Australian
Competition &
Consumer
Commission

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

For the period
1 July 2010 to 30 June 2011

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Australian Competition and Consumer Commission
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Executive Summary

This is the 13th report prepared by the Australian Competition and Consumer Commission (ACCC) for the Australian Senate on the issue of private health insurance and covers the period 1 July 2010 to 30 June 2011 (PHI Report) during which significant changes to Australian consumer laws were introduced. The Senate requires the ACCC to report on: "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 PHI Report broadly comprises of two parts: context setting (chapters 1, 2 and 3: *Introduction*, *Private health insurance in Australia* and *Complaints*) and analysis of various industry issues through the lens of the *Competition and Consumer Act 2010* (CCA) (chapters 4, 5 and 6: *Informed Financial Consent*, *Contracting*, and *Other issues*).

The ACCC's activities during the period, further detail on the application of the CCA and report methodology can be found in the appendices.

In terms of perceived anti-competitive practices some issues have remained contentious (preferred provider schemes) while others appear to have become less controversial (contracting between industry participants).

An overall trend affecting the sector appears to be a potential shortfall in the provision of adequate consumer information.

The key concern arising from the data gathered in preparing the report is an ongoing confusion about the roles and responsibilities of industry participants in ensuring that consumers are empowered to give their informed financial consent (IFC) to any treatments they undertake.

For the first time the ACCC is making available the submissions received during the consultation process, in order that readers of the report may better understand the competing policy considerations (outside of the competition regulator's remit) which are a contextual backdrop to many of the submissions.

1. Introduction

1.1. Senate Order

A number of government agencies are involved in administering and regulating a broad and complex framework of laws relating to private health insurance in Australia. While not involved in this framework the ACCC is tasked by an order of the Australian Senate to provide an annual report about the competition and consumer issues in private health insurance sector.

The Senate requires the ACCC to provide an annual assessment of: "any anti-competitive or other practices by health funds or providers which reduce the extent of health cover for consumers and increase their out-of-pocket medical and other expenses".

This report covers the period 1 July 2010 to 30 June 2011 (the 2010–11 period). It is the 13th report prepared by the ACCC in compliance with an order agreed to by the Australian Senate on 25 March 1999 and amended on 18 September 2002.

The order is set out below.

Senate procedural order no. 17 Health—Assessment reports by the Australian Competition and Consumer Commission
There be laid on the table as soon as practicable after the end of each period of 12 months ending on or after 30 June 2003, a report by the Australian Competition and Consumer Commission containing an assessment of any anti-competitive or other practices by health insurers or providers which reduce the extent of health cover for consumers and increase their out-of-pocket medical and other expenses.
Agreed to 25 March 1999, by means of an amendment to the motion that the report of the committee on the Health Legislation Amendment Bill (No. 2) 1999 be adopted. J.626, amended 18 September 2002 J.761.

This report has been prepared in compliance with that order.

The ACCC objective in producing the PHI Report is to comply with the Senate Order and to improve market practices in private health insurance. ACCC responsibility in the private health insurance sector is limited to encouraging compliance with and enforcing the *Competition and Consumer Act 2010* (CCA).

The Department of Health and Ageing (DoHA) administers the *Private Health Insurance Act 2007* (PHI Act) and health insurance provider rules, while the Private Health Insurance Administration Council (PHIAC) is charged with the registration and prudential regulation of insurers. In addition, the Public Health Insurance Ombudsman (PHIO) is established to manage consumer complaints.

Issues within the realm of health policy sit outside the remit of the ACCC.

Previous PHI reports can be viewed on the ACCC website at www.accc.gov.au.

1.2. Methodology

The ACCC sought submissions from interested parties including:

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

To focus submissions the ACCC:

- wrote to previously consulted stakeholders
- wrote to newly identified stakeholders.

Twenty-seven submissions were received and taken into account in the compilation of this report along with data gathered in the everyday activities of the ACCC.

The issues, developments and questions put to stakeholders for comment are at Appendix 2 Invitations to consult and a list of those who made submissions, along with links to publicly available submissions, is available at Appendix 3 Submissions received. The ACCC consulted with stakeholders on its proposal to publish submissions received and many consented to the publication of their submission.

The ACCC thanks stakeholders for their time in making submissions to the 2010–11 PHI Report.

1.3. Australian Competition and Consumer Commission

The ACCC is an independent statutory authority established to enforce and encourage compliance with the CCA. The purpose of the CCA is to enhance the welfare of Australians by promoting competition and fair trading. The CCA provides for the protection of consumers in their dealings with business, including prohibitions against misleading and deceptive conduct and anti-competitive conduct.

The principles adopted by the ACCC to achieve compliance with the law are set out in our Compliance and enforcement policy[1] which outlines the ACCC's enforcement powers, functions and priorities.

In carrying out its duties under the CCA, the ACCC has a dual role as:

- a national enforcement agency, and
- a provider of education and information for business (including the professions) and consumers in relation to compliance with the CCA.

The ACCC undertakes enforcement action where appropriate and necessary to underpin its compliance objectives. The ACCC has varied and extensive enforcement powers, recently enhanced by amendments to the CCA. These powers are detailed in the ACCC's publication *Business snapshot: ACCC powers to issue notices*.

To achieve compliance with the CCA the ACCC takes a flexible and integrated strategic approach, from education and liaison work through to enforcement action.

1 ACCC website: http://www.accc.gov.au/cepolicy

A large component of the ACCC's work is directed towards preventing breaches from occurring. This is done by educating industry, the professions and consumers about their rights and obligations under the CCA.

The ACCC's education work can take the form of publications, as well as speeches, presentations and submissions.

The ACCC's liaison work has also included hosting various incarnations of a Health Sector Consultative Committee (HSCC) between 2003 and 2011 to promote consultation and the exchange of information between the ACCC and health professionals on matters relevant to effective compliance with competition and consumer laws. In consultation with the sector the ACCC decided in 2011 to use alternative methods of engagement with key members of the health industry, such as liaising with a select number of interested and active participants of the broader health services sector as required.

In addition to the economy-wide role the ACCC has in promoting competition and protecting consumers, certain sectors are, from time to time, made the subject of more explicit roles by the ACCC. In the private health insurance sector, pursuant to the Senate Order, the ACCC has a specific reporting role.

1.4. The CCA

The Trade Practices Act, a key feature of the Australian business landscape since 1974, on 1 January 2011 became the *Competition and Consumer Act 2010* and now incorporates the new Australian Consumer Law (ACL)—a national set of consumer protections.

A quick reference guide to the laws can be seen in Appendix 4 Reference table to the *Competition and Consumer Act 2010*.

The ACL[2] is a single national law that provides uniform laws across Australia. It is enforced by the ACCC and all state and territory consumer protection agencies and, where it applies to financial services, the Australian Securities and Investments Commission (ASIC).

The ACL gives the ACCC new enforcement powers to protect consumers, including the ability to seek or issue:

- civil monetary penalties
- banning orders
- substantiation notices
- infringement notices
- refunds for consumers, and
- public warnings.

2 Further in-depth information about the ACL is available at www.consumer.gov.au or on the ACCC website at www.accc.gov.au/acl. To order hard copy publications or discuss the ACL call the ACCC Infocentre on 1300 302 502.

1.5. Limited availability of immunity from ACCC action

The ACCC may authorise or allow notification of proposed conduct to stand, where businesses seek to engage in arrangements or conduct that would otherwise breach the competition provisions of the CCA when it is satisfied that the public benefit from the arrangements or conduct outweighs any public detriment. Just like businesses in other sectors, businesses and professional representative groups in the private health insurance sector can apply for authorisation and notification from the ACCC.

Authorisation

The ACCC may authorise businesses to engage in certain arrangements or conduct that would otherwise breach the competition provisions of the CCA when it is satisfied that the public benefit from the arrangements or conduct outweighs any public detriment.

The authorisation provides protection from legal action under the CCA for the arrangement or conduct. Authorisation can be sought for a range of conduct, including that which might constitute cartel conduct such as price fixing provisions and other forms of anti-competitive agreement including exclusive dealing.

Notification

Notification is a process through which parties proposing to engage in collective bargaining or exclusive dealing conduct may, by lodging a notification with the ACCC, obtain protection from legal action under the CCA for the proposed conduct. The notification process differs slightly according to the conduct being notified. Further information on authorisations and notifications is available at www.accc.gov.au.

1.6. Industry codes of conduct

The ACCC has considerable experience in the use of codes of conduct to regulate market behaviour. Effective codes can potentially assist in achieving compliance with the CCA; deliver increased consumer protection and reduce regulatory burdens for business. In contrast, ineffective codes may place compliance burdens on business without any realisable benefits and potentially make signatories to it less competitive.

Effective voluntary codes of conduct must be well designed, effectively implemented, administered and properly enforced. The ACCC publication *Guidelines for developing effective voluntary codes of conduct* provides guidance to assist industries and professional associations to develop and implement effective voluntary codes of conduct.

In addition to codes administered by industry, it is possible for industry codes of conduct to be made law. No codes of conduct have been prescribed under the CCA in relation to the health sector.

1.7. Mergers

The CCA prohibits acquisitions that would have the effect, or likely effect, of substantially lessening competition in a market in Australia.

The role of the ACCC regarding mergers of businesses in the private health insurance sector is to ensure that the structure of various markets in the health sector remains competitive. This is to prevent such a concentration of firms through mergers that there is a substantial lessening of competition.

1.8. ACCC activities in the period

This chapter provides an overview of ACCC activities relating to or impacting upon the private health insurance sector during the 2010–11 reporting period.

1.8.1. Enforcement activities

While several of the ACCC's enforcement activities during the 2010–11 period affected the broad health sector, there were no enforcement activities in the private health insurance sector.

1.8.2. Mergers, authorisations and notifications

In the period from 1 July 2010 and 30 June 2011 the ACCC engaged in the following activities of direct relevance to the private health insurance sector:

- two informal merger reviews
- one authorisation (finalised in the 2011–12 financial year)
- eighteen exclusive dealing notifications.

(See further, Appendix 6 Mergers, authorisations and notifications for the period.)

1.8.3. Engagement with other agencies

The ACCC maintained contact with the DoHA, PHIO and PHIAC in relation to issues of mutual interest as necessary from time to time.

- During June 2010 the ACCC and PHIAC negotiated, drafted and agreed upon a Memorandum of Understanding (MoU) to assist both agencies to effectively and efficiently discharge their respective administrative and regulatory functions. The terms included mutual assistance in relation to information provision and referral of matters where appropriate under their relevant legislative frameworks. This MoU came into effect on 19 July 2011.
- In April 2011 the ACCC made a submission to the Australian Health Ministers' Advisory Council's (AHMAC's) Consultation paper Options for regulation of unregistered health practitioners February 2011.

- At the August 2010 meeting of the Heath Services Consultative Committee (HSCC), the ACCC committed to circulate a survey to HSCC members to seek input to a review on how best the ACCC could communicate with the health sector, including health consumers more broadly and whether the composition of the HSCC was sufficiently representative of the health sector. In January 2011, the ACCC surveyed members on a range of issues relating to the operation of the HSCC. In November 2011 HSCC members were advised that upon consideration the ACCC had decided the HSCC be discontinued and that the ACCC use alternative methods of engagement with key members of the health industry, such as liaising with a select number of interested and active participants of the health sector as required.

2. Private health insurance in Australia[3]

Within the health sector private health insurance is a voluntary facility for private funding of hospital care and ancillaries.[4] Private health insurers may cover the costs of treatment for private patients in private or public hospitals and can include some services that Medicare[5] does not cover, such as dental care, optical care, physiotherapy and chiropractic care.

Private health insurance is a dynamic industry in Australia's largest economic sector—health care.[6] Over the past five years, the number of people with private health insurance in Australia has increased at an annualised rate of 3.1 per cent. IBISWorld forecasts that with current policy settings the number of people with private health insurance will grow at an annualised rate of 1.3 per cent over the five years to 2015–16.[7]

Of the 11.6 million privately insured Australians, 5.6 million have an annual household income less than $50 000 and of those, 3.4 million have an annual household income of less than $35 000.[8] Depending on circumstances, such policy holders may qualify as what the ACCC considers 'disadvantaged and vulnerable' and therefore high-priority consumers.

Private health insurance industry practices are highly regulated by government because they affect every Australian requiring health care. This is due to the impact of private health insurance on the usage of private health services versus the public health system.

2.1. Regulation of private health insurance

As noted previously, PHIAC is the independent statutory authority responsible for: regulating the private health insurance industry; private health insurance policy is administered by DoHA; and PHIO is responsible for dealing with consumer complaints regarding private health insurance.

Both DoHA and PHIAC are involved in regulating private health insurers. These regulatory activities relate to the registration of the funds, solvency and adequacy standards, portability, mergers and acquisitions and premium increase.

