ASA

Serving Australian Anaesthetists for 75 years

SUBMISSION BY THE AUSTRALIAN SOCIETY OF ANAESTHETISTS ON THE PERFORMANCE OF PUBLIC AND PRIVATE HOSPITAL SYSTEMS TO THE PRODUCTIVITY COMMISSION 27 JULY 2009

Executive Summary

Anaesthetists, as a specialty, are at the forefront of any interactions between medical consumers and the health system. Any changes to the health system must include careful consideration of anaesthesia services and how they are delivered in an efficient Australian health sector. This submission by the Australian Society of Anaesthetist focuses on two of the investigative areas of Productivity Commissions' terms of reference. The submission is informed from data obtained from national member surveys and that provided through third parties.

The ASA contends that a lack of nursing staff is a significant impediment to efficiency in both the public and private sectors. It also considers that the ICU/HDU bed mix in public hospitals should be appraised to allow the separation of the elective caseload from the emergency caseload. 'Restrictive work practice/hours' is also identified as a particular issue in the public sector, and is felt to be a consequence of 'budget comes first' in State delivered public healthcare. The time and resources required for teaching in the public sector has always been acknowledged as a fact, though was not found to be the impediment expected. However, the impact that will flow on to the private sector in coming years with a move to increased training in the private sector needs to be considered in any productivity review. Finally, the belief that private facilities are regarded as much more efficient than public facilities must be recognised as a perceptive assessment of the relative performance of the two players in the dual service delivery model that characterises Australian healthcare.

The ASA fully supports the principle of ensuring that patients are fully informed about all aspects of their treatment, including relevant information about the costs involved. Private health insurance is unnecessarily complex placing consumers in the vulnerable position of a lack of knowledge of the extent of their insurance cover and the details of the limitations of their policies. Due to widespread misinformation and a lack of understanding of their insurance many consumers have been led to have an expectation of 'gap-free' medical treatment in hospital where this will not be the case.

Despite the above it is known that just under 85% of all medical services are at no out-of-pocket expense to the patient and a further 5% are covered by mandatory IFC (through the health fund known-gap products). For the remaining 10% of services where IFC should occur, the ASA is not aware of any data indicating that inappropriate IFC practice is a major concern or problem for consumers. The PHIO has stated in their annual report that "*The number of complaints regarding IFC and medical gaps is now lower than at any time since the Ombudsman's office was established*"[1].

[1] PHIO Annual Report 2007-08 Protecting the interests of people covered by private health insurance

Introduction

The Australian Government has asked the Productivity Commission to examine and report on the relative performance of public and private hospital systems, and related data issues. Included in the Terms of Reference, the Productivity Commission has been asked to consider two issues relevant to the Australian Society of Anaesthetists (ASA). They are, inter alia:

- comparative hospital and medical costs for clinically similar procedures performed by public and private hospitals; and
- rates of fully-informed financial consent (IFC) by privately-insured patients, out-of-pocket expenses for patients who do not give such consent, and best-practice examples where fully-informed financial consent is provided for every procedure.

Objective

The objective of this submission is to provide to the Productivity Commission relevant and current advice on (A) Public and Private Hospital Systems – Efficiency and Performance and (B) Informed Financial Consent.

The ASA

The ASA is one of the largest medical associations in Australia. It is a national organisation with 2,700 members. Established in 1934, the Society promotes and protect the status, independence and best interests of Australian anaesthetists. The ASA's membership is voluntary and consists of specialist medical anaesthetists and GP anaesthetists.

Operationally, the ASA represents the economic, workforce and professional interests of Australian anaesthetists through policy development, guideline publication and negotiations with state and federal health departments and associated statutory and medical bodies. In conjunction with the Australian and New Zealand College of Anaesthetists (ANZCA), the Society also provides representation to Standards Australia. When required, representatives are provided to government and industry bodies such as the Medical Services Advisory Committee, the Professional Services Review and Medicines Australia.

Additionally, the ASA actively promotes anaesthesia education through publishing the international peer reviewed scientific journal *Anaesthesia and Intensive Care* and conducts an annual National Scientific Congress. Together with ANZCA, the Society provides Continuing Medical Education events at individual state and territory levels, contributes to the operations of 15 Special Interest groups and is a partner is capturing, assessing and publishing anaesthesia patient safety data.

