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QUARTERLY BULLETIN NO 13 (October to December 1999)

SENATE ORDER WITH RESPECT TO THE HEALTH LEGISLATION AMENDMENT BILL (No.2) 1999.

Following the passage through the Parliament of the Health Legislation Amendment Bill (No.2) 1999, the Senate agreed the following order on 25 March 1999.

That there be laid on the table as soon as practicable after the end of each period of six months, commencing with the six months ending 31 December 1999, a report by the Australian Competition and Consumers Commission containing an assessment of any anti-competitive or other practices by health funds or providers which reduce the extent of health cover for consumers and increase their out –of-pocket medical and other expenses.

Like most other affected organisations this Office received a request for information from the ACCC to assist them in complying with the Order. Our original response pointed to areas that fitted the general guidelines of the Order but questioned the amount of detail required as the task for us could be extremely large.

What followed was a meeting with the Commission where we received clarification of the scope of the Order. It was more extensive than we had at first thought. What is more the process needs to be repeated each six months.

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

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

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

The defined scope of the Senate Order involved this Office in identifying those practices which impacted on individuals or groups within the community. In our initial response we cautioned the ACCC "*that although the complaints received within this office would appear to fall within the bounds of the Harradine request, with the resolution of some individual dispute, the remedy may not always be in the best interest of the total consumer body.*"

None-the-less, the picture that emerged on closer examination was one which showed a need for the private health industry to progress issues that continue to cause real problems for consumers. This does not only involve the insurers, but also providers at all levels. Our response focussed on ten areas, most of which have systemic problems as well as problems for individuals.

This quarterly bulletin will be devoted to a short exposition of those problem areas and proffer some possible solutions.

INFORMED FINANCIAL CONSENT

This single category creates significant problems for this office and often involves very large sums of money. Section 73BD(2)(d) was put in place ostensibly to help overcome the problem of informed financial consent where there is a contract between a fund and a hospital. *The agreement must require the hospital or day hospital facility, in accordance with subsection(6), to inform any eligible contributor in respect of whom hospital treatment is to be provided at the hospital or day hospital facility of the amounts that the eligible contributor will be liable to pay to the hospital or day hospital facility in respect of the hospital treatment.* Unfortunately as it transpires, this section seems merely to create a contractual obligation on behalf of the hospital to the health fund. It is so often not complied with by the hospital as to be meaningless. There is no evidence of any health fund ever invoking the requirements of Section 73BD(2)(d) on a hospital when a dispute arises. There is no remedy available to the consumer as a consequence of the provisions of this section, which was incorporated as a consumer safeguard.

The private health industry and the Parliament have been discussing the issue of informed financial consent in detail for quite some time and it figures prominently in the Harradine requirements. It is an administrative issue that for most instances is easily overcome. Granted emergency admissions could still create a problem, but the majority of cases which come to this Office relate to non emergency admissions. What is needed is a quick turn around of paper or electronic information from the provider to the fund and return detailing the patient status.
This office has been working within the industry to see what the issues are and what solutions are available. We have recently presented to the Department a background paper addressing possible short -term solution.

PRE EXISTING AILMENTS

Like informed financial consent (indeed it sometimes falls into that category) Pre Existing Ailments cause unexpected high costs to consumers. Most health funds adopt a responsible position in both their literature and their communication with members relating to this issue, but still it remains a problem. There is no universal application of the rule even though it is part of legislation. Some funds do not apply it in a consistent manner, and this office would contend that others (although few in number) apply it incorrectly. No doubt the eminent persons' committee will be able to tighten up the definition so there is universality in the application in future.
Even when universal application does occur there will need to be a campaign to inform medical practitioners across the board of what the rule is. Far too often this office is left to fix the problems created by the medical profession where they have told their patients not to worry because they have never seen them before for this particular condition, therefore it could not be a pre existing ailment.

This Office will be providing the eminent persons' committee set up by the Minister with detailed information and guidance with respect to the whole issue of pre existing ailments and their effect on consumers.