2.1.1. Private health insurers' registration

Private health insurers are required to be registered under the PHI Act. If the registration conditions, which relate to matters such as waiting periods, portability between insurers, categories of membership and the types and levels of benefits, are not met, an insurer can be deregistered.

3 This chapter was complied with the extensive assistance of the Private Health Insurance Administration Council: www.phiac.gov.au
4 (2007) *The Impact and Cost of Health Sector Regulation* for Australian Centre For Health Research Limited.
5 Medicare is Australia's universal system for financing public hospitals and services provided by private doctors and some additional health costs. It was introduced by the federal government in 1984 to ensure all Australians had access to medical and hospital care.
6 http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/6291.0.55.003Feb per cent202011?OpenDocument
7 IBISWorld Business Environment Report *Private health insurance membership in Australia* (April 2011).
8 http://www.ahia.org.au/news/media_releases/means-testing-affects-entire-australian-health-system/

2.1.2. Solvency and capital adequacy standards

Part of PHIAC's regulatory activity is to ensure that private health insurers meet the solvency and capital adequacy standards expressed in the PHI Act and the Private Health Insurance (Health Benefits Fund Administration) Rules 2007. Private health insurers are required to regularly provide PHIAC with relevant information to demonstrate that they will be able to fulfil health insurance claims made by their policyholders.

2.1.3. Portability

Regulations require that consumers are able to move between private health insurers freely without incurring financial loss or have to re-serve waiting periods for products they were already covered for. Private health insurers are also required to issue a clearance certificate to allow the transfer to take place.

2.1.4. Waiting periods

Waiting periods help insurers to bear the risks and manage their claims. A waiting period must be served when a person starts a new private health insurance policy or increases their level of cover. A waiting period protects policy holders of the private health insurer by ensuring no policyholder makes a large claim shortly after joining and then drops their coverage. This kind of behaviour would result in increased premiums for all policy holders.

2.1.5. Premium increases

Private health insurers must apply to the Minister for Health and Ageing for approval of premium changes (increases or decreases). Private health insurers must provide an extensive amount of information to support their premium application, and in 2010–11, all 35 insurers applied for and received a premium increase. The premium increases took effect on 1 April 2011, with a weighted industry average premium increase of 5.56 per cent.

All applications are assessed by the Minister for Health and Ageing, DoHA and PHIAC. It is common practice for PHIAC to refer some applications to the Australian Government Actuary for a further independent assessment.

Premium increases must be approved unless they are not in the public interest. The Minister for Health and Ageing considers premium increases to be in the public interest if they are the minimum necessary to ensure insurer solvency, support benefits outlays, and meet prudential standards concerning capital adequacy, while also ensuring the affordability and value of private health insurance as a product. Consideration is also given to a private health insurer's management expenses ratio, which measures the relationship between the operating expenses incurred in the course of an insurer's normal operations and its contribution income.[9]

9 DOHA, *Submission in relation to Reserve Bank Health Society Ltd's authorisation application,* 1 June 2011.

2.2. Private health insurance market

Generally private health insurance refers to the provision of two types of cover, hospital cover and ancillary cover (for instance, dentistry, optometry and physiotherapy). Consumers may purchase this cover separately or as part of a combined policy and may also choose to split the types of cover between different private health insurers.

The main participants in the private health insurance industry are private health insurers, insurer industry groups, health services providers (such as private hospitals and specialist doctors), consumers and consumer groups and Australian Government agencies.

Private health insurers negotiate with health service providers on the price that will be paid by the fund for the provision of health services to its members. Private health insurers then offer a range of insurance cover to consumers. For instance, some policies will provide full cover for treatment, whereas others will require members to meet part of the cost of any services received in exchange for lower premiums.[10]

In the 2010–11 financial year, 35 insurers were registered and conducted health insurance business. Following a merger of two insurers on 30 June 2011, there are currently 34 registered health insurers.

Private health insurers may be registered as open or restricted funds. Open funds may provide cover to anyone, while restricted funds may only provide cover for specific groups of people, generally from certain professional associations. There are currently 21 open and 13 restricted insurers.

Private health insurers can also be registered as for profit or not for profit. In the 2010–11 financial year eight registered health insurers operated on a for profit basis. As a consequence of the 30 June 2011 merger, there are now seven for profit and 27 not for profit insurers.

2.2.1. Government initiatives

The Australian Government has a number of policies to encourage consumers to purchase private health insurance early and maintain cover throughout their life, and to ensure the industry is sustainable and competitive.

2.2.2. The 30% rebate

During the 2010–11 period the Australian Government provided a 30 per cent rebate on private health insurance cover. There were higher rebates for older people: 35 per cent for people aged 65–69 years and 40 per cent for people aged 70 years and over.

Anyone could claim the private health insurance rebate if they are eligible for Medicare and have a complying private health insurance policy that provides hospital cover, general (also called ancillary or extras) cover, or both.

10 Private Health Insurance Ombudsman (PHIO) http://www.privatehealth.gov.au/healthfunds/howhealthfundswork/ (accessed 14 June 2011).

2.2.3. Medicare Levy Surcharge

The Medicare Levy Surcharge (MLS) is levied on Australian taxpayers who do not have hospital cover and who earn above a certain income. The thresholds for the 2010–11 reporting period were:

- $77 000 for a single person with no dependants
- $154 000 for a couple with no children or one dependent child, plus $1500 for each additional dependent child.

The MLS is calculated at the rate of 1 per cent of taxable income. This is in addition to the Medicare Levy of 1.5 per cent, which is paid by most Australian taxpayers.

To be exempt from the MLS, the hospital cover must be held with a registered private health insurer and cover some or all of the fees and charges for a stay in hospital. General (also called ancillary or extras) cover *without* hospital cover will not provide an exemption from the MLS.

2.2.4. Lifetime Health Cover

The Lifetime Health Cover loading is an additional charge consumers may have to pay for hospital cover, depending on their age and how long they have had private health insurance.

To avoid paying this extra loading, consumers need to purchase hospital cover by 1 July in the year following their 31st birthday. If hospital cover is purchased after this date, consumers may be required to pay a Lifetime Health Cover loading—2 per cent for each year over 30.

Once the Lifetime Health Cover loading has been paid on private hospital insurance for 10 continuous years, the loading is removed, as long as hospital cover is retained. A gap of 12 months in coverage is permitted, provided coverage is resumed, without affecting Lifetime Health Cover status.

2.2.5. Risk equalisation

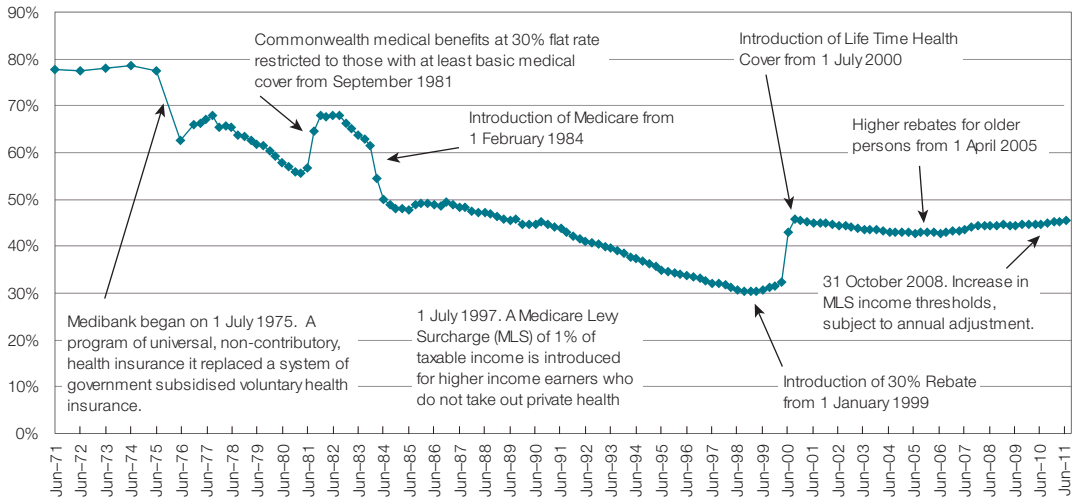
Private health insurers providing cover for less risky people are required to subsidise other insurers who provide cover for a more risky group. This is called 'risk equalisation' whereby risks are shared among insurers so that consumers can pay a reasonable premium when they have greater health treatment needs.

The rationale behind risk equalisation is a policy called 'community rating'. The principle of this policy is that private health insurers have to base their prices on the type of policy only and not according to the risk. This means that every person purchasing the same policy will be charged the same price, regardless of their age or health condition. This is a major difference compared to other types of insurance where the price structure is set according to the risks represented by a particular insured person.

2.3. Numbers of Australians with private health insurance

At 30 June 2011, 10 255 675 Australians held private health insurance hospital treatment cover, an increase of 281 811 (2.8 per cent) from 30 June 2010, which represents an increase from 44.7 per cent to 45.3 per cent of the Australian population. Figure 1 demonstrates the change in percentage over time.

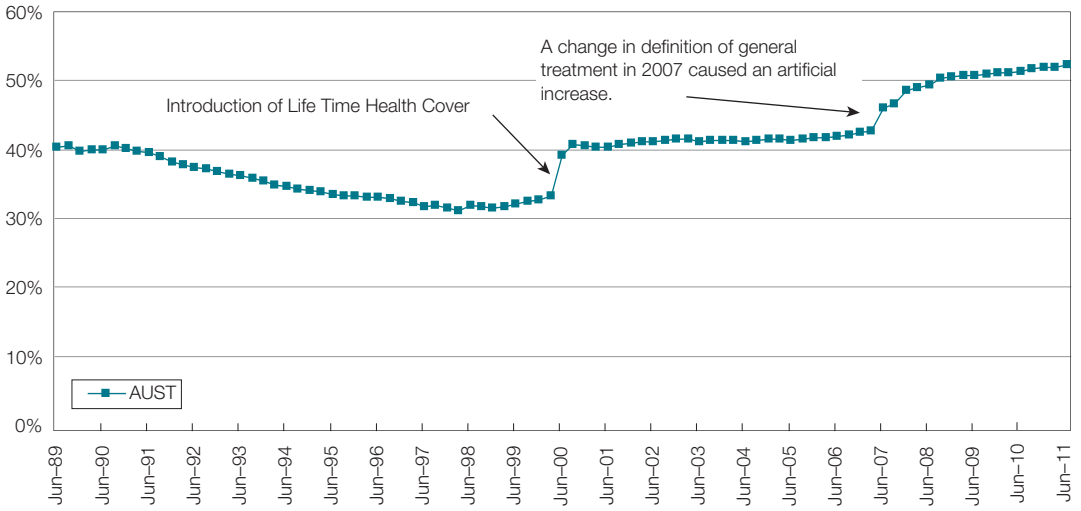
Figure 1 Australians with private health insurance hospital treatment cover, June 1971 to June 2011



Source: Australian Government, PHIAC.

At 30 June 2011, 52.5 per cent of Australians held private health insurance general treatment cover, an increase of 0.8 per cent from 30 June 2010. The total number of people with private health insurance general treatment coverage at 30 June 2011 was 11 888 197. This is an increase of 346 496 (3.0 per cent) from the previous financial year. Figure 2 demonstrates the change in percentage over time.

Figure 2 Australians with private health insurance general treatment cover, June 1989 to June 2011



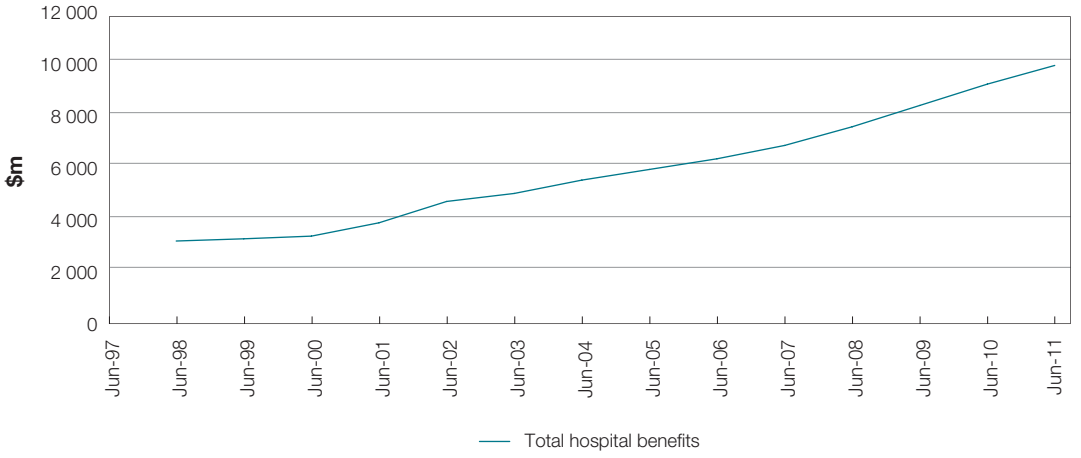
Source: Australian Government, PHIAC.