The Society provides an array of information for patients and the public and acts as the representative of Australia's anaesthetists to government enquiries and reviews.

(A) Public and Private Hospital Systems – Efficiency and Performance

In preparing this submission the ASA engaged its members through an on line survey to determine current practices and issues. The results of a membership wide survey conducted in late July 2009 have been used throughout this submission to substantiate the ASA's position. A copy of the survey is reproduced at Attachment 1. In the first 24 hours, 439 responses from active anaesthetists were received. This submission is based on 605 responses received in the first seven days of the survey.

96.2% of responses to the survey were from specialist Anaesthetists. Just over half of respondents had a mixed salaried/private practice (best described as VMOs), with almost 40% being exclusively in private practice, and 10.6% working as salaried anaesthetists in the public sector i.e. usually described as 'staff specialists'. Approximately 60% in total of respondents practised in public/teaching hospitals, with almost 40% having exposure only to the private sector.

In relation to the number of 'sessions' worked ('sessions' is often used as a measure of anaesthesia work activity, and is normally assumed to be approximately 3-4 hours per session within the public system and during morning sessions in private hospitals though this may extend up to 6 or even 8 hours in the afternoons in private facilities), just over half of respondents worked eight or nine sessions per week, with two thirds of respondents working eight or more sessions per week. The majority

(72.9%) of the respondents thought their workload was ‘about right’, 19.7% thought they were too busy, and 7.1% ‘not busy enough’.

The respondents practised in metropolitan areas (78.3%), and regional/rural areas (21.7%), with 75.8% of respondents from the Eastern States (QLD, NSW and Victoria).

In relation to rostering and availability for ‘out of hours’ at work, 85% were rostered or available, with 74.4% actually called in ‘out of hours’.

Given the assumed focus of the Productivity Commission, questions were then asked in relation to the perceived efficiency of the public and private facilities in which respondents worked, with three categories of response possible, namely ‘highly efficient’, ‘efficient’, or ‘not efficient’. Respondents were then asked what factors they thought might have contributed to any inefficiencies in the public and private hospitals in which they worked. The survey structure permitted only one answer to the questions, with the rank order of responses indicating the most significant impediments in each sector.

Public facilities were weighted as highly efficient by just 1% of respondents, efficient by 30.7%, and not efficient in 54.2% of those surveyed. 14% did not respond to this question.

Private facilities were rated as highly efficient by 31.2%, efficient in 56.7%, and not efficient by just 2.5% of respondents. There were 9.6% non responders to this question.

In relation to factors thought to contribute to inefficiency in the public sector, lack of ICU/HDU beds was cited by 28.4%, lack of nursing staff by 25.5%, restrictive work practices and hours by 21.3%, and the extra time and resources required for teaching 11.8%.

In relation to inefficiencies in the private sector, lack of nursing staff was cited in 28.6% of cases, and lack of ICU/HDU beds in 9.6% of cases. In contradistinction to the public sector, almost half (47.6%) identified no factors contributing to inefficiency in private facilities, with this finding in line with the assessment of 87.9% of the respondents that private facilities were efficient or highly efficient.

The obvious findings, thought to be representative of the specialty’s views, are that private hospitals are regarded as much more efficient than public hospitals. A lack of nursing staff is regarded as an issue in both areas. However, the lack of ICU/HDU beds was identified as a particular problem in the public sector (and this is to be expected given the particular characteristics of the public sector work load) though the identification of restrictive work practice/hours was somewhat unexpected, and is an area not normally commented upon. The extra time and resources required for teaching in the public sector is however understood, and it is expected that an impact in this area will be seen in the private sector in coming years with a move to increased training in the private sector being advocated.

Conclusion Part A

A lack of nursing staff is seen as a significant impediment to efficiency in both the public and private sectors. Efforts to bring nurses back to nursing, to facilitate their efficiency in the ‘face to face’ nursing craft, to reward “patient based” care, and to mitigate the risk containment forces that favour paperwork over patient care should be investigated. More efficient use of nurses and their unique skills is seen as central to improved productivity in the both the public and private hospital systems.

The ICU/HDU bed mix in public hospitals should be appraised to allow the separation of the elective caseload from the emergency caseload. Anaesthetists and other qualified specialists in perioperative care may be able to care for postoperative patients of lesser and more predictable acuity, freeing up Intensive care specialists and ‘traditional’ ICUs to concentrate on the care of the sickest emergency presentations. Alternate models of postoperative “high dependency” care should be investigated with a broad group of stakeholders.

