AMA and chiropractic: a trade practices viewpoint', *ACCC Journal*, No.16, pages 7 to 11.

[76] ibid.

The Dietitians Association of Australia is concerned that several funds are offering packages that do not include dietitians but include other disciplines such as naturopaths and chiropractors.

Individual health funds are free to unilaterally design ancillary benefit covers as they see fit, including the nature of services to be covered and any limitations on benefits. The Government does not interfere in this area, and this policy is reflected in the fact that there is no specific provision in the health insurance legislation relating to ancillary tables other than a requirement that they be community rated.

It is important to bear in mind that funds have to develop products that are attractive to consumers as well as sustainable in price. Products are designed to provide a reasonable level of cover to most consumers.

Commercial decisions by health funds whether or not to include particular services within their ancillary tables, and the limits on those services, do not raise trade practices issues. Provided such decisions are made unilaterally by individual funds and not for any of the anti-competitive purposes proscribed under s. 46 of the Act.

The Association of Massage Therapists raised concerns at the different treatment of naturopaths, acupuncturists and herbalists (Traditional Chinese Medicine) on the one hand, who are provided with an exemption from the GST, and massage therapists on the other hand, who do not benefit from the same exemption. The association indicated that a third of naturopaths hold some form of massage qualifications and in many naturopathic practices, massage therapists and naturopaths work side by side commonly treating the same patients. The association is concerned that a massage treatment will be GST exempt if it is provided by a naturopath, while the same treatment on the same patient at the same clinic will not be GST exempt, and thus will be more expensive, if it is provided by a massage therapist. The association concluded that:

> The government through this decision has discriminated against Massage Therapists making it difficult for them to compete on an equal basis in an open market place as they have been relegated to the status of Non Health Professional.

The Association of Massage Therapists is also concerned that health funds, which have recognised massage therapy as part of their ancillary benefits over the last 2–3 years, may receive a similar message, that is Government no longer sees massage as a health service.

12.5 Consumer information

In order for consumers to be able to make an informed choice about purchasing a particular health service from a particular provider, consumers need reliable information about the proposed service or procedure and the provider, quality and price.

12.5.1 Advertising

The Commission believes that advertising can be a way of providing some quality and price information needed by consumers, although it is not necessarily always the only or most effective vehicle. However, advertising that is inaccurate, misleading or deceptive does not assist consumers in making informed decisions. While the Commission is keen to see factual information provided to consumers, it is of course imperative that the information provided is honest, accurate and complete. That is, advertising of health services must comply with the provisions of the Act and the State and Territory Fair Trading Acts.

Some allied health practitioners are regulated by State and Territory legislation. Such legislation may contain restrictions on advertising. These restrictions are therefore beyond the reach of the Act. It should be noted that with the adoption of the Competition Principles Agreement, State and Territory Governments have undertaken or are undertaking reviews of anti-competitive restriction in their legislation. A number of those reviews in the health sector are currently under way or have been completed. The Commission has no formal role to play in the legislative review process.

Historically, professional associations have also imposed restrictions on advertising by their members in codes of conduct and other by-laws. Codes of conduct which impose restrictions on advertising may be at risk of breaching s. 45 of the Act. The Commission has had discussions with many practitioners' associations on this and other aspects of their codes. It has investigated, and will continue to investigate, any complaint by practitioners about restrictions imposed by professional associations on their ability to advertise.

Recent changes in laws have relaxed many of the previous restrictions, giving practitioners much wider opportunities to communicate directly with consumers to help them make more informed decisions. The transition to this new environment appears to have created some problems and members of the community, regulators and health professionals have raised concerns. As indicated in chapter 4, the Commission has received complaints about misleading and deceptive conduct with regard to advertising and other promotional activities by health practitioners, which led to the Commission taking enforcement action in this sector.

These problems have also shown that there was a lack of understanding by some health professionals of the requirements of the Act, now the main regulatory instrument in relation to advertising and promotional activity in the health sector. As indicated in chapter 4, the Commission, in conjunction with the NSW Health Care Complaints Commissioner, has produced a draft guide to the promotion of medical and health services to provide guidance for health practitioners to develop strategies that will improve compliance with the Act.

12.5.2 Price information

As indicated in chapter 11, historically, professional associations have contributed to the lack of pricing information by imposing restrictions on advertising by members, as indicated above. Some practitioners had even been threatened with disciplinary action by their professional associations for 'unprofessional conduct' for simply advertising

the fees they charged. This attitude regarding disclosure of fee information was not restricted to the health professions but was widespread across all professions.