NB: The introduction of the PHI Act in 2007 caused an artificial increase in General Treatment as a result of changes in definitions and reclassification of policies.

2.4. Total health benefits paid by health insurers

Figure 3 shows that there was a net increase over the reporting year in the total hospital benefits paid by private health insurers (including public, private, acute, hospital-substitute, medical, prostheses and nursing home-type patients). At 30 June 2011, the total amount of hospital benefits paid was $9701 million, an increase of $727 million (8.1 per cent) from the previous financial year.

Figure 3 Total hospital benefits paid, June 1997 to June 2011

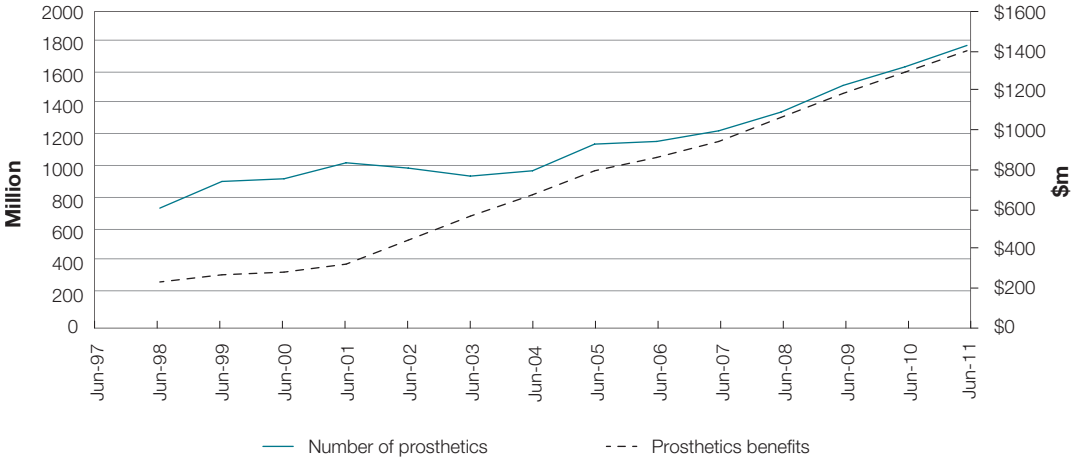


Source: Australian Government, PHIAC.

2.5. Benefits paid for prostheses

Figure 4 shows that the cost of benefits paid for prosthetic devices continues to escalate. At 30 June 2011 the total amount of benefits paid for prostheses in the 2010—11 financial year was $1380 million, an increase of $109 million (8.6 per cent) over the year. Growth in expenditure is largely driven by increased utilisation, which has risen by 8.5 per cent from the previous financial year.

Figure 4 Benefits paid for prostheses, June 1997 to June 2011



Source: Australian Government, PHIAC.

3. Complaints[11]

Consumers can contact several organisations if they have complaints or enquiries about health related issues. These bodies include health complaints offices in each state and territory, the ACCC or a health practitioner's professional association. Consumers with complaints or enquiries about private health insurance (or health insurers, medical practitioners or hospitals) can also approach the PHIO.

3.1. Contacts to the ACCC

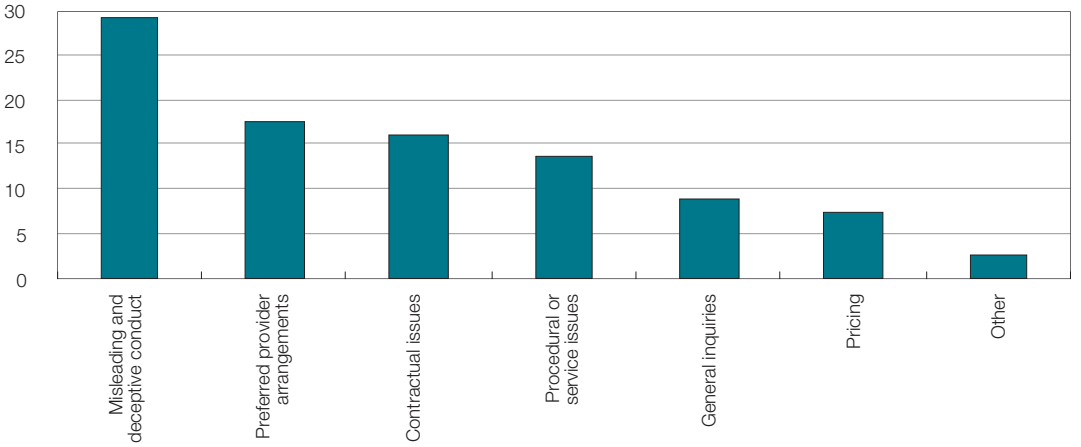
The ACCC considers all contacts it receives in the context of the CCA. During the 2010–11 period, the ACCC received 706 health sector contacts compared to 632 in 2009–10. This represents an increase of 11.9 per cent. While there has been an increase in contacts, this is considerably less than the overall increase in contacts during the period and represents less than one per cent of the total contacts received.

There were 99 private health insurance-related contacts in 2010–11 compared to 75 in the previous period.

The relatively low number of contacts may indicate that the private health insurance sector is operating well overall. Alternatively, it could indicate that consumers and other private health insurance sector participants raise issues of concern with other organisations.

A review of the 99 private health insurance contacts revealed the following breakdown of complaints as outlined in Figure 5.

Figure 5 ACCC private health insurance contacts 2010–11



The most common issues from the contacts related to:

- concerns of misleading or deceptive conduct relating to the advertising and sale of insurance products
- concerns about preferred provider schemes

11 This chapter was compiled thanks to the extensive contribution of the Private Health Insurance Ombudsman (www.phio.gov.au)

- concerns about some of the contractual terms and conditions imposed by the insurance provider including application of excesses or refusal to cover certain conditions
- procedural or service issues such as delays in rebates and mistakes made in processing claims
- concerns about the pricing of cover, in particular the increase in premiums or a reduction in policy cover.

Competition issues raised were generally in relation to exclusive dealing arrangements common with preferred provider arrangements.

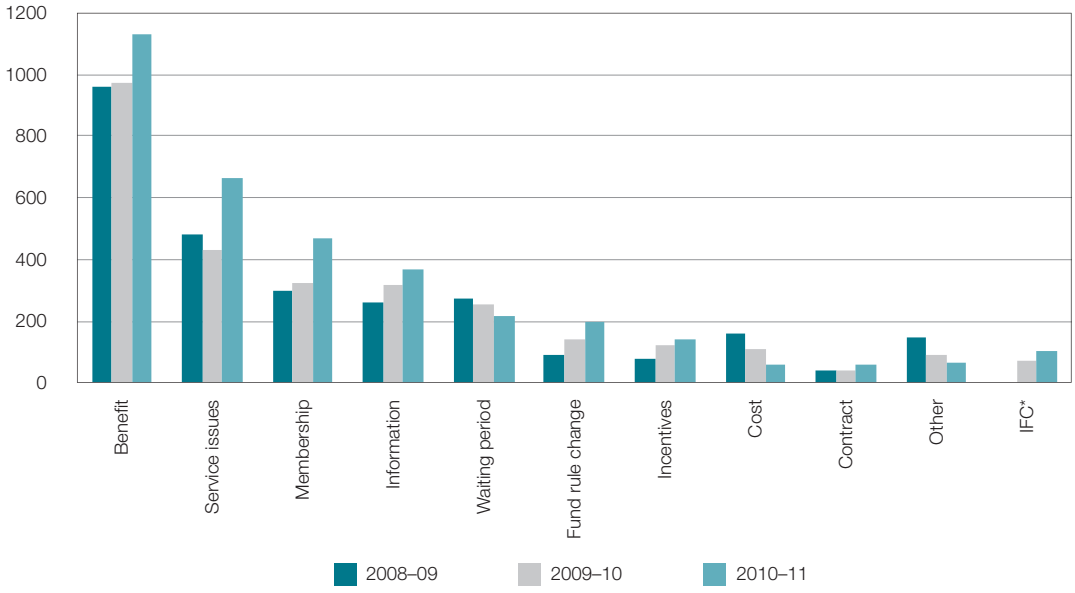
3.2. PHIO complaints

3.2.1. Trends

The PHIO received 3070 complaints during 2010–11, which was an increase of 17 per cent on the previous year. This jump in overall complaints numbers represented quite a radical change from the pattern of the past five years, which had seen only small but consistent increases in the number of complaints to the PHIO. These previous increases were within expectations, given that private health insurance membership levels also increased during that time.

Figure 6 PHIO overall complaint issues 2008–09 to 2010–11 demonstrates that while several complaint categories have risen in the depicted period, others have declined.

Figure 6 PHIO overall complaint issues 2008–09 to 2010–11



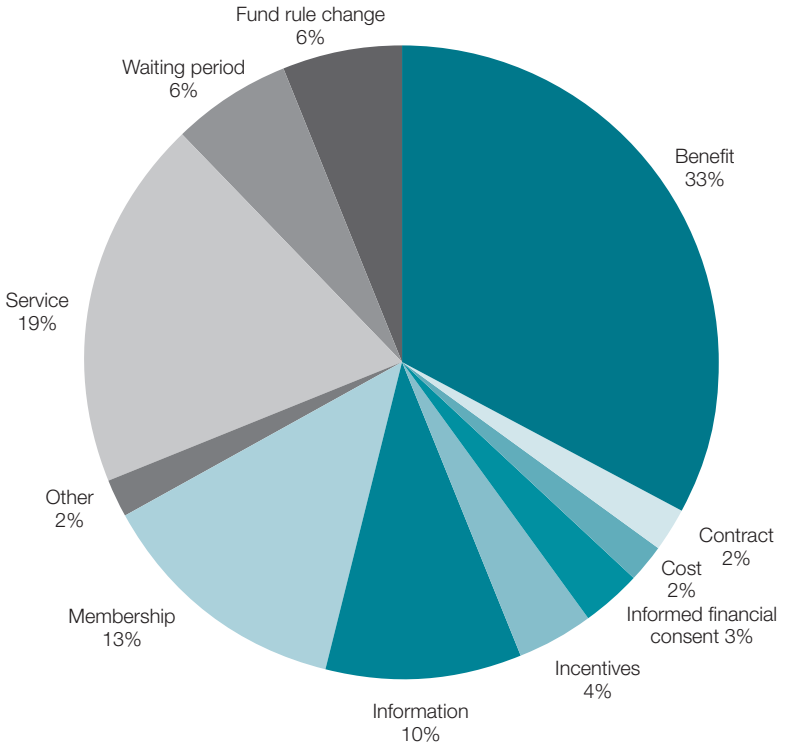
* IFC (informed financial consent) is a new category, introduced mid-year in 2009–10.

3.2.2. Current issues

In reviewing the PHIO complaints data, it is apparent that the issues in 2010–11 where there was an increase in complaints included: level of cover; private health insurance policy rule changes; and general service issues.

Figure 7 PHIO complaint issues 2010–11 sets out the key areas of complaint for the 2010–11 period.

Figure 7 PHIO complaint issues 2010–11



Not all complaints to PHIO converge with areas of concern to the ACCC. Complaints to PHIO regarding level of coverage intersect with concerns about gaps and exclusions highlighted later in this report by the ACCC in discussing informed financial consent.

Specific private health insurance complaints of interest to the ACCC under the CCA also included reports that one private health insurer changed the restrictions on a number of its policies to exclusions with effect from 1 July 2010 and also made changes to excesses on some policies later that year. In addition, another private health insurance group moved some of its major dental treatments into the general dental category, which reduced the benefits members received and also made some changes to ambulance policies.

As has been noted in previous PHIO annual reports, developing policies with restrictions and exclusions, or adding them to existing policies, assists private health insurers in managing premium costs and meeting demand from consumers for more affordable policies.

Private health insurance legislation requires that if a private health insurer makes a detrimental change to a policy, it must inform members in advance of the change. The information the private health insurer provides in its letter to members is very important in ensuring members understand the change and its impact on them. This enables the member to accept the change, or to look at other policy options if the change means their policy no longer meets their needs.

The consumer protection and fair trading provisions of the ACL can also apply to this scenario. The ACL places obligations on businesses not to mislead their customers, prohibits unconscionable conduct and allows for unfair contract terms to be declared void.

PHIO reported it was disappointed to note that some of the letters about detrimental rule changes that were sent in 2010 did not contain adequate advice about changes to policies. Copies of these letters were not provided to PHIO for review (which is encouraged by PHIO), which meant that PHIO were not able to advise private health insurers to include more specific information to assist members to understand the impact of the changes. This resulted in higher levels of complaints from members of these private health insurers and to PHIO.