‘Restrictive work practice/hours’ is identified as a particular issue in the public sector, and is felt to be a consequence of ‘budget comes first’ in State-delivered public healthcare.

The time and resources required for teaching in the public sector has always been acknowledged as a fact, though was not found to be the impediment expected. However, the impact that will flow on to the private sector in coming years with a move to increased training in the private sector needs to be considered in any productivity review.

Finally, the belief that private facilities are regarded as much more efficient than public facilities must be recognised as a perceptive assessment of the relative performance of the two players in the dual service delivery model that characterises Australian healthcare.

(B) Informed Financial Consent

Background
The terms of reference ask the Commission to examine aspects of IFC for privately-insured patients, both in public and private hospitals. In this section consideration will be given to background information on IFC, discussion on the particular relevance and application of IFC to anaesthesia services, an examination of the available data, the role of health funds in IFC and conclude with some observations and recommendations.

IFC Definition
In the 'Issues Paper' released by the Productivity Commission the definition of IFC is stated as:

"*… the provision of cost information to patients, including notification of likely out-of-pocket expenses (gaps), by all relevant service providers, preferably in writing, prior to admission to hospital or treatment. (DOHA 2008b)"*

Clearly when examining the issue of IFC in detail the definition is most important. The ASA believes that the definition as suggested by the Commission is too narrow, focusing simply on the medical and hospital providers and omitting the very important role of the health insurers in the appropriate provision of fee and rebate information to the private health consumer.

IFC will only be truly relevant where there is a gap between the fees charged for a medical service and the available rebates. The IPSOS consumer surveys defined IFC compliance as those services where appropriate IFC has been provided *or* the service is at no out-of-pocket cost to the consumer.
For privately insured consumers, the available rebates will generally derive from two sources, one being Medicare and the other from their private health insurer. For any given medical service provided in hospital to a consumer, the benefits provided through Medicare are published in the Medicare Benefits Schedule (MBS). The benefits listed in the MBS are legally required to be provided to all eligible consumers and therefore do not vary and are also published in a publicly available document. However benefits provided by the approximately 38 health funds are quite different. All health funds provide benefits to their members on at least two different levels for all medical services. There is a legally required minimum level of benefits equal to 25% of the MBS listed 'schedule fee'. However all funds also provide a higher level of benefits to some members on some occasions through Gapcover schemes and agreements. The level of benefits through these Gapcover schemes is generally not publically available for scrutiny and comparison between funds and varies significantly from one fund to another. Due to the widely different but often strict criteria applied by the health funds not all consumers or even members of a particular health fund are eligible to receive the full level of Gapcover benefits. The Gapcover schedules are usually changed annually but are frequently not available until after the date from which they apply. These features of the Gapcover schemes can leave both consumers and medical providers uncertain as to the exact level of benefits available from the fund for any particular given service. Further problems arise with the discretionary nature of the operation of these schemes. Many health funds will only provide the higher level of benefits if a range of administrative and other criteria are met, usually by the treating doctors. For some funds these rules and regulations can be quite restrictive and may be applied differently in different locations and times. Each fund administers these Gapcover schemes differently. It goes without saying that without exact knowledge of the level of the benefits provided by health funds to the consumer, it will be impossible (and therefore impractical) for doctors to be able to notify patients of their likely out-of-pocket expenses in advance of their treatment.

The ASA strongly believes that health insurers have an important role to play in IFC and must be included in any definition and investigation of IFC.

Recent History of IFC

The continuing reduction in MBS rebates in real terms through the 1980's and 1990's by successive Federal Governments led to the growth of gaps faced by consumers of medical services, being the difference between the MBS 'schedule fee', unilaterally set by the Federal Government and the fees charged by doctors for those services. Legislative controls restricted health insurers to providing just 25% of the MBS listed fee for any medical service with the result that consumers were facing larger and larger gaps. Coincident with this growth in gaps there was a significant reduction in the proportion of the population covered by private health insurance throughout the 1990's. To improve this situation the Federal Government passed legislation (in the 1990's and 2000's) that allowed health insurers to provide benefits to their members at above the MBS listed 'schedule fee'.