The environment in which professionals operate has changed. In many professions, disclosure of fee information to consumers has become a requirement of all ethical professionals.

More particularly, as indicated in chapter 11, the whole debate about community dissatisfaction with unexpected gap payments and the need for no or known gap private health insurance products highlights the importance members of the public place on price information in the health sector and on the actual amount they pay for particular health services.

Price information is an essential element of competition. Consumers need to know what they are going to be charged for a particular procedure by a range of practitioners in order to make an informed choice. Naturally, price is not the only basis for selecting a practitioner but it is an important element.

In that regard, HCF has established a network of HCF dental centres throughout the Sydney metropolitan area where its members do not incur out-of-pocket expenses for general preventive and diagnostic dental services and a known gap for major dental services. HCF regularly conducts a dental patient satisfaction survey. The 1999 dental patient satisfaction survey found that HCF members using HCF dental centres rated them overall as being better than private practices and that the most important reason for choosing a HCF dental centre was the cost savings compared to private dentists.[77]

The Australian Dental Association notes that there is a wide variation in fees charged by dentists throughout Australia generally and even within discrete geographic areas. This may well be the case of most services provided by allied health practitioners. However, consumers may not be aware of that fact as they have very little knowledge of the individual fee structure of practitioners. In fact, consumers may not even be able to judge whether the price they are quoted for a particular service is high, low, or close to the average.

In order to address this issue, HCF has published an Annual Dental Charges Survey since 1994. The aim of this survey is to provide HCF members with information showing the range of charges made by dentists for the most common dental procedures. HCF states that:

> HCF believes that people should be able to make informed decisions about all aspects of their treatment, including the cost. This survey will help members assess what their dentist charges, particularly for high cost items such as crowns and bridges.[78]

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[77] In April 1999 HCF surveyed 500 members, 300 of whom were users of HCF dental centres and 200 of whom used private practitioners. This was the third in this series designed by HCF to assess the performance of its dental centre network in comparison to private practices and in meeting its members' needs.

[78] HCF, *1998 Annual Dental Charges Survey*. The survey covers charges for the most common dental procedures totalling $77 million by all private practitioner dentists who treated HCF members during

Consumers not only need to have a general idea of the range of charges for particular procedures, they also need to know the actual fee charged by a range of individual providers. Obtaining such information directly from providers, prior to making an appointment, is often challenging for consumers.

Effective competition will only exist if consumers shop around for the best provider for their particular needs (including price and quality considerations). It is therefore essential that consumers are provided with comparative information about charges that they can use for price comparison. There is scope for others to make that information available for consumers.

Allied health professionals themselves could make more use of advertising to make their quality of service and fees known to consumers. Allied health professional associations could take a leadership role in helping the community to better understand the services their members provide and how to select appropriate professionals to provide these services. This could include advertising or other information to consumers and regularly publishing directories of their members and including, where individual practitioners choose to do so, the fees they charge.

Health funds may be able to play a greater role as well. Funds do have a record of the fees charged by the practitioners who have treated their members. Funds could set up their own database of practitioners' fees for their members to access.

12.6 Compliance programs

Now that allied health practitioners and their associations better understand how the Act applies to their activities, they need to better identify their compliance risks. Professional associations can help their members and themselves by putting in place systems to ensure compliance with the Act.

As indicated in chapter 11, Australian courts have consistently stated that they will take into account the effectiveness of trade practices compliance programs in assessing penalty for breaches of the Act.

One of the best starting points for achieving effective compliance is to refer to the Australian Standard on Compliance Program (AS 3806–1998). The standard sets down performance criteria for the operation, structure and maintenance of an effective compliance system, and gives guidance on how to achieve this.

The standard also provides guidance for small business. It recognises that while some of the basic concepts of compliance are fundamental to any organisation regardless of their size, the method of their application will vary. This may be particularly important given the structure of some professions in the Australian economy.

The Commission has also released a publication, *Corporate trade practices compliance programs*, to assist Australian businesses, including those in the allied health sector, to

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the 1998 calendar year. HCF indicates the a useful guide in this survey is the 75th percentile point. This is the maximum amount charged for a procedure by up to 75 per cent of dentists.

achieve effective compliance. As indicated earlier, the Commission is happy to discuss any trade practices compliance matters with allied health practitioners and/or their associations, and to refer them to appropriate sources for specific advice.

13 Informed financial consent

13.1 Background

There is considerable uncertainty for patients due to unexpected gaps between benefits and expenses in the private health sector.