MEMBER VERIFICATION SYSTEMS

This office reported in detail to the ACCC on problems associated with membership verification systems. In principle they do exist, but are in a lot of instances ineffectual. Some funds regard this member service to be a secondary or even lower order priority and members suffer as a consequence. One only needs to look at the case reported in our September Bulletin to see the priority some funds place on this fundamental aspect of their member service. As indicated above, this office will be developing a draft system to assist in overcoming this problem.

SELECTIVE CONTRACTING WITH HOSPITALS

This office has made no judgement on the principle of selective contracting, but did signal that it has the propensity to increase out of pocket costs for those members who choose a non-contracted hospital. On one hand selective contracting is designed to bring about a reduction in overall costs to contributors by ensuring increased efficiency and quality by participating hospitals. On the other hand it does have the effect of reducing choice for 100% cover and increases the possibility that patients choosing to use non contracted hospitals will face a moiety.

SELECTIVE CONTRACTING WITH ANCILLARY PROVIDERS

Again this office made no judgement on the principle of selective contracting as it could mean that for certain groups of consumers greater benefits would be payable if selected contractors were utilised. This Office does though receive regular complaints from consumers where they are concerned their particular provider is not recognised by their fund (in some cases at all) for extended benefits.

INTER FUND TRANSFERS

The portability provisions of the Health Act are supposed to provide seamless transfer of memberships between health funds. This was appropriate under earlier circumstances when the provisions were written, but now with the multitude of offerings from funds this is no longer the case. The Act provides for transfer from like product to like product without penalty. As there are virtually no like products to choose from, transferring members find themselves facing extended waiting periods for marginally differing products.
This office will be asking one of its reference groups to assist in devising guidelines appropriate for inter fund transfers.

WAITING PERIOD WAIVERS

This Office reported this as a significant problem to the ACCC. Funds exercise their discretion to waive waiting periods during periods of membership drives. Unfortunately there is confusion amongst the general public as to what the waiver really means. Not a week goes by in this Office without a significant complaint relating to waiting period waivers. We reported to the ACCC that in our opinion, funds should be compelled to provide clear and concise detail as to what is or is not included in the waiver of waiting periods and this should be by way of an individually addressed letter and not a general brochure.

EXCLUSIONARY PRODUCTS

This office recognises an argument exists for exclusionary products in the market place, particularly for specific target groups to try and reduce the costs for young and healthy members. However, we indicated they pose a problem for consumers who take out these products in mid life or later, or those who have had them in their youth and forget to update them when their needs alter. We also drew attention to the need for any product sold to be fit for purpose for the individual consumer and to this end saw sale of “hip and eye” exclusions as being questionable when sold to the over 80’s market. It just isn’t good enough to deny liability when an elderly consumer is holding a product which provides little in the way of benefit for the highly likely health expenses they may face.

PRACTITIONER CONTRACTS

The Harradine instigated Order, specifically requires detail on “*those funds or providers who uniformly charge a significant gap fee”*. One of the major complaint areas for this office is the apparent failure of funds to be able to provide gap insurance for in-hospital episodes. We are aware that progress is being made but it still only covers a minor proportion of episodes of care. Although there has been legislative backing to enable gap payments, the vociferous campaign waged by the medical profession against any form of third party contract has not allowed contracting to advance.

The campaign by the medical practitioners is predicated on a public position that contracting must ultimately lead to professional judgements being taken away from the practitioner and placed in the hands of case managers employed by funds. This is clearly not envisaged by the legislation nor sanctioned in any way. This office would campaign on behalf of consumers to ensure this situation did not arise. A possible way to overcome the current impasse would be for the medical fraternity to agree a set of words which enshrined safeguards into the pre-amble of a contract which provides for absolute medical discretion within college acceptable standards.

ANCILLARY BENEFIT LIMITS

For completeness in complying with the extent of the Order, this office reported on complaints commonly received with respect to the out of pocket costs that arise as a consequence of benefit limits for ancillary products. We made the point that ancillary benefits are there to reduce the cost impact on consumers and not to assume the whole burden.