However the existence of gaps has led to the debate on IFC. Along with informed consent in general for medical procedures, the concept of informed financial consent is supported by the medical profession. Since 2000 the Private Health Insurance Administration Council (PHIAC) has collected data supplied by health insurers on the fees charged for medical procedures provided to inpatients. As will be discussed later in this paper, this data has shown a steady decline in the rate of gaps and a growth in the utilization of health fund Gapcover schemes such that now 84.9% of all 24 million services for the 12 months up to March 2009 are provided at no out-of-pocket expense to consumers[2]

There is very little evidence of a major problem with IFC from the consumer's perspective. The Office of the Private Health Insurance Ombudsman (PHIO) receives and collects data relating to complaints including those involving medical fees. In the PHIO Annual Report for 2007-08[3] there were a total of just 56 complaints made against doctors involving IFC. This represented just 2.3% of all complaints received (92% of complaints were directed at health funds). Further the Ombudsman stated that "*The number of complaints regarding IFC and medical gaps is now lower than at any time since the Ombudsman's office was established*".

Despite a lack of any substantial data the health insurers have raised concerns with previous federal governments that both gaps and IFC are major problems that need addressing, preferably with legislative control. In response to the total lack of data on IFC, the Government commissioned IPSOS to conduct a total of three consumer surveys examining various financial aspects of hospital treatment including the provision of IFC. These surveys will be discussed in more detail later in this submission but it can be stated that despite methodological shortcomings these surveys demonstrated that the vast majority (83%) of medical services provided to consumers are 'IFC compliant' as per the definition used in the IPSOS surveys[4].

A significant and consistent reported finding of the three IPSOS surveys was the prominence of certain specialties in the area of consumers not receiving adequate information about medical gaps. Anaesthesia was reported in the surveys as a specialty where the IFC rate was relatively low. However when examining the data in detail a clearer picture emerges. Anaesthesia services as reported in the IPSOS survey were associated with a lower than average (across all medical specialties) rate of gaps and a lower than average size of the gap. However, anaesthetists provide a very large number of services to the Australian community – to approximately 67% of all in-patients in the IPSOS surveys. In the survey report the number of consumers potentially affected by a non-IFC compliant gap was extrapolated by the proportion of consumers treated and the rate of non-IFC compliant gaps as reported in the survey. For this reason anaesthesia is often highlighted as a 'problem area' despite having a lower than average rate of gaps and lower than average size of gaps.

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[2] Quarterly Gap Payment & Medical Benefit Statistics, March 2009. From www.phiac.gov.au/for-industry/industry-statistics/quarterly-gap-payment-medical-benefit-statistics/ Accessed July 2009

[3] PHIO Annual Report 2007-08 Protecting the interests of people covered by private health insurance

[4] IPSOS Consumer Survey- Informed Financial Consent 2007

The medical profession has responded to Government concerns about IFC by raising the profile of appropriate 'IFC practice' and seeking to educate medical practitioners in ways to improve the already high rate of IFC. The Australian Medical Association (AMA) launched a national campaign in 2007 seeking better awareness of IFC among consumers and doctors, developing key partnerships with Government and members of the health industry and the provision of materials to assist doctors achieve desirable IFC outcomes. Other craft groups (such as the Australian Society of Anaesthetists) also participated in a range of IFC activities leading to a higher profile and better understanding of IFC within the medical profession.

One of the major obstacles to achieving close to 100% IFC rates for consumers is the amount of misleading information and general lack of consumer knowledge of their own insurance product. Health insurers constantly promote 'no-gap' insurance products which in reality **do not guarantee no out-of-pocket expenses at all**. Many health insurers inform their members that they will be 'fully covered' for the costs of their medical treatment when this is clearly not the case. It is often left to the doctor providing the treatment to explain to patients the true nature of the health insurance product purchased by the consumer.

As will be discussed in the section examining available IFC data, despite the lack of any data indicating a major problem with IFC in the minds of consumers, and despite medical gaps being at an all-time low, the medical profession has devoted enormous resources to raising the profile of IFC and improving IFC practice amongst doctors.

IFC and Anaesthesia

While undertaking this study the Commission will of course examine IFC practice across the full range of medical services provided to in-patients of hospitals from all treating doctors. However, the ASA wishes to highlight the unique characteristics of IFC in relation to private anaesthesia services and the response of the anaesthesia specialty to this issue. We feel this is most important in light of the fact of the previously mentioned reporting from the IPSOS consumer surveys of anaesthesia being a 'problem area' for IFC.