It is important to note that even where a private health insurer has worked to ensure that a letter does contain the information members need to know about a change to their cover, complaints to the private health insurer and to PHIO can reveal issues that are not well understood by members. For example, one private health insurer removed obesity/lap band surgery from one of its policies last year. A number of members on the policy who had already had a lap band fitted did not realise they needed to upgrade their policy to cover the adjustment or removal of the lap band.

4. Informed financial consent

4.1. Introduction

As the national consumer protection agency the ACCC is a strong advocate of the importance of informed financial consent (IFC) in the health care sector. The concept of IFC is that consumers are given all the necessary information to enable them to make fully informed decisions about acquiring health care services.

IFC was defined in the explanatory memorandum of the Private Health Insurance Bill 2006 as:

> "… the consent to treatment obtained by a medical practitioner from a patient, prior to that treatment whenever possible, where the practitioner has sufficiently explained his or her fees to the patient to enable the patient to make a fully informed decision about costs. Medical specialists who participate in health funds' gap cover arrangements are required to provide informed financial consent prior to treatment where possible."

For consumers, the health services market is characterised by information asymmetry. That is, consumers hold less information than providers. For this reason, the ACCC considers it to be essential that consumers are clearly informed.

Certainly, the health care sector differs in some respects from many other service industries in the Australian economy. The ACCC acknowledges that decisions regarding medical treatment are often made in circumstances where there is not a lot of time for reflection. Unforeseen circumstances do arise and numerous service providers are often involved.

However it is clear from both contact data and submissions that there are persistent information gaps for consumers and that no one cohort of health sector participants accepts responsibility for providing the consumer with full disclosure of all the costs they will face.

4.2. The ACL and IFC issues

The ACL does not include a provision that deals explicitly with IFC. However it places an obligation on businesses not to engage in misleading or deceptive conduct or conduct that is likely to mislead or deceive. As such silence as to extra charges or restrictions or exclusions on benefits may be unlawful. Further, a failure to be open about price may result in an allegation or finding of unconscionable conduct—as the inherent information asymmetry in the relationship between health care provider and consumer/patient means that consumers are often in a position of being unable to properly assess whether the price being charged is fair or if they can 'do better', which may affect their ability to give their IFC.

The ACCC understands consumers commonly face significant out-of-pocket expenses that are not explained in advance. Government research first cited by CHOICE magazine in 2007 showed this to be on average $720 per in-patient procedure. And 21 per cent of people did not know they would be facing gap payments.[12]

12 http://www.yourhealthinsurance.com.au/how-to-get-the-best-health-insurance-cover-in-australia/

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

Issues of concern include:

- consumers not being covered for things which they understood were covered
- consumers being offered products that do not cover common surgical procedures.

4.3. Submissions

This year the submissions to the ACCC again raised these issues. In addition, some submissions indicated there was confusion surrounding the responsibilities of various private health insurance sector participants for obtaining IFC from consumers.

4.3.1. General

Submissions on gap charges were received from regulators, professional associations and private health insurers in the 2010–11 period.

According to DoHA there were increased complaints (from 99 to 154) about IFC issues including medical gaps and hospitals gaps to PHIO in the period. The reason for this is unknown. DoHA postulated this increase may have been due to increasing consumer awareness of the issue. DoHA also noted that complaints about gaps are not necessarily complaints about IFC.

DoHA also explained that most issues with out of pocket costs arose with bills for medical specialists such as radiologists and anaesthetists which could be partially explained by the number of services supplied by these providers and the fact that there is a low bulk billing rate for such services.

The Health and Community Services Complaints Commissioner, South Australia (HCSCC) provided a detailed submission based on their experience since October 2005. According to the HCSCC a consumer is usually provided with sufficient information to grant their IFC by the treating doctor, the hospital or the anaesthetist however there may be other service providers involved, such as pharmacists and critical care specialists (or 'third party providers'). The HCSCC explained the problem here as being a lack of a direct relationship between the consumer and the third party provider meaning the consumer was not in a proper position to grant their IFC.

The HCSCC noted that for elective procedures, the treating doctor is aware that is it highly probable that a third party provider will be involved (for example critical care specialists following cardiac surgery) and of other treatments that may require subsequent intensive or high dependency acute care. Yet consumers may not be informed about this and thus not given the opportunity to give their IFC for the additional costs involved. They may also not be aware what arrangements the third party provider may have with a private health insurer provider. This problem is exacerbated where the patient is not told at all and is therefore unable to even seek information regarding coverage from their private health insurer. In the HCSCC's experience consumer complaints can result from lack of financial consent for treatment received from a third party provider who does not have a 'no-gap', or 'known gap', arrangement with their insurer.

The HCSCC indicated that treating doctors involved in complaints about these situations either deny they are responsible for informing consumers about costs that may be incurred if third party providers are required, or rely upon general statements in their IFC paperwork about the possibility of other costs, such as pharmacy, that do not specify the full range of third party providers whose services may attract separate fees.

Medibank Private submitted that while hospitals often have well established protocols to ensure IFC was obtained, such protocols do not always exist for individual doctors.

Reiterating previous submissions the Consumers Health Forum (CHF) argued that IFC must remain at the top of the agenda and that improvements were required by both private health insurers and health service providers. The CHF stressed this was an important issue in a climate of rising healthcare costs.

The Australian Dental Association (ADA) reported it had advocated the use of written treatment plans to its members which could be presented to the private health insurer by the consumer to gauge available rebates and likely out of pocket costs. The ADA argued that imposing an obligation on dentists to provide their patients with advice about gaps is unreasonable because of the large number of different private health insurers and the even larger number of cover levels on the market.

The Australian Society of Anaesthetists (ASA) reiterated its ongoing concerns as expressed in several previous submissions about the issue of IFC. The ASA submission highlighted that it is the private insurers who can calculate the rebate (and hence the gap) and should therefore have an obligation to inform consumers as to the implications of their rules and regulations.

The ASA also stated that describing private health insurance products as 'gap cover/no gap' causes confusion because it leads consumers to believe that in purchasing 'top cover' or 'full hospital cover' private health insurance policies there will be no out-of-pocket expense. The ASA said this was not the case and private health insurers had a responsibility to inform consumers of this at the time they purchase cover.

4.3.2. Submissions on responsibility for obtaining IFC

The submissions on this issue disclosed a lack of agreement within the industry regarding what each participant in a transaction is required to do to provide information to a patient to allow IFC.

The Australian Medical Association (AMA) argued that private health insurers should publish their medical benefits schedules on their websites. According to the AMA this would reduce the onus on doctors to communicate costs of hospitalisation to patients as it also depends on the hospital and the insurer.

As noted above the ADA also said IFC should not just be up to the practitioner, it should be the responsibility of private health insurers.

Along the same lines and reiterating its previous submission, the Australian Day Hospital Association (ADHA) noted that it is problematic that service providers other than the private health insurer be expected to provide information about the net cost to a patient of a medical episode. This is due to the possibly large number of providers involved and the role played by the private health insurer in setting terms and conditions. The ADHA argued that it is the responsibility of the private health insurer to provide specific and real time information to their membership relative to the policy purchased from the insurer.

Two private health insurers addressed the issue of responsibility for providing information that would enable consumers to give their IFC in this period. Each said health service providers are failing in performing their obligation to obtain IFC and that obligation needs to be enforced. One private health insurer called for legislated requirements for health service providers. The private health insurers said that health service providers have to be clear on all costs as private health insurers only have an obligation to advise of benefits paid and not the fees to be charged. The consumer needs both the fees and the benefits to assess gap charges resulting in out of pocket expenses if they are to give their IFC for procedures.

4.3.3. Submissions on exclusions and restrictions

The ACCC received reports of policies excluding a wide and varying range of procedures, such as major eye surgery and heart-related surgery.

Data from PHIAC showed that while the number of private health insurance products with exclusions was increasing significantly, they still represented a very small proportion of products on offer.

The Australian Society of Plastic Surgeons submitted that consumers unwittingly restrict themselves to health insurance products that place restrictions on plastic and reconstructive surgery due to confusion in relation to the terms used in policies. This led to it receiving complaints that patients were unable to receive reconstructive treatment following the removal of a cancer.

The Mental Health Council of Australia and beyondblue provided a joint submission which, among other things, noted that there is a lack of awareness among consumers with mental illness as to their rights and responsibilities in relation to insurance e.g. exclusions, restrictions and limitations for pre-existing conditions and the level of cover required for rebates on treatment for mental illness.

The CHF noted that the number of products with exclusions was rising at the same time as the proportion of consumers with full hospital cover was falling. The CHF also expressed the view that there were many products marketed to certain groups of people with inappropriate exclusions and restrictions for services that those groups of people could be expected to want to access.

The ADHA also argued that each patient should be able to contact their fund and get a full list of exclusions/restrictions.

One private health insurer argued for the strengthening of the National Healthcare Agreement which requires that public hospitals fully explain to patients that electing to be private patients may result in out of pocket costs. The private health insurer said this did not always occur and resulted in consumers making uninformed decisions.

The Australian Physiotherapists' Association (APA) was concerned that some private health insurers subjected their members to 'step-downs' (reducing the benefit paid for a service when they come close to their annual limit for physiotherapy, resulting in unexpected out of pocket costs for the client). The APA argued that these step-downs served no benefit to members and they made it difficult for physiotherapists to give advice about these costs. Another concern was the lack of transparency about widening discrepancy between rebates paid to visits to network and non-network physiotherapists (or 'preferred providers').

4.4. Other developments

4.4.1. Compulsory incidentals fee

A number of the submissions brought the ACCC's attention to the imposition by a major private hospital group of a compulsory incidentals fee levied to cover the costs associated with the provision of pay television, internet access and individual robes. This fee had been levied on day patients as well as those staying overnight or longer. Concerns expressed about the fee in the context of IFC included:

- its disclosure to patients being relatively late in the admission process
- its compulsory nature
- concerns that that those paying the fee were not actually using the services it was levied to provide.

The consumer group CHF primary concern was that consumers were not given a real choice as to whether or not to pay the incidentals fee.

Various private health insurers also weighed in on this development saying, that the charges:

- were a departure from 'normal' industry practice for sundry items
- challenged the underlying premise of private health insurers' hospital products
- undermined the concept of Participating Hospital providers
- diminished the value proposition of the health insurance product
- represented exploitation of the imbalance in bargaining power between the private hospital group and consumers as it was not a fee for actual goods or services.

While noting the private health insurers' concerns that such fees challenge the value of private health insurance products, the ACCC took the view that the private hospital group was taking reasonable steps to inform prospective patients of the fee and as such there did not appear to be a failure to comply with obligations under the ACL. It did however request that the group disseminate information about the compulsory fee more broadly to assist prospective patients to have access to all relevant information as early as possible.[13]

4.4.2. Overseas students

The ASA's submission on gap charges for the period dealt with particular issues relevant to overseas students. Overseas students are required to have private health insurance and DoHA sets out deeds which private health insurers are meant to follow in providing this insurance including encouraging affordable care, discouraging bad debts and providing full information. The ASA said this is not done. According to the ASA this is exacerbated because the Medicare Benefits Schedule fee is used which is inadequate and often leads to very high out of pocket expenses and bad debts and neither students nor anaesthetists were sufficiently aware of this discrepancy. The ASA said requests to private health insurers to improve the situation have not been heeded.

13 The ACCC wrote to the private hospital group outside the reporting period advising it was not proposing to take further action.

4.5. Summary and recommendations

The issue of responsibility for the attainment of IFC is vexed and is ongoing. This issue has been noted as a problem in the private health insurance industry in each and every report of the ACCC to the Senate on anti-competitive and other practices by health funds and providers in relation to private health insurance, for periods spanning 1999 to 2011.

The ACCC notes that each of the various parties involved in the provision of private health care to consumers is in a contractual arrangement with the consumer and may face problems where the consumer arguably has not consented to the price of a procedure and disputes their obligation to pay. The ACCC has repeatedly stated its view that:

- Consumers have a right to seek and obtain information regarding costs—where possible—in advance of the services being provided.
- Health care providers and private health insurers have a duty to provide consumers with clear, straightforward information about the total cost of health services to enable consumers to attempt to determine the amount that they will be able to claim back from their private insurer.
- It is best practice for private health insurers to facilitate a detailed breakdown of costs based on information provided by consumers and health care providers particularly where restrictions and exclusions apply.

In regard to health insurance benefits (or rebates), providers cannot be expected to know the relevant benefits available from all private health insurers but should be able to advise the cost for the procedure being considered, which insurers they have arrangements with (and the usual benefits the insurer pay for the procedures). This should equip consumers with sufficient information to make informed decisions or to seek further information from that insurer or other providers.