Unknown medical gaps together with the complicated billing and payment arrangements are seriously affecting the perceived value of private health insurance. While there are other gaps (some of which may be unknown) it is the uncertainty over in-hospital medical gaps that primarily causes concern.

The amount medical practitioners will charge (and thus the gap to be paid) may not be known until the time the patient receives the account. In addition, the number of accounts patients will receive from different medical practitioners and the timeframe over which such accounts will be received is often unknown. Uncertainty, leading to a lack of confidence in the system, also results from the complexity of the claim and reimbursement process.

The Private Health Insurance Ombudsman notes in his submission:

> The Ombudsman receives a significant number of complaints about unexpected out of pocket costs for hospital and doctors' bills. In the main, the complainant has been unable to give informed financial consent to these costs, as information on which to base such a decision has not been given to them.

One fund is quoted in the Australian Health Service Alliance submission as being typical of its members' views:

> We get many calls from members unaware of the Doctors Schedule Fees. Many members are surprised and dismayed at the level of out of pocket expenses they have to incur even though they have full cover. This leads us to believe the Doctors are not fully explaining the total cost to members.

A survey of members by HBF found that:

- 91 per cent wanted to know their out of pocket costs before committing to treatment if hospitalisation was required;
- 88 per cent wanted to know if their specialist charged fees that were totally covered by insurance;
- 87 per cent wanted the doctor's medical gap to be covered as a part of health insurance.

HBF also conducted several focus groups on the gap issue. It received the following comments from members:

'One of the biggest issues is the surprise of it. It's not something you can negotiate when you're in hospital. And the shock comes several weeks later when you find that there are a whole list of contingencies that you hadn't thought of, like charging for individual dressings and medication.'

'Doctor recommends somebody but fails to recommend on price.'

'You're not going to go specialist shopping if you are under some sort of crisis. You just don't get the opportunity.'

'It's not a case of you can't negotiate, it's the degree of awkwardness. I've been in considerable pain and the last thing on my mind is talking about the fee with the person who is going to supposedly supply the remedy.'

'It would be good if the insurer had a list of Doctors.'

'You ring up and say am I going to be fully covered on the table if I see Dr Jones. They could say no you'll have to pay so much, but I'll know before hand and I can make a choice myself.'

HBF made the following comments in its submission:

> Although doctors may inform the patient during the consultation of the costs of their services these costs are limited to their own charges and generally patients often feel that at this time they are no longer in a position to reject the services of that specialist.
>
> Informed financial consent should involve an estimate of the total cost of the procedure including the cost of ancillary or likely services and other professional services like the anaesthetist. Until patients have this information they are really not fully informed as to the costs they are likely to face. Also consumers should have this information prior to them visiting the specialist.

The Australian Consumers' Association reported that:

> We have also received complaints from consumers who claim that providers, frequently medical specialists, do not inform them that there will be out-of-pocket expenses or do not inform them of the amount of out-of-pocket expenses […]. This amounts to anti-competitive behaviour because consumers cannot compare providers on the basis of price.
>
> Consumers have also complained in the past about receiving bills from practitioners, when they had not been informed that the particular practitioner would be involved in their care (eg assisting surgeon or assisting anaesthetist).

Uncertainty relating to the cost of treatment can be addressed by providing patients with cost estimates. In particular, details as to any medical gap, which the patient will be liable to pay, is necessary to enable patients to make informed financial decisions about treatment options. Informed financial consent in relation to medical gap payments improves accountability and leads to increased patient satisfaction with their treatment episode.

The Ombudsman believes that:

> Where a doctor chooses to set a fee which is significantly higher than the scheduled fee, the patient must be informed of this prior to surgery and also informed of the portion which they can expect to be refunded from other sources. Otherwise, the member is unable to give informed financial consent to their proposed treatment.

The official policy of the Australian Medical Association (AMA) is one of support for informed financial consent. For in-hospital elective procedures, the AMA has developed an 'estimate of fees' form, which practitioners can use to provide patients with likely costs associated with the service. Importantly, the AMA encourages the principal practitioner to provide estimates of the fees of other practitioners involved in the episode of care. The patient signs the form, indicating that the doctor has explained the costs to them and that they understand the costs involved.