In the 12 months to March 2009 Australian anaesthetists provided over 5.8 million services[5] to approximately 2 million patients[6]. This places anaesthetists at the forefront of any interactions between medical consumers and the health system. Any changes to the health system must include careful consideration of anaesthesia services and how they are delivered in an efficient private health sector. The ASA fully supports the IFC process for patients undergoing medical treatment and anaesthesia in particular. The ASA has not only publicly stated such support but also has published a position statement on IFC (see Attachment 2) which clearly demonstrates its support for the rights of consumer to be fully informed concerning the financial and other aspects of medical care in hospital. Further the ASA reminds members in newsletters, billing information and surveys of the 'gold standard' for IFC. It is however most important to consider the many unique characteristics of private anaesthesia practice and the health system in Australia which, while they have delivered many benefits in terms of efficiency gains, safety and rapidity of access for consumers to the private health system place considerable obstacles in the way of achieving full IFC for every patient receiving anaesthesia.

1. Short Lead-Time admissions

An important consideration in the IFC debate relates to the time available for appropriate fee information to be provided to consumers as part of the IFC process. This is more important for 'downstream' specialists such as anaesthetists and also where the lead time from the decision

[5] Quarterly Gap Payment & Medical Benefit Statistics , June, September, December 2008 and March 2009. From www.phiac.gov.au/for-industry/industry-statistics/quarterly-gap-payment-medical-benefit-statistics/ Accessed July 2009

[6] Medicare Australia – Medicare Item Reports From www.medicareaustralia.gov.au/statistics/mbs_item.shtml Accessed July 2009

to undergo treatment and admission to hospital is short. A common misunderstanding of IFC in anaesthesia arises out of a lack of appreciation of modern anaesthesia work practices in Australia. Anaesthesia in Australia has an enviable safety record second to none. It has achieved this level of safety while at the same time developing a highly efficient and flexible model of service delivery able to respond to the demands of patients wishing to access the private hospital system in a timely fashion. In polling it is evident that anaesthetists require five working days to be able to effect IFC with patients. The results of the current survey (Attachment 1) show clearly while 25% believe they can obtain IFC within two days, 93% require 5 days.

While the majority of patients requiring anaesthesia are undergoing elective procedures, a significant minority of patients require their procedures with much shorter lead times. This does not only include emergency procedures, but also many other procedures where the time from decision to treat in hospital to the time of admission may be only hours or one or two days. The ASA's own private polling of members has demonstrated that this group of patients represent approximately 20-25% of all patients. While for fully elective patients the IFC process is reasonably straightforward, it is this group of short lead-time patients where there is a greater challenge. Without knowledge of the patient and the proposed treatment it is not possible to deliver accurate fee information to the patient prior to admission to hospital.

2. Emergency Services

The incidence of emergency services is higher in anaesthesia than in most specialties. Clearly the provision of full IFC prior to hospital admission cannot generally occur in emergency situations and is usually excluded from any requirements for IFC. The higher rate of emergency services in anaesthesia will have an impact in any study of IFC rates.

3. Patient Contact

Modern anaesthesia has permitted the growth of day-surgery such that now in excess of 60% of all surgical procedures in hospital are performed as day surgery[7] and further day-of-surgery-admissions constitute another approximately 20% of surgical admissions to hospital[8]. This much shorter time in hospital has lead to many benefits but clearly reduces the available time for anaesthetists to consult with patients.

4. Health Fund Policies

Many patients poorly understand their level of cover provided by their health insurance policy and often erroneously believe they are 'fully covered' when clearly this is not the case. Often the health funds further contribute to this misunderstanding by naming their products "No-Gap" or GapCover" along with many consumers being informed by the fund that they are 'fully covered' with 'top cover'. For the consumer not only is this confusing and misleading, but it also discourages consumers from appropriately seeking information about fees from medical providers.

ASA IFC Campaign

The ASA has publicly stated its full support for improving IFC where practicable and for ensuring that consumers are as fully informed as possible about the financial aspects of their treatment in hospital. Following concerns raised by a previous Federal Health Minister the ASA worked closely with the AMA in delivering a campaign ("Let's Talk about Fees") aimed at highlighting the importance and improving the practice of IFC amongst anaesthetists.