The ACCC's sphere of responsibility does not extend to the ability to instruct private health insurance sector participants to act on the issue of IFC. As noted it is unlawful under the ACL to provide information that is misleading or deceptive about the price of a service. While it is possible failure to provide sufficient information to allow an informed treatment decision will breach the ACL, in the ACCC's experience this will rarely be the case, such complaints invariably involve facts and disclaimers specific to the case.

The ACCC notes that many stakeholders have called for a change to the manner in which the full terms and conditions of particular insurance policies, or changes thereto, are communicated to consumers to make the information more clear. These submissions go beyond the provision of standard information statements required by the PHI Act. The ACCC concludes there are information gaps for consumers paying for private health insurance in relation to the extent of cover obtained.

Under the PHI Act insurers are required to provide a standard information statement for every single insurance policy. This is to allow consumers to compare simple one page information on each policy. The ACCC understands that DoHA regularly reviews these to identify opportunities for improvement. Any changes are made by regulation via the *Private Health Insurance (Complying Product) Rules*. The ACCC recommends that the concerns outlined by stakeholders in this Report be taken into account in the formulation of any future changes by DoHA.

Problems surrounding IFC have been commented upon by the ACCC in each of its 13 PHI reports. For there to be a significant change for the better there needs to be either government or industry commitment to change the status quo.

5. Contracting

5.1. Introduction

The ACCC notes that a key aspect of the private health insurance sector is conducting business transactions including entering into negotiations and contractual arrangements. This is common in commercial dealings in all sectors and mostly will not raise any issue under competition or consumer law.

However there are instances where the circumstances surrounding entry into a contract, or the terms and conditions contained in a contract, may intersect with the CCA. For example, companies are free to set the terms and conditions of their contracts as long as they do not engage in misleading and deceptive conduct, abuse a position of market power or breach the laws governing unconscionable conduct. Some provisions of Australia's competition law specifically prohibit the making or giving effect to a contract containing a cartel provision, or which has the purpose, effect or likely effect of substantially lessening competition.

In this chapter various contractual arrangements between different parties are examined, including:

- private hospitals and health funds—generally
- private hospitals and health funds—second tier default benefits
- individual professionals and health funds
- consumers and health funds
- unfair contract terms
- preferred provider schemes.

The following areas were also within the ambit of consultation for the report however there were no submissions received or issues to report for the period:

- individual professionals and private hospitals
- consumers and private hospitals
- consumers and individual professionals
- unconscionable conduct.

5.2. Private hospitals and health funds

5.2.1. Background

The contracts (hospital purchaser provider agreements or HPPAs) negotiated between private health insurers and private hospitals generally result in fund members benefitting from a regime of no/known gaps for accommodation services at the particular hospital.

The contracting process between hospitals and private health insurers has not been without its problems.

A typical scenario reported to the ACCC has been where a large private health insurer contracts with one hospital and declines to award a contract to another, with the latter hospital alleging it is being prevented from engaging in competitive conduct.

If the private health insurer has sound commercial reasons for the selection of only one provider, and no proscribed anti-competitive purpose, the behaviour is not likely to be caught by the CCA.

5.2.2. Submissions on HPPA negotiations

In compiling this report the ACCC received a variety of submissions which addressed the issue of HPPA negotiations.

Interestingly two of these submissions, from private health insurers, indicated that a change of dynamic may be occurring in the negotiating environment.

One insurer expressed concerns about the perceived trend of larger hospital groups adopting a 'one-in, all-in' position and a resultant weakened bargaining position for private health insurers. Another insurer also noted that the increasing use of contracted or consultant negotiators by hospitals has led to concerns these advisors have the potential to use pricing information from different organisations to maximise the price paid by insurers to hospitals.

5.2.3. ACCC contacts

Contacts made to the ACCC on the issue of HPPA negotiations during the report period from private hospitals seeking information about collective bargaining under the CCA's authorisation and notification provisions support these observations.

5.2.4. Summary

From the ACCC's perspective, there is recognition that relativities in bargaining power may affect the outcome of HPPA negotiations and that this in itself is not unlawful. Although there will be some circumstances where conduct in the context of negotiations may breach the CCA, no conduct of such concern came to the attention of the ACCC during the period.

The ACCC will continue to monitor developments in this space but notes it would appear that the increased cut and thrust of negotiating tactics and alliances between both insurer and hospital groups do not appear to be having a detrimental effect on consumers, such as an increase in premiums paid or a decrease in services obtained.

5.3. Second tier default benefits regime

5.3.1. Background

Second tier default benefits enable certain hospitals that do not have a HPPA with a particular fund to receive a default benefit of no less than 85 per cent of the average scheduled benefit payable by that fund to comparable hospitals for psychiatric, rehabilitation, palliative care and other hospital treatment.[14]

5.3.2. Submissions on Second tier default benefits regime

Several of the submissions to the PHI Report received by the ACCC addressed the issue of second tier default benefits.

PHIO reported it saw a trebling of complaints (from three to nine) from healthcare providers about the second tier default benefit. A number of these complaints showed dissatisfaction with the rules governing these arrangements. This is a matter the ACCC understands that PHIO is intending to take up with DoHA.

Three private health insurers said the second tier default benefits regime stifles competition and bargaining because of an advantageous fall-back position and argue the presence of this regime within a negotiated price market is undermining the prices of contracted hospital facilities as it is used as a price negotiation strategy by hospitals.

The same private health insurers argued the regime is unduly favourable to some hospitals and does not incentivise hospitals to improve clinical outcomes or to stop hospitals from charging members additional amounts via out of pocket expenses.

Conversely, one private hospital group supported the second tier default benefit regime, submitting that it was an essential policy initiative and that it acted as a safety net for hospital negotiations. However, the group noted some drawbacks and called for legislative change to ensure the second tier rate be set at 95 per cent and for second tier rates to be made public.

5.3.3. Summary

The ACCC sees the second tier default benefit regime as predominantly a government policy initiative set outside the boundaries of the CCA. However, the CCA will apply to the conduct of negotiations. Compliance with other government regulations governing the regime will not automatically provide a defence to allegations of anticompetitive conduct.

14 In 2010 the *Private Health Insurance (Benefit Requirement) Rules* were amended to restore the ability of hospitals and insurers to negotiate agreements relating to the payment of private health insurance benefits for hospital accommodation costs at a rate below the legislated minimum benefit payable for an episode of hospital treatment. The legislated default benefit would only apply when there was no negotiated agreement in place. See http://immunise.health.gov.au/internet/main/publishing.nsf/Content/8127DF8BDA0A160CCA25791200181C8C/$File/AnnRegPlan2011-12.rtf

5.4. Individual professionals and health funds

5.4.1. Background

Many health service providers and their professional associations have expressed firm philosophical opposition in the past to entering into contractual arrangements with private health insurers in relation to services they provide to patients (medical purchaser provider agreements or MPPAs). They have argued such contracts can lead to private health insurers interfering with their clinical independence. Conversely, some practitioners, particularly in the allied health fields, have been concerned that a refusal to deal by private health insurers has led to a competitive disadvantage for them.

5.4.2. Submissions

The Australian Society of Clinical Hypnotherapists (ASHC) submitted that the failure of most private health insurers to provide benefits for hypnotherapy or restrictions imposed on coverage puts their members at a competitive disadvantage in many ways.

5.4.3. Summary

In limited circumstances a refusal to deal may be illegal under the CCA where the refusal is motivated by an anticompetitive purpose. In general, businesses may decide for themselves with whom they wish to deal. The ASHC concerns do not appear to raise CCA issues.

5.5. Consumers and health funds

During the reporting period the ACCC received low levels of contact from consumers regarding health funds.

A possible issue of concern to the ACCC is the unilateral variation of contract terms for private health insurance, especially where consumers have paid in advance. The inclusion of such clauses usually reflects a significant imbalance in the relative power of the parties to the contract. The new Unfair Contract Terms (UCT) provisions in the ACL make a term in a consumer contract void if the term is unfair and the contract is a standard form contract.

While businesses may use standard terms in consumer contracts to protect their legitimate commercial interests and improve efficiency, a term in a standard form consumer contract is unfair if:

- it would cause a significant imbalance in the parties' rights and obligations arising under the contract, and
- the term is not reasonably necessary to protect the legitimate interests of the party who would be advantaged by the term, and
- it would cause detriment (whether financial or otherwise) to a party if it were to be applied or relied on.

While health insurance contracts may be subject to the UCT laws the ACCC notes that all terms in private health insurance products are subject to review by the Minister for Health and Ageing and permitted either under the Private Health Insurance Act or Regulation. In these circumstances, it is unlikely that a variation will be unfair.

Further detailed information about the UCT laws is available at www.accc.gov.au/acl or www.consumer.gov.au.

The ACCC also received low levels of contact indicating that consumers were unaware that the terms of their cover had been changed and that notices advising of reductions in coverage gave little prominence to such changes. The ACCC has previously recommended that private health insurers have regard to CCA considerations when exercising their rights to vary contracts in compliance with the PHI Act. This would include clear and unambiguous communications with policy holders.

Finally, it is noted that a small number of complaints were received from consumers that representations were made by private health insurers that the consumer would receive more benefits by changing policies and that this, allegedly, did not turn out to be the truth.

A number of these complaints were referred to appropriate agencies and the ACCC will continue to monitor these issues.

It should also be noted that health consumers are also provided the right of appeal and redress through the PHIO in relation to contractual disputes with private health insurers. PHIO's role is to mediate an outcome between the complainant and the service provider.

5.6. Preferred provider schemes

5.6.1. Introduction

A number of private health insurers have preferred provider arrangements with allied health practitioners, with stated aims such as ensuring that members have no gap or a known gap for ancillary services (not necessarily to decrease premiums, or increase annual limits). The theory is that similar treatment with a preferred provider will give consumers higher rebates and lower gap payments, while still paying the same annual rebate.

Preferred provider schemes raise important issues for patients who are members of private health insurers as well as for allied health care service providers.

To become a preferred provider the allied health service provider signs a contract with the private health insurer agreeing to charge patients a pre-determined fee for any treatment carried out. The allied health service provider hopes to obtain a competitive advantage by marketing themselves as a preferred provider.[15]

The ACCC understands that regulations permit private health insurers to have preferred provider schemes.

15 This section of the PHI Report is confined to preferred provider arrangements with allied health service providers. It does not consider the broader issue of members of a health fund being offered discounts by commercial entities more generally, e.g. in relation to travel or entertainment, on the basis of their membership of a particular fund.

The main issue as far as consumers are concerned, is that of choice, i.e. potentially suffering a financial penalty if they decide not to seek treatment with a preferred provider with whom their insurer has arrangements.

Where a consumer has a private health insurance policy that includes a preferred provider arrangement they may receive a greater rebate or better deal when choosing to have treatment at a private health insurer's preferred provider. However, they are still free to seek treatment elsewhere if they wish—they simply receive a lower rebate.

5.6.2. Submissions

In seeking submissions to this PHI Report the ACCC sought the view of individuals and organisations on third line forcing as it applies to preferred provider schemes.

Over the life of this report and within the 2010–11 period, 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 private health insurer interfering in the clinical decision making of the practitioner.

They have also raised concerns that the schemes may breach the CCA. Such concerns fall into four categories:

- allegations by allied health service providers not part of preferred provider schemes that the private health insurer is restricting their right to practice by not granting them preferred provider status
- that in engaging in the conduct the private health insurer is breaching the CCA by abusing their market power
- that in referring to its contracted suppliers as 'preferred providers', private health insurers are engaged in conduct which may be misleading or deceptive, or are making false misrepresentations about, the price, quality or standard of different allied health service providers
- most commonly, it is alleged that private health insurers, in requiring attendance by members at a preferred provider in order to attain higher rebates/lower gaps are engaging in 'third line forcing'.

Regulators' submissions reflected a lack of concern about such schemes. Private health insurers argued that these schemes are designed and administered in the best interests of consumers.

For the first time, the bulk of the submissions informing the report are available to read in full.

Third line forcing explained

Broadly speaking, exclusive dealing occurs when one person trading with another imposes some restrictions on the other's freedom to choose with whom, in what, or where they deal. Section 47 of the CCA prohibits various forms of exclusive dealing. Broadly, it captures two types of anti-competitive transactions:

1. the conditional supply of goods or services, and
2. refusing to supply for specified reasons (generally because the prospective acquirer has a commercial relationship with a competitor of the would-be supplier).

Most forms of exclusive dealing are captured only if it can be demonstrated that they either have the purpose, effect or likely effect of substantially lessening competition. However, third line forcing is captured regardless of its anti-competitive effect.

Essentially, third line forcing captures the supply of goods or services on condition that the customer acquires other goods or services from a third party (or refusing to supply because the customer will not agree to such an acquisition).

Recognising potential benefits associated with exclusive dealing, including third line forcing, a system of notification and authorisation is available.