13.1.1 Hospital gaps

Unlike medical gaps, information about potential hospital gaps is most often provided to the patient before treatment. In fact, where a hospital is covered by a hospital purchaser provider agreement (see chapter 6) the hospital is required by legislation to inform the health fund member of any amounts the member will be liable to pay to the hospital in addition to their health fund benefits. Around 70 per cent of hospital services are covered by these agreements.[79]

Where there is no agreement between the patient's fund and the hospital the provision of information by the hospital on likely benefits is more difficult. Members may be eligible for a 'second tier default benefit' where a hospital meets certain conditions (see chapter 6 on the regulation of private health insurance for more detail). Benefits under these arrangements are paid at 85 per cent of the average benefits currently payable by the fund for the episode in comparable hospitals. Hospitals have sought to establish in advance of making a specific claim on behalf of a member that they meet the required conditions and an estimate of the likely benefits to be received (and thus any gap to be paid).

According to the Australian Private Hospitals Association:

> The variation between and within funds as to the interpretation of the second tier default benefit arrangements prevents non-contracted hospitals from meaningfully advising fund members prior to admission, of any likely out of pocket expenses.

13.1.2 Disclosure of financial interests and informed financial consent

In some areas of medical and health services, professionals and other service providers may have financial or other interests in promoting a particular service, product, practitioner, clinic or hospital. Another aspect of informed financial consent is the disclosure of such financial or other interests where there may be potential for a conflict of interest.

Consumers rely heavily on the understanding that medical and allied health professionals will have their best interests as the prime consideration. However, a practitioner's ability to provide dispassionate advice about the most appropriate course of action for a patient could be compromised if the practitioner has a financial interest in promoting one course of action over another. Even if there is no risk of compromise, patients are entitled to know of such interests as part of their decision-making process.

A failure to disclose such financial interests to patients may, in some circumstances, contravene the Act. The Act does not impose a general duty to disclose information. However, the courts have held that silence is to be assessed as a circumstance like any other in determining whether conduct is misleading or deceptive.

By way of an analogy, the principle that financial interests should be disclosed where there is an arrangement with a third party found support in the recent Commercial

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[79] This is an underestimate, as AXA Health Insurance does not report any episodes as being contracted in its HCP data submissions. In fact the majority of AXA episodes are contracted.

Radio Inquiry by the Australian Broadcasting Authority (ABA). It was the ABA's view that:

> The disclosure of any relevant commercial interest by a presenter is an essential element of fairness in the presentation of broadcast material. […] Listeners are entitled to believe, in the absence of specific disclosure to the contrary, that there was no commercial arrangement between the presenter and the person who was the subject of the broadcast.

13.2 Issues

13.2.1 When should a patient be informed and by whom?

In order to make a financially informed decision about treatment options, the patient has to know about the likely costs of alternative treatment options prior to giving consent to receive treatment. Receiving information from the hospital just prior to admission does not allow a patient to make comparisons about alternative treatment.

At the very least, the principal treating specialist should provide information to the patient about their likely charges. However, they cannot be expected to provide cost information about alternative specialists. The patient will need to be provided with information on the cost of alternative treatments from other sources to allow a comparison to be made.

For some episodes, patients would not be aware of all the doctors involved in their treatment and would not have the opportunity to discuss fees with each doctor. The patient therefore also needs to be provided with information on charging by practitioners (other than the principal treating specialist) likely to be involved in an episode of care. For example, a gastroenterologist could display the fees of all doctors involved in a gastroscopy so that patients are informed of the total cost of the procedure, not just the fees of the surgeon with whom the patient has a consultation.

Patients need information about the likely cost of a treatment before they visit a specialist and even before making an appointment for a consultation. Indeed, once they have organised a consultation with a specialist, many patients would feel they can no longer reject the services of that particular specialist.

Information about alternative specialists and their fees may be provided by the referring GP. However, some doctors are reluctant to 'quote' on services provided by other practitioners. In addition, one cannot expect GPs to know the charges of a number of specialists in each specialty, and whether these specialists participate in any no-gap arrangements with particular funds.

Health funds are well placed to provide this information to their members. Fund members could contact their fund to check the charges of the specialist their GP has referred them to, and whether this specialist participates in the fund's no-gap arrangement. The member could also obtain price information from their fund about other specialists for comparison. If the member considers that the charges of the specialist he/she has been referred to are too high, the member could go back to his/her GP to discuss this matter, including the possibility of asking for a referral to another specialist. Alternatively, GPs may propose more than one specialist and only finalise a

referral after the member has checked with his/her fund what the charges would be. As indicated in chapter 11, health funds could set up their own database of specialists' fees, including whether the specialists participate in any no or known gap arrangement, for their members to access.