It is apparent the Senate Order is wide in scope and must be responded to each six months. It would be pleasing to be able to report at the next juncture, that significant progress had been made towards resolving the systemic issues outlined in this bulletin. This office will be working with the private health industry and Government to attain this objective.

Complaints (Problems, Grievances & Disputes) by health fund

Name of Fund	Total number of complaints (1)	% of total complaints	Total number of disputes (2)	% of total disputes	Health fund Market share (3)
ACA Health Benefits Fund	0	-	0	-	0.1
AMA Health Fund Ltd	1	0.3	1	0.7	0.1
Australian Health Management	10	2.7	4	2.8	2.4
Australian Unity Health Fund	4	1.1	1	0.7	2.7
AXA Australia Health Insurance	63	16.8	30	21.0	10.6*
CBHS Friendly Society	3	0.8	0	-	1.0
CDH Benefits Fund	0	-	0	-	-
Credicare Health Fund	2	0.5	1	0.7	0.5
Defence Health Benefits Society	5	1.3	1	0.7	1.3
Geelong Medical & Hospital Benefits Association	2	0.5	1	0.7	1.0
Goldfields Medical Fund Inc	0	-	0	-	0.2
Grand United Corporate Health Ltd	6	1.6	1	0.7	0.3
Grand United Friendly Society	7	1.9	3	2.1	0.5
Health Care Insurance Ltd	3	0.8	0	-	0.1
Health Insurance Fund of WA	2	0.5	0	-	0.3
Health-Partners	2	0.5	1	0.7	0.6
Healthguard Health Benefits Fund Ltd	0	-	0	-	0.1
Hospital Benefit Fund of WA (Inc)	8	2.1	2	1.4	11.0
Hospital Contribution Fund of Australia Ltd	24	6.4	9	6.3	8.5
IOOF Friendly Society of Victoria	1	0.3	1	0.7	0.2
IOR Australia Pty Ltd	7	1.9	4	2.8	0.7
Latrobe Health Services (VIC)	0	-	0	-	0.4
Lysaght	0	-	0	-	0.2
Manchester Unity Friendly Society In NSW	6	1.6	4	2.8	1.0
Medibank Private	87	23.2	36	25.2	26.9
Medical Benefits Fund Of Australia Ltd	85	22.7	29	20.3	18.1
Mildura District Hospital Fund	1	0.3	0	-	0.3
Naval Health Benefits Society	0	-	0	-	0.3
NIB Health Funds Ltd	24	6.4	8	5.6	4.7
NSW Teachers Federation Health Society	6	1.6	1	0.7	1.5
Phoenix Welfare Association Ltd	0	-	0	-	0.2
Queensland Country Health Ltd	1	0.3	1	0.7	0.2
Queensland Teachers Union Health Society	2	0.5	1	0.7	0.4
Railway & Transport Employees Friendly Society	4	1.1	1	0.7	0.4
Reserve Bank Health Fund Friendly Society	0	-	0	-	0.1
SA Police Employees Health Fund Inc	0	-	0	-	0.1
SGIO Health Pty Ltd	3	0.8	0	-	1.3
St Lukes Medical & Hospital Benefits Association	1	0.3	0	-	0.5
Transition Benefits Fund	0	-	0	-	0.2
Transport Friendly Society	1	0.3	0	-	0.1
United Ancient Order of Druids Victoria	2	0.5	1	0.7	0.1
United Ancient Order of Druids Grand Lodge NSW	0	-	0	-	0.1
Western District Health Fund Ltd	1	0.3	0	-	0.5
Yallourn Medical & Hospital Society	1	0.3	1	0.7	0.1
Total for Registered Funds	**375**	**100.0**	**143**	**100.0**	**100.0**

1 Complaints = problems, grievances and disputes
2 Disputes require intervention by the Ombudsman and the fund
3 Proportion of people covered by health fund as at 30 June 1999 as reported in the PHIAC Annual Report -
* Previously National Mutual Health Insurance Pty Ltd