The ACCC may authorise or allow notification of proposed conduct to stand, where businesses seek to engage in arrangements or conduct that would otherwise breach the competition provisions of the CCA when it is satisfied that the public benefit from the arrangements or conduct outweighs any public detriment.

In order for an exclusive dealing notification to be valid, among other things, the notified conduct must be conduct of a kind referred to in section 47. The assessment of each notice for validity does not require the applicant to prove conclusively that the conduct will in fact breach the relevant provisions. Rather, the notice can be assessed on a preliminary basis as valid if it is arguable that the notified conduct could constitute exclusive dealing conduct. ACCC staff will subsequently consider whether the notice should be revoked on the basis that the benefits of the proposed arrangements do not outweigh the public detriment.

During the reporting period the ACCC received 18 notifications for conduct that could amount to third line forcing from participants in the industry. A list of the ACCC's considerations during the period can be found at Appendix 6 Mergers, authorisations and notifications for the period.

5.6.3. Summary

Submissions to the ACCC and contact data for the 2010–11 period reveals that consumers are, on the whole, satisfied with preferred provider schemes though they had some concerns about having to make a decision on receiving a higher rebate or choosing an allied health service provider they preferred on the basis of relationship, convenience or quality. However, professional associations and individual allied health care providers have, not for the first time, raised numerous concerns about such schemes.

In summary, the allied health service providers' position is that preferred provider arrangements have the effect of limiting allied health services provided. The providers say private health insurers have increased rebates for consumers using preferred providers at a higher rate than for non-contracted services and that this exacerbates the discriminatory approach by private health insurers to non-contracted providers.

The ACCC has on a number of occasions assessed whether private health insurers, through their preferred provider arrangements, are engaging in conduct in contravention of the third line forcing provisions contained in section 47 of the CCA.

The ACCC remains of the view that the conduct engaged in by the private health insurers is unlikely to constitute a contravention of section 47 of the CCA.

5.7. Chapter summary

In terms of perceived anti-competitive practices some issues have remained contentious (preferred provider schemes) while others appear to have become less controversial (contracting between industry participants).

The contracting process, to the extent that it may raise issues under the CCA is of importance to the ACCC. It will continue to examine any allegations of breaches of the CCA raised in relation to the contracting process and will further investigate, and if necessary litigate any such matters that raise competition and consumer issues in line with its Compliance and enforcement policy.

6. Other issues

In compiling the 2010–11 PHI Report the ACCC consulted on several industry developments that had not previously featured in this report.

The issues were:

- the development of industry-run online comparison tools for finding and comparing health specialists
- moves by insurers to provide primary (chronic disease management) and preventative healthcare services to members
- increasing awareness and utilisation of non-traditional or alternative health services by consumers.

Submissions on these issues and complaint levels do not indicate the existence of significant concerns that warrant specific ACCC intervention. As always the ACCC will continue to monitor industry developments.

An environmental scan also indicated that issues which had previously appeared on the ACCC's radar in constructing annual PHI Reports, specifically portability and prostheses, were no longer red-light issues in the industry.

6.1. The development of industry-run online comparison tools for finding and comparing health specialists

In the private health insurance sector online comparison sites are not new. Certainly, the Private Health Insurance Ombudsman has for many years run such a service and has only recently relaunched its independent comparator site and is seeking opportunities to disseminate this to consumers.[16]

Private operators representing various private health insurers have also established such tools (i.e. www.iselect.com.au) and the ACCC's approach has been to caution traders, as in any industry, that comparisons which are not meaningful (i.e. like for like) may be misleading to consumers and therefore risk breaching the CCA.

In 2011 a new development was the contemplation by individual health insurers of creating comparison sites that would feature health care service providers instead of private health insurers such as dentists, physiotherapists, chiropractors, optometrists, podiatrists and naturopaths.

Concerned whether there may be potential for consumer detriment or anticompetitive conduct in this newer sphere the ACCC sought submissions from stakeholders. These submissions predominantly adopted a cautiously welcoming approach to the developments.

From the perspective of a government regulator, PHIO submitted that it encourages comparison tools however is concerned that information which is subjective or irrelevant may be misleading to consumers. PHIO planned to monitor these developments and take up any complaints with the private health insurer, independent private operator or health care provider as they arose.

DoHA commented that such tools are very much in their infancy so their likely impact on consumers had not been assessed by DoHA at this time.

Private health insurers had an obvious interest in this issue.

16 See further http://www.privatehealth.gov.au/dynamic/compare.aspx

NIB health insurance, whose mooted www.whitecoat.com.au site was one of the prompts for the ACCC's enquiries in this area stated they were acting in response to clear customer demand and that they would welcome any approach by the ACCC to discuss any concerns as they arose.

iSelect wrote to the ACCC and submitted that the development of private health insurance and intermediation tools reflects the combined impact of the general move by consumers online and the economic imperatives for private health insurers to attract and retain customers.

Bupa said it would welcome additional regulatory protections for consumers in relation to online brokers.

6.2. Provision of primary healthcare by private health insurers

In conducting literature reviews in the broad area of public health strategy the ACCC found private health insurers were increasingly beginning to provide primary (chronic disease management) and preventative healthcare services to members. This is not mandatory and is currently being provided at no extra cost by participating insurers.

PHIO and DOHA informed the ACCC that this was first enabled in 2007 and that the *Private Health Insurance (Health Insurance Business) Rules 2010* allow private health insurers to provide chronic disease management and preventative health services to members.

PHIO submitted it expects the trend to provide such services will continue and increase and will be for the benefit of members.

DOHA said it is aware that some private health insurers are operating health care centres which offer allied health care services such as dentistry to both members and non members and expects this trend will increase.

The Private Health Insurance Intermediaries Assoc (PHIIA) applauded the move of health insurers into preventative and primary health provided they maintained a broad spread of practitioners in their general coverage.

However divergent views were put by different individual private health insurers.

One private health insurer said that benefits paid at its private dental centres are enhanced to incentivise preventative health.

Another reasoned that the provision of new services would increase population health amongst their members and put downward pressure on premiums which could be passed on to the general population.

However, another private health insurer in the market cautioned that such developments were an outcome of acquisitions of health management and corporate health promotion companies by large private health insurers. It submitted various acquisitions had reduced the available procurement options for other private health insurers to enhance their own health management capabilities and limited competition.

6.3. Increasing awareness and utilisation of non-traditional or alternative health services by consumers

The ACCC received no submissions pertaining to any potential competition or consumer detriments associated with the increased activity in the non-traditional or alternative health service sector.[17]

17 However the Australian Homeopathic Association expressed concern that private health insurers may withdraw rebates for services provided for homeopaths at a point in the future on the basis of a leaked draft research report.

Appendix 1 Glossary

ABS	Australian Bureau of Statistics
ACL	Australian Consumer Law
ancillary cover	A form of private health insurance that covers the cost of some non-hospital services such as physiotherapy or dental treatment—see 'hospital cover' (also known as general cover).
CCA	*Competition and Consumer Act 2010*
CPI	Consumer price index
gap	The difference between the benefit payable by a health insurer and the cost of treatment.
hospital cover	A form of health insurance that covers hospital treatment costs such as accommodation or medical fees for in-hospital services—see 'ancillary cover'.
IFC	Informed financial consent
PHIAC	Private Health Insurance Administration Council
PHIO	Private Health Insurance Ombudsman
MBS	Medical Benefits Schedule—schedule of medical fees set by the government. People can claim a rebate of 75 per cent of the MBS fee for in-hospital medical fees and 85 per cent of the MBS fee for medical fees incurred out of hospital, whether or not they are members of a health insurer.
Medicare levy surcharge	An additional 1 per cent surcharge on the taxable income of high income earners who are eligible for Medicare but who do not have an appropriate level of hospital insurance with a registered health insurer.
no gap/known gap	Arrangements by which a health insurer covers the entire gap or requires members to contribute towards the gap but informs them in advance of the amount that they will need to pay.
second tier (or 2nd tier) benefit arrangement	A legislative arrangement setting the level of benefit payable to a default benefit hospital that does not have a contract with a health insurer at 85 per cent of the average benefits currently paid by that health insurer for the episode of care in comparable private hospital facilities with which the health insurer has contracts.

Appendix 2 Invitation to consult

10 August 2011

Dear Stakeholder,

The Australian Competition and Consumer Commission (ACCC) is inviting interested parties to comment on preliminary issues identified by the ACCC in preparing a report for the Australian Senate on private health insurance (the PHI report).

The Senate requires the ACCC to provide an annual assessment of: "any anti-competitive or other practices by health funds or providers which reduce the extent of health cover for consumers and increase their out-of-pocket medical and other expenses."

This PHI report will cover the period 01 July 2010 to 30 June 2011 (the 2010–11 period). It is the 13th report prepared by the ACCC in compliance with an order agreed to by the Senate on 25 March 1999 and amended on 18 September 2002.

Previous PHI reports can be viewed on the ACCC website at www.accc.gov.au.

The law

The *Competition and Consumer Act 2010* (the CCA)—formerly known as the *Trade Practices Act 1974*—contains rules against anti-competitive conduct to ensure fair and effective competition. The CCA also contains consumer protection rules—known as the Australian Consumer Law (ACL)—which businesses must abide by in their dealings with consumers.

The ACCC is the independent statutory authority established to enforce and encourage compliance with the CCA.

Preliminary issues and developments identified

1. Contracting issues

Question 1

The CCA applies to the complex set of arrangements that exist between private health insurance sector participants. Examples of such relationships could include negotiations between:

- private hospitals and health funds
- individual professionals and private hospitals
- individual professionals and health funds
- consumers and health funds and/or private hospitals and/or individual professionals

(a) the ACCC seeks comment on any developments or trends in the sector in 2010–11 that have impacted on these contractual arrangements

(b) the ACCC understands that differences in bargaining power may affect the outcome of Hospital Purchaser Provider Agreement (HPPA) negotiations both in and outside of the legislated default benefit regime. Submissions addressing these issues are of interest to the ACCC

(c) the ACCC welcomes any submissions about existing industry codes of practice which regulate contract negotiations between hospitals and health funds.

2. Preferred provider schemes

Under the CCA third line forcing involves the supply of goods or services on condition that the purchaser buys goods or services from a particular third party, or a refusal to supply because the purchaser will not agree to that condition. The ACCC is of the view that private health insurers, through their preferred provider arrangements, are unlikely to be engaging in conduct in contravention of the CCA.

Question 2

Please provide any views you/your organisation may have on third line forcing as it applies to preferred provider schemes.

3. Informed financial consent

Private health insurance sector participants have a duty to inform their patients about the cost of the services they provide. This allows consumers to give their informed financial consent regarding the net costs of medical services after benefit payments, particularly those involving more than one provider.

Question 3

Issues surrounding lack of consumer awareness of gaps and exclusions in private health insurance are not new and have been the subject of comments in previous ACCC PHI reports:

- please comment on any trends in the private health insurance sector affecting informed financial consent in the 2010–11 period
- have you identified any trends in advertising private health insurance during the 2010–11 period? If so, please provide details.

4. Developments

Question 4

The ACCC would welcome further information and comment on any initiatives or developments over the 2010–11 period including:

- the development of industry-run online tools allowing consumers to find and compare healthcare specialists in their local area
- the development of private health insurance comparison tools to compare the cost and terms and conditions of private health insurance policies
- moves by private health insurers to provide preventative and primary health services
- comments on the role of allied health service providers and their relationship with the private health insurance sector.

5. ACCC stakeholder engagement

Question 5

The ACCC encourages feedback on the utility of the PHI report to the private health insurance sector and consumers.

6. How to make a submission

Submissions can be in writing by 5 September 2011. Please indicate if any part of a submission to the ACCC contains confidential information.