GPs could advise patients, at the time of referral, to check with their fund how much the specialist is going to charge as well as alert patients to the fact that funds have no or known gap arrangements in place, and that patients should ask about these arrangements.

As indicated in chapter 11, patients may also be able to obtain information on the charges of various specialists from professional associations' directories of their members.

13.2.2 What if the costs vary from the estimate?

Medical procedures often unearth or result in complications requiring treatment that differs to that expected. The patient cannot always be advised of either the changes in treatment or the associated changes in costs. There will also be situations where there will be last minute changes in the doctors performing the procedure. For example, a particular anaesthetist may be unavailable and the replacement may have different charges.

Some doctors will be concerned that by providing an estimate of cost there will be an obligation to charge no more than the estimate.

This is essentially a misunderstanding of the implications of informed financial consent and the limitations of the 'quote' needs to be explained to patients when information is being provided.

13.2.3 Emergency procedures and procedures involving patients with a limited ability to understand their situation

Informed financial consent will not be possible in all situations. For example, where patients are admitted in emergencies, where the patient is a child or has some form of disability and may not be able of understanding either the treatment options or the associated costs. In these cases it may be possible for information on costs to be provided to significant others.

13.2.4 Complicated procedures

It needs to be acknowledged that there is difficulty in providing informed financial consent depending on the complexity of the procedure. For example, providing informed financial consent is relatively straightforward for day hospital procedures where one or two doctors are involved, whereas for cardiac surgery it is much more difficult to achieve.

13.3 Reforms that have promoted informed financial consent

13.3.1 Contracting and informed financial consent

If the patient does not experience a medical gap then there is no longer a requirement for informed financial consent.

There have been several reforms to either eliminate or make known the medical gap. The key reforms for addressing medical gaps were the legislative changes in 1995 and 1998 that allowed health funds to cover above MBS charges for in-hospital medical services, where the doctor was covered by an agreement (see chapter 6 — the regulation of private health insurance).

In most cases where a doctor is covered by an agreement (medical purchaser provider agreement or practitioner agreement) the gap (and the need for informed financial consent) will have been eliminated. However, gaps can still be charged where there is an agreement but it has to be specified in the agreement. Furthermore, in these circumstances the National Health Act requires that the patient be informed of all expected costs to be incurred prior to treatment.

13.3.2 Legislating for no or known gaps

The *Private Health Insurance Incentives Act 1998* requires health funds on or after 1 July 2000 to offer its members a choice of no or known gap policies in order to be able to deliver the private health insurance rebate as a premium reduction (see chapter 6).

13.3.3 Simplified billing

The Government is also encouraging and promoting simplified billing. Simplified billing involves the aggregation of patients' bills for in-hospital care into one single bill, the streamlining of claims procedures to minimise patient involvement and the provision of informed financial consent.

Seven trial sites for simplified billing were established in 1997 and to date 36 billing agents have been registered. Around 12 per cent of all in-hospital services are claimed under simplified billing arrangements.[80]

According to the Department of Health and Aged Care simplified billing is:

> Strongly linked to the concept of informed financial consent, under which patients must receive advice about likely medical expenses and an opportunity to discuss any concerns prior to hospitalisation. The patient is then able to make an informed decision about their options and health care treatment and be prepared for any out-of-pocket expenses that may be incurred.

While simplified billing does not necessarily ensure that medical gaps are covered, it has helped the industry recognise the importance of providing information relating to the cost of their procedure.

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[80] This is comprised of around 9 per cent claimed by health funds under agreement arrangements such as AXA Mediplus Ezyclaim and 3 per cent claimed by billing agents.

The Department of Health and Aged Care indicated that:

> The Federal Government will be acting to strengthen simplified billing and informed financial consent through a range of initiatives, including promotion and dissemination of electronic commerce, billing agency, and informed financial consent arrangements.

13.3.4 Proposed legislation for no or known gap schemes

Government legislation for the development of schemes that provide no gap and/or known gap insurance cover without contractual agreements with practitioners is being considered by Parliament. These schemes would provide a mechanism additional to the medical purchaser provider agreements and practitioner agreements through which the gap may be reduced or eliminated. Like agreements, any gaps must be known gaps.

This legislation has the support of the AMA.

Even if the take up of these schemes is limited, the mere existence of such schemes, public knowledge of its existence and the public support of the AMA could be expected to encourage doctors to enter into gap arrangements with health funds, either contract or scheme based.