The ASA IFC campaign included the following activities over an eighteen month period to August 2008:

- Publication of a special edition of the ASA Newsletter solely on IFC.
- Initiation of a new area of our website devoted to IFC and associated resources for anaesthetists.

[7] Australian Day Hospital Association 2005 – From http://www.adha.asn.au/ Accessed July 2009

[8] Personal Communication - Data from AHSA for 12 months to June 2003

- Mailing out to all anaesthetists (including non-ASA members) an 'IFC Campaign Kit' containing resources and detailed guidance on how to improve IFC in anaesthetic practice.
- Redesign of our popular 'Anaesthesia and You' brochure with an improved section devoted to anaesthesia fees.
- The publication of the results of our initial 'baseline' e-poll with results from over 600 anaesthetists covering up to 1 million patients.
- The commencement of specific IFC educational meetings to be held in capital cities and major regional centres throughout Australia this year.
- Practice Manager Workshops targeting practice staff and managers to educate and share successful anaesthesia IFC processes.
- Working with the AMA and Government on research into obstacles to effective IFC and the development of key IFC strategies.

Looking closely at existing workforce structure and delivery of anaesthesia services in the private sector, the ASA has realised that a single IFC strategy will not be successful for anaesthesia services. We have provided a range of solutions for anaesthetists to apply to their own particular practice profile to allow maximum 'penetration' and the highest success rate. Common elements of solutions include the provision of printed information to consumers, encouraging the availability of generic fee information at points of patient contact (e.g. surgeon's rooms, hospital clinics) and encouraging good communication between medical providers.

IFC Data

Limited data is available from a range of sources examining the provision of IFC by consumers prior to in-hospital medical treatment.

IPSOS Consumer Surveys

These three surveys were conducted in 2004, 2006 and 2007 with a specific focus on IFC and the general provision of financial information to consumers prior to admission to hospital. The Commission will be examining these surveys in detail during this study. However the ASA would like to highlight several aspects of these consumer surveys. The major findings included the following:

- The survey (2007) reveals that approximately 83% of all in-patient medical services (>20 million per annum) are IFC compliant.
- Anaesthesia gaps occurred in 25% of services, which is lower than that for many specialties.
- A significant improvement in the overall IFC compliance rate from the first survey to the later two.

While the IPSOS surveys represent a significant source of information it is important to consider the limitations of the findings and the danger of extrapolating to the wider population (as the authors of the reports have done). The most significant limitation is that the surveys are just that – surveys. The methodology employed for the surveys reveals several potential problems.

1. Self-Selection Bias

   Firstly the respondents are partially self-selected. 10,000 recently discharged patients were asked to respond to a survey concerning the costs of their recent medical treatment episode. Clearly those patients who are more infirm, have serious health problems, are elderly or are experiencing a prolonged recovery period would be less likely to respond to such a survey. It is these very same patients who would be much more likely to have received gap-free medical treatment as doctors take such factors into account when setting fees. A very common practice amongst the medical profession is to not charge out-of-pocket expenses to elderly or seriously ill patients. Had these patients been included in the surveys it is likely that the overall compliance rate would have been higher.

2. Response Rate

   The response rate in each survey was just 42%. Results from this small number of patients (~4,000) have then been extrapolated to represent what occurs with the delivery of over 20 million services to more than 2 million patients annually. A very small error in the original

sample (produced for example by the self-selection bias as described above) would lead to a very large error when extrapolated to the whole population. This fact must be borne in mind.

3. Method of data Collection

All data presented in the IPSOS surveys was derived from the complex four page consumer questionnaires that were required to be filled out by participants in the study. Apart from accidental incorrect filling out of the forms, the sole method of examining IFC in these surveys is from the patients' recollection of past events. It is well known that consumers who have been recently hospitalized and found their way through the mountain of paper-work associated with the various claims from health insurers and Medicare for the myriad of providers of medical and other treatments may not have a perfect understanding nor recollection of all information provided, nor by whom or exactly when it was provided. This could be another major source of error in the surveys.

4. Timing of the Last Survey

Unfortunately the last IPSOS survey was conducted shortly after both the AMA and the ASA had commenced their respective IFC educational campaigns. The beneficial effects of the IFC awareness campaigns would have been better reflected by a survey conducted at the conclusion of the campaigns.

PHIAC Data

The Private Health Insurance Administration Council (PHIAC) collects a range