Appendix 3 Submissions received

Australian Acupuncture and Chinese Medicine Association Ltd

Australian Day Hospital Association Ltd

Australian Dental Association Inc

Australian Government Department of Health and Ageing

Australian Homeopathic Association Inc

Australian Medical Association

Australian Physiotherapy Association

Australian Society of Anaesthetists

Australian Society of Orthodontists

Australian Society of Plastic Surgeons

Australian Traditional-Medicine Society

Bupa Australia Pty Limited

Consumers Health Forum of Australia

HBF Health Limited

iSelect Limited

Medibank Private Limited

Medical Technology Association of Australia

Mental Health Council of Australia and beyondblue (joint submission)

NIB Health Funds Ltd

Office of the Health & Community Services Complaints Commissioner

Private Health Insurance Administration Council

Private Health Insurance Intermediaries Association

Private Health Insurance Ombudsman

The Australian Society of Clinical Hypnotherapists

The Hospitals Contribution Fund of Australia Limited

The Royal Australian and New Zealand College of Psychiatrists

Wesley Mission

Appendix 4 Reference table to the *Competition and Consumer Act 2010*

COMPETITION

Prohibited business practices under the *Competition and Consumer Act 2010* (CCA)

Cartel conduct	CCA sections 44ZZRF-44ZZRK	Agreements between competitors to: • fix prices • restrict outputs • allocate customers, suppliers or territories • rig bids • are illegal as a criminal offence (punishable by 10 years imprisonment) and as a civil prohibition.
Anti-competitive agreements	CCA sections 45, 45D-45E	The CCA prohibits anti-competitive agreements and exclusionary provisions, including primary or secondary boycotts. Section 45 of the CCA provides a general prohibition on contracts, arrangements or understandings that have the purpose, effect or likely effect of substantially lessening competition.
Exclusive dealing	CCA section 47	The CCA prohibits exclusive dealing; the offering to supply or acquire on condition where this has the purpose or effect of substantially lessening competition. Third line forcing is a specific form of exclusive dealing prohibited outright by the CCA. It is not subject to the substantial lessening of competition test. It involves the supply of goods or services on condition that the purchaser buys 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	CCA section 48	Suppliers, manufacturers and wholesalers are prohibited from specifying a minimum price below which goods or services may not be resold or advertised for resale.

Misuse of market power	CCA sections 46, 46(1AA)	The CCA prohibits powerful players from abusing their market power. In general, to determine whether there has been a misuse of market power, three questions have to be answered. • Does the company have a substantial degree of market power? • Has it taken advantage of that power? • Did it take advantage of that power for the purpose of: – eliminating or substantially damaging a competitor – preventing the entry of a person into that or any other market – deterring or preventing a person from engaging in competitive conduct in any market? Predatory pricing can be addressed under both sections 46 and 46(1AA).
Mergers	CCA section 50	Section 50 of the CCA prohibits acquisitions that would have the effect, or likely effect, of substantially lessening competition in a market in Australia, or a state, territory or region of Australia.[17]
Exemptions		
Authorisation	CCA section 88	Authorisation may be sought in relation to any of the competition provisions under Part IV of the CCA except for misuse of market power. Immunity may be granted under the authorisation provisions of the CCA when the public benefit from the anti-competitive conduct outweighs any public detriment.
Collective bargaining notifications	CCA section 44ZZRL	Collective bargaining occurs when two or more competitors in an industry agree to negotiate terms and conditions (which can include price) with a supplier or a customer. Notification of collective bargaining arrangements provides immunity for potential breaches of the CCA against anti-competitive agreements, price fixing and exclusionary provisions. If the ACCC concludes that the public benefits likely to result from the collective bargaining arrangement will not outweigh the likely anti-competitive detriments the ACCC can remove the immunity provided by the notification.

Exclusive dealing notifications	CCA section 93	Notification of exclusive dealing conduct provides immunity for potential breaches of the exclusive dealing provisions of the CCA. Immunity from an exclusive dealing notification operates from the date it is validly lodged (or soon after in the case of third line forcing conduct) and remains unless revoked by the ACCC. Third line forcing conduct: The ACCC may revoke such a notification if it is satisfied that the likely public benefit will not outweigh the likely public detriment from the conduct. Exclusive dealing conduct other than third line forcing: The ACCC may revoke such a notification if it is satisfied that the conduct would have the purpose, or is likely to have the effect or likely effect, of substantially lessening competition and the conduct has not resulted (or is not likely to result) in a benefit to the public, or any benefit to the public would not outweigh the detriment from any lessening of competition by the conduct.

CONSUMER PROTECTION

The Australian Consumer Law (ACL): general protections

Misleading or deceptive Conduct	ACL section 18	It is unlawful for a business to make statements in trade or commerce that: • are misleading or deceptive • would be likely to mislead or deceive.
False or misleading representations	ACL section 29	When supplying or promoting goods or services, a business must not make a false or misleading representation in relation to: • the standard, quality, value or grade of the goods or services • testimonials by any person relating to the goods or services • the sponsorship, approval, performance characteristics, accessories, benefits and uses of the goods or services • the price of the goods or services • a buyer's need for the goods or services • any guarantee, warranty or condition on the goods or services.

Unconscionable conduct	ACL sections 20–22	Section 20 of the ACL prohibits unconscionable conduct within the meaning of the unwritten law, from time to time. Section 21 of the ACL prohibits unconscionable conduct in connection with the supply of goods or services to a person.[18] Over time the courts have described unconscionable conduct as: • Something being clearly unfair and unreasonable. • Conduct which shows no regard for conscience. • Conduct which is irreconcilable with what is right or reasonable.
Unfair contract terms	ACL section 23	Unfair terms in consumer contracts are void. A 'consumer contract' is a standard-form agreement for the supply of goods or services which is wholly or predominantly for personal, domestic or household use or consumption. A term is 'unfair' when it: • causes a significant imbalance in the parties' rights and obligations arising under the contract, and • is not reasonably necessary to protect the legitimate interests of the supplier, and • causes financial or non-financial detriment to a party.

18 In June 2011 the Australian Government introduced the Competition and Consumer Legislation Amendment Bill 2011, which was passed by Parliament in November 2011. Provisions in the Bill relating to mergers came into effect on 7 February 2012, removing the requirement in section 50 that a market be a 'substantial' market.

19 In June 2011 the Australian Government introduced the Competition and Consumer Legislation Amendment Bill 2011, which was passed by Parliament in November 2011. Provisions in the Bill relating to unconscionable conduct came into effect on 1 January 2012, inserting a set of interpretive principles for unconscionable conduct into the ACL and unifying the consumer and business-related provisions prohibiting unconscionable conduct.

Appendix 5 Compliance and enforcement policy

Policy purpose

This policy sets out the principles adopted by the Australian Competition and Consumer Commission to achieve compliance with the law, and outlines the ACCC's enforcement powers, functions, priorities, strategies and regime.

ACCC jurisdiction and available enforcement options

The ACCC is Australia's peak consumer protection and competition agency. The ACCC is an independent statutory government authority serving the public interest. Most of the ACCC's enforcement work is conducted under the provisions of the *Competition and Consumer Act 2010*.

The purpose of the Competition and Consumer Act is to enhance the welfare of Australians by:

- promoting competition among business
- promoting fair trading by business
- providing for the protection of consumers in their dealings with business.

The Competition and Consumer Act provides the ACCC with a range of enforcement remedies, including court-based outcomes and court enforceable undertakings. The ACCC also resolves many matters administratively. These options are discussed more fully below.

Australian Consumer Law

The Australian Consumer Law is the national consumer law and is applied at the Commonwealth level and in each state and territory.

At the Commonwealth level it is included as part of the Competition and Consumer Act. Compliance and enforcement with the law will be on a 'one-law, multiple-regulators' model, with existing consumer regulators enforcing the uniform law.

This policy is consistent with and expands on the principles in the ACL Compliance and Enforcement Guide and outlines the ACCC's approach to compliance and enforcement more generally.

Prioritisation of enforcement matters and the exercise of the ACCC's discretion

In enforcing the provisions of the Competition and Consumer Act, the ACCC's primary aims are to:

- stop the unlawful conduct
- deter future offending conduct
- undo the harm caused by the contravening conduct (for example by corrective advertising or restitution for consumers and businesses adversely affected)

- encourage the effective use of compliance systems
- where warranted, punish the wrongdoer by the imposition of penalties or fines.

The ACCC cannot pursue all the complaints it receives and the ACCC is unlikely to become involved in resolving individual disputes. While all complaints are carefully considered, the ACCC's role is to focus on widespread consumer detriment and the ACCC exercises its discretion to direct resources to the investigation and resolution of matters that provide the greatest overall benefit for consumers.

To assist with this determination, the ACCC gives enforcement priority to matters that demonstrate one or more of the following factors:

- conduct of significant public interest or concern
- conduct resulting in a substantial consumer (including small business) detriment
- anticompetitive conduct involving cartel behaviour or misuse of market power
- unconscionable conduct, particularly involving large national companies or traders
- conduct demonstrating a blatant disregard for the law
- conduct involving issues of national or international significance
- conduct detrimentally affecting disadvantaged or vulnerable consumer groups
- conduct in concentrated markets which impacts on small business consumers or suppliers
- conduct involving a significant new or emerging market issue
- conduct that is industry-wide or is likely to become widespread if the ACCC does not intervene
- where ACCC action is likely to have a worthwhile educative or deterrent effect, and/or
- where the person, business or industry has a history of previous contraventions of competition, consumer protection or fair trading laws.

Where appropriate the ACCC may also pursue matters that test or clarify the law.

The ACCC reviews its priorities regularly. In addition to those matters that demonstrate the factors above, the ACCC is currently prioritising its work in the following areas:

- consumer protection in the telecommunications and energy sectors
- conduct that may impede emerging competition involving online traders
- competition and consumer issues in highly concentrated sectors, in particular in the supermarket and fuel sectors
- carbon pricing representations
- the ACL consumer guarantees regime
- consumer protection issues impacting on Indigenous consumers.

When the ACCC decides not to pursue enforcement action in relation to complaints it receives, it may nevertheless:

- provide information to the parties to help them deal with the matter and gain a better understanding of the Competition and Consumer Act even where a possible contravention of the Act is unlikely
- postpone or cease investigations where insufficient information is available to it, with a view to later investigation should further information become available
- draw the possible contravention to relevant parties' attention and provide information to encourage rectification and future compliance where the possible contravention appears accidental, of limited detriment to consumers, or of limited gain to the business concerned

- place the relevant parties on notice about the ACCC's concerns and the possibility of future investigation and action should the conduct continue or re-emerge
- deal with the matter informally where a business has promptly and effectively corrected a possible contravention and has implemented measures to prevent recurrence.

While the ACCC relies on complaints to identify issues and inform its compliance and enforcement activities, the ACCC is not a complaint handling body that seeks to resolve every approach. It is unlikely to pursue matters that:

- are one-off, isolated events, unless the conduct involves a blatant and deliberate breach of the law
- are more appropriately resolved directly between the parties under an industry code (for example by way of mediation)
- involve issues more effectively dealt with at the local level by state and territory agencies (for example by way of individual dispute resolution of a complaint)
- are primarily contractual or private right disputes (the Competition and Consumer Act provides complainants with a private right of action in these circumstances).

Principles and approaches underlying this policy

The ACCC exercises its enforcement powers independently in the public interest with integrity and professionalism and without fear, favour or bias.

The ACCC's enforcement response is proportionate to the conduct and resulting harm, and the implementation of the ACCC's enforcement policy is governed by the following guiding principles:

- Transparency—this has two aspects:
  - the ACCC's decision-making takes place within rigorous corporate governance processes and is able to be reviewed by a range of agencies, including the Commonwealth Ombudsman and the courts
  - the ACCC does not do private deals—every enforcement matter that is dealt with through litigation or formal resolution is made public.
- Confidentiality—in general, investigations are conducted confidentially and the ACCC does not comment on matters it may or may not be investigating.
- Timeliness—the investigative process and the resolution of enforcement matters are conducted as efficiently as possible to avoid costly delays and business uncertainty.
- Consistency—the ACCC does not make ad hoc decisions; it sets its focus clearly to give business certainty about its actions.
- Fairness—the ACCC seeks to strike the right balance between voluntary compliance and enforcement while responding to many competing interests.

ACCC compliance and enforcement strategy

To achieve its compliance objectives the ACCC employs three flexible and integrated strategies:

- enforcement of the law, including resolution of possible contraventions both administratively and by litigation
- encouraging compliance with the law by educating and informing consumers and businesses about their rights and responsibilities under the Competition and Consumer Act
- working with other agencies to implement these strategies.

These strategies are discussed further below.

The ACCC has two additional enforcement strategies, the cooperation policy and the immunity policy for cartels. These are discussed briefly below.

Cooperation policy

The ACCC encourages persons and companies who might have contravened the Competition and Consumer Act to come forward and cooperate with the ACCC to address these possible contraventions.

The ACCC may recognise cooperation by:

- permitting complete or partial immunity from ACCC action
- making submissions to the court for a reduction in penalty, or
- agreeing to an administrative settlement instead of litigation.

This policy is flexible, with the ACCC determining each case on its merits. Further information regarding the ACCC cooperation policy for enforcement matters is available at the ACCC website www.accc.gov.au.

Immunity policy for cartels

The ACCC also has an immunity policy designed to encourage self-reporting of cartel involvement. The immunity policy confers immunity from ACCC action to the first eligible cartel participant to report involvement in a cartel. Immunity is provided subject to certain conditions being met, including full, frank and truthful disclosure and continued cooperation with the ACCC's investigation and any subsequent legal proceedings against other participants. Further information regarding the ACCC immunity policy for cartels is available at the ACCC website www.accc.gov.au.