The gap schemes will provide funds with another mechanism for meeting the requirements of the Private Health Insurance Incentives Act to deliver no or known gap products.

14 Attachment A. Senate order

15 Attachment B. Consultation process

The Commission wrote to the following organisations as part of the consultation process it undertook in order to comply with the Senate order. An asterisk indicates when a meeting was held with a particular organisation.

ACA Health Benefits Fund

AMA Health Fund Limited

Association of Massage Therapists Australia Inc

Australian Association of Consultant Physicians

Australian Association of Occupational Therapists

Australian Association of Pathology Practices Inc

Australian Association of Surgeons

Australian Consumers' Association*

Australian Dental Association

Australian Health Insurance Association*

Australian Health Management Group

Australian Health Service Alliance Ltd*

Australian Institute of Radiography

Australian Medical Association Limited (ACT)

Australian Medical Association Limited (Federal)*

Australian Medical Association Limited (NSW)

Australian Medical Association Limited (NT)

Australian Medical Association Limited (QLD)

Australian Medical Association Limited (SA)

Australian Medical Association Limited (TAS)

Australian Medical Association Limited (Victoria)

Australian Medical Association Limited (WA)

Australian Orthopaedic Association

Australian Osteopathic Association

Australian Physiotherapy Association

Australian Podiatry Council

Australian Private Hospitals Association*

Australian Psychological Society Ltd

Australian Society of Anaesthetists

Australian Society of Ophthalmologists

Australian Society of Otolaryngology, Head & Neck Surgery Ltd

Australian Society of Plastic Surgeons Inc.

Australian Unity Health Limited

AXA Health Insurance Pty Ltd (formerly National Mutual Health Insurance)*

Cardiac Society of Australia

Catholic Care of 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 and Traditional Therapists

Geelong Medical and Hospital benefits Association Ltd

Goldfields Medical Fund (Inc)

Grand United Health Fund

Health & Community Services Complaints Commission (Northern Territory)

Health Care Complaints Commission (NSW)

Health Care Insurance Ltd

Health Care of Australia

Health Complaints Commissioner (Tasmania)

Health Insurance Commission*

Health Insurance Fund of WA

Health Rights Commission (Queensland)

Health Services Commission (Victoria)

Healthguard Health Benefits Fund Ltd

Health-Partners

Hospital Benefit Fund of Western Australia*

Hospitals Contribution Fund of Australia Limited*

Independent Order of Odd Fellows of Victoria

IOR Australia Pty Ltd

Latrobe Health Services Inc

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 Fund Limited*

NSW Health Funds Association

NSW Private Hospitals Association

NSW Teachers' Federation Health Society

Office of Health Review (Western Australia)

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 WA

Qld Teachers' Union Health Society

Queensland Country Health Limited

Queensland Private Hospitals Association

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

SA State Ombudsman

SGIO Health Pty Limited

Speech Pathology Association of Australia

St Luke's Medical & Hospital Benefits Association

Transition Benefits Fund Pty Ltd

Transport Friendly Society

United Ancient Order of Druids

United Ancient Order of Druids Registered Friendly Society Grand Lodge of NSW

Urological Society of Australasia

Victorian Private Hospitals Association

Western District Health Fund Ltd

Yallourn Medical and Hospital Society

16 Attachment C. List of submissions

Health fund sector

Australian Health Insurance Association Ltd

Australian Health Service Alliance Ltd

AXA Australia Health Insurance

HBF

HCF

MBF

Medibank Private

Medical and allied health practitioners sector

Association of Massage Therapists

Australian Association of Pathology Practices Inc.

Australian Association of Surgeons

Australian Dental Association Inc.

Australian Doctors' Fund

Australian Institute of Radiography

Australian Medical Association Limited

Australian Osteopathic Association

Australian Physiotherapy Association

Chiropractors' Association of Australia (National) Limited

Council of Procedural Specialists

Dietitians Association of Australia

Royal Australian College of General Practitioners

Speech Pathology Australia

The Association for the Advancement of Private Health

The Australian Society of Otolaryngology Head and Neck Surgery Ltd

Hospital sector

Australian Private Hospital Association Limited (including submission from the National Private Rehabilitation Group)

Jessie McPherson Private Hospital

Consumer organisations

Australian Consumers' Association

State and Territory health complaints bodies

Health and Community Services Complaints Commission

Health Rights Commission

Office of Health Review

Commonwealth departments and agencies

Commonwealth Department of Health and Aged Care

Private Health Insurance Ombudsman

The Commission also received two confidential submissions.

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