Compliance and enforcement outcomes

The ACCC uses a range of compliance and enforcement tools in order to encourage compliance with the Competition and Consumer Act. In deciding which compliance or enforcement tool (or the combination of such tools) to use, the ACCC's first priority is always to achieve the best possible outcome for the community.

Education, advice and persuasion

The ACCC makes comprehensive use of educational campaigns to provide information and advice to consumers and businesses, and to use persuasion to encourage compliance with the Competition and Consumer Act. The ACCC takes the firm view that prevention of a breach of the Competition and Consumer Act is always preferable to taking action after a breach has occurred.

The ACCC provides targeted and general publications; it liaises broadly with business, consumer and government agencies about the Competition and Consumer Act and the ACCC's role in its administration. The ACCC aims to ensure that consumers are sufficiently well-informed to benefit from, and stimulate, effective competition.

Communicating its enforcement role is fundamental to the effectiveness of the ACCC's information and liaison activities.

Voluntary industry self-regulation codes and schemes

The ACCC encourages and assists genuine voluntary compliance initiatives by individual businesses and industry sectors. These initiatives range from individual trader compliance programs to sector-wide initiatives, including industry charters and voluntary codes of conduct that apply the requirements of the Competition and Consumer Act to the specific circumstances of a particular industry sector.

Administrative resolution

In some cases—for example, where the ACCC assesses potential risk flowing from conduct as low—the ACCC may accept an administrative resolution. Depending on the circumstances, administrative resolutions can range from a commitment by a trader in correspondence to a signed agreement between the ACCC and a trader setting out detailed terms and conditions of the resolution. Administrative resolutions generally involve the trader agreeing to stop the conduct and compensate those who have suffered a detriment because of it, and to take other measures necessary to ensure that the conduct does not recur. The ACCC is unlikely to accept an administrative resolution for conduct that recurs after having been subject to a previous administrative resolution.

Infringement notices

The ACCC may issue an infringement notice where it believes there has been a contravention of the Competition and Consumer Act that requires a more formal sanction than an administrative resolution but where the ACCC considers that the matter may be resolved without legal proceedings.

Section 87B enforceable undertakings

The ACCC often resolves contraventions of the Competition and Consumer Act by accepting court enforceable undertakings under s. 87B of the Act. In these undertakings, which are on the public record, companies or individuals generally agree to:

- remedy the mischief
- accept responsibility for their actions
- establish or review and improve their trade practices compliance programs and culture.

Court cases

Legal action is taken where, having regard to all the circumstances, the ACCC considers litigation is the most appropriate way to achieve its enforcement and compliance objectives. The ACCC is more likely to proceed to litigation in circumstances where the conduct is particularly egregious (having regard to the factors set out on page 2), where there is reason to be concerned about future behaviour or where the party involved is unwilling to provide a satisfactory resolution.

Under the Competition and Consumer Act, legal action may result in the court:

- making declarations that a company or individual has contravened the Act
- making injunctions restraining current or future conduct, or requiring respondents to take certain action
- requiring respondents to publish notices about their conduct and corrective advertising, and to disclose relevant information to others (for example to their customers)
- making findings of fact that show contraventions of the Act so that damages may be recovered by consumers and businesses affected by the conduct
- making orders to achieve financial redress for consumers or businesses harmed by the conduct
- making various non-punitive orders, including community service or probation orders (which may include orders for implementing a compliance or an education and training program)
- imposing significant pecuniary penalties for breaches of the consumer protection or restrictive trade practices provisions (the ACCC is more likely to seek pecuniary penalties in matters which result in significant consumer detriment, involve blatant conduct or where the traders or individuals concerned have a history of past conduct)
- convicting persons found to have contravened various offence provisions in the Act, and/or
- imposing prison sentences for serious cartel conduct.

Appendix 6 Mergers, authorisations and notifications for the period

Informal merger clearances 2010–11

- **Genesis Care Pty Limited—proposed acquisition of Perth Radiation Oncology**
  http://www.accc.gov.au/content/index.phtml/itemId/991441/fromItemId/751046

  The ACCC considered the competitive effects of the proposed acquisition in the context of a market for the supply of radiation oncology services in the greater Perth region.
- **Luxottica Retail Australia Pty Limited—proposed acquisition of Optifashion Group**
  http://www.accc.gov.au/content/index.phtml/itemId/956947/fromItemId/751043

  In response to competition concerns which were identified during the ACCC's market inquiries process, Luxottica and Optifashion agreed to exclude the acquisition of four optical dispensing retail outlets trading under the Just Spectacles brand name from the proposed acquisition.

Authorisation considerations 2010–11

- **The Reserve Bank Health Society Ltd—Authorisation—A91264**
  http://www.accc.gov.au/content/index.phtml/itemId/986430/fromItemId/401858

  Reserve Bank Health Society Ltd (RBHS) entered into a management services agreement with Lysaght Peoplecare Ltd (Peoplecare), a fellow provider of private health insurance, for Peoplecare to provide administrative, operational and management services to RBHS. Information flow between RBHS and Peoplecare and Peoplecare's role in advising the RBHS Board, including on setting premiums and benefits, may potentially be interpreted as cartel provisions under the *Competition and Consumer Act 2010*.

  The application for authorisation was lodged on 29 April 2011 and consultation with third parties occurred in May 2011. On 27 July 2011, the ACCC issued a draft determination proposing to grant authorisation to RBHS for the proposed arrangements for a period of 10 years. On 25 August 2011, the ACCC issued a final determination granting authorisation to RBHS for the proposed arrangements for a period of 10 years.

Exclusive dealing notifications 2010–11

- **Attendant Care Industry Association of NSW Inc (ACiA)—Notification—N95116**
  http://www.accc.gov.au/content/index.phtml/itemId/955718/fromItemId/909727

  The Attendant Care Industry Association of NSW Inc. (ACiA) provides ACiA Endorsed Certification to attendant care provider organisations on condition that they are audited by an ACiA Endorsed Certifying Body. There is currently only one ACiA Endorsed Certifying Body. However, ACiA submits that it is currently taking steps towards endorsing other Certifying Bodies.

- **Australian Natural Brands Pty Ltd T/A In Essence Aromatherapy—Notification—N95203**
  http://www.accc.gov.au/content/index.phtml/itemId/960901/fromItemId/909727

  Australian Natural Brands Pty Ltd T/A In Essence Aromatherapy (In Essence) offers members of Bupa Australia Pty Ltd discounts off its products from time to time.
- **Bupa Australia Pty Ltd—Notification—N94896**
  http://www.accc.gov.au/content/index.phtml/itemId/945201/fromItemId/909727

  Bupa Australia has provider recognition criteria for the payment of benefits to health providers. As part of this provider recognition criteria Bupa Australia requires its providers of ancillary services who are Eye Therapists to receive certification from Medibank Private Limited.
- **Bupa Australia Pty Ltd—Notification—N94897**
  http://www.accc.gov.au/content/index.phtml/itemId/945187/fromItemId/909727

  Bupa Australia has provider recognition criteria for the payment of benefits to health providers. As part of this provider recognition criteria Bupa Australia requires its providers of ancillary services to be members of specified professional associations.
- **Claude Viale & Ors—Notifications—N95259—N95269**
  http://www.accc.gov.au/content/index.phtml/itemId/972941/fromItemId/977921

  Pharmacists supply Non Prescription Goods (that is, goods other than pharmaceuticals available with a medical practitioner's prescription) at a discount of 20 per cent off the normal price on the condition that the person to whom the Pharmacist supplies the goods is a member of Health Partners and elects to contribute to its 'Extras' tables for general treatment health benefits services (Health Partners Extras Members).
- **ClearView Life Assurance Limited—Notification—N94901**
  http://www.accc.gov.au/content/index.phtml/itemId/945573/fromItemId/909727

  ClearView Life Assurance offers additional benefits to consumers who purchase life insurance from ClearView Life Assurance on condition that the consumers are members of the BUPA Australia Health Fund. The additional benefits include specific premium discounts, bonus gifts and other benefits. They will be offered under a series of campaigns over the next three years.
- **EFM Corporate Pty Ltd—Notification—N95235**
  http://www.accc.gov.au/content/index.phtml/itemId/967484/fromItemId/977921

  EFM Corporate Pty Ltd (health clubs) offers a discount when supplying products to members of Bupa Australia Pty Ltd T/A MBF, HBA or Mutual Community (Bupa Australia). That is, those who have health insurance policies with Bupa Australia.
- **Fitness First Australia Pty Ltd—Notification—N95332**
  http://www.accc.gov.au/content/index.phtml/itemId/980813/fromItemId/977921

  Fitness First, which operates health clubs and gyms, offers members of Bupa Australia Pty Ltd, that is those who have health insurance with MBF, HBA or Mutual Community, discounts off its products from time to time.
- **Friendly Society Medical Association Limited—Notification—N95227**
  http://www.accc.gov.au/content/index.phtml/itemId/964568/fromItemId/909727

  Friendly Society Medical Association Limited (trading as National Pharmacies Optical) offers a discount when supplying products to members of Bupa Australia Pty Ltd (that is, those who have health insurance with Bupa Australia).

- **GMHBA Limited—Notification—N95071**
  http://www.accc.gov.au/content/index.phtml/itemId/953487/fromItemId/909727

  GMHBA Ltd, a health fund provider offers its members a higher level of reimbursement on the fees incurred as a result of a medical consultation or surgical procedure on condition that the member has either:
  - consulted with a Sports Titled or Sports Specialist of the Australian Physiotherapy Association or has been referred to a surgeon for the surgical procedure by a member of the AFL Medical Officers Association, or
  - a fellow of the Australasian College of Sports Physicians.
- **Good Life Health Clubs, a division of Ardent Leisure Limited—Notification—N95236**
  http://www.accc.gov.au/content/index.phtml/itemId/967507/fromItemId/977921

  Goodlife proposes to offers a discount when supplying products and services to members of Bupa Australia Pty Ltd T/A MBF, HBA or Mutual Community (Bupa Australia), that is, those who have taken out a health insurance policy with Bupa Australia.
- **Guy Leech World of Fitness Pty Ltd—Notification—N95231**
  http://www.accc.gov.au/content/index.phtml/itemId/966248/fromItemId/977921

  Guy Leech Fitness offers members of Bupa Australia Pty Ltd (trading as MBF, HBA and Mutual Community) discounts when supplying food and exercise products from its online store from time to time.
- **NIB Health Funds Limited and Specsavers Pty Limited—Notifications—N95369 and N95370**
  http://www.accc.gov.au/content/index.phtml/itemId/984406/fromItemId/977921

  NIB Health Funds Limited (NIB) runs a promotion (eligible customers may claim per person benefits despite any sub-limit which would otherwise apply) on condition that the eligible customer purchases certain single vision Budget Products from Specsavers Pty Limited (Specsavers) (in Victoria during the trial period and throughout Australia thereafter).

  Specsavers Pty Limited supplies retail eye care products at a discount to customers on condition that those customers are customers of NIB Health Funds Limited.
- **Pacific Smiles Group Limited (PSG)—Notification—N94916**
  http://www.accc.gov.au/content/index.phtml/itemId/948701/fromItemId/909727

  The Pacific Smiles Group offers first time patients of its Pacific Smiles Dental and NIB Dental Care centres a $50 credit towards general or specialist dental services on condition that the patient is a member of a NIB health fund.
- **PGD Assistance Program Limited atf the PGD Assistance Program Trust—Notification—N95343**
  http://www.accc.gov.au/content/index.phtml/itemId/981060/fromItemId/977921

  PGD* Assistance Program Limited provides an interest free loan and gift to couples selected for financial assistance by the PGD Assistance Program Committee on condition that the couples use that assistance to acquire Assisted Reproductive Treatment with PGD services from one of the medical fertility specialists accredited to treat patients at a clinic operated by Sydney IVF Limited.

  *PGD is an acronym for Pre-implantation Genetic Diagnosis.

- **Sunglass World Holdings Pty Limited—Notification—N95274**
  http://www.accc.gov.au/content/index.phtml/itemId/973937/fromItemId/977921

  Sunglass World Holdings Pty Limited trading as Sunglass Hut offers a discount of $50 on a selection of sunglasses on the condition that the purchaser has acquired insurance services from Medibank Private.
- **The Optical Superstore Pty Ltd—Notification—N95394**
  http://www.accc.gov.au/content/index.phtml/itemId/988022/fromItemId/977921

  The Optical Superstore Pty Ltd offers customers a discount on relevant products and/or benefits (such as the waiving of 'out of pocket' expenses) on the condition that the customer is a member of the Medibank Private Limited's Members' Choice network or an employee thereof. The Optical Superstore Pty Ltd offers further discounts on the condition that the Members' Choice employee has optical cover with an Australian private health insurer.

ACCC contacts

Infocentre: 1300 302 502

Website: www.accc.gov.au

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

For other business information, go to www.business.gov.au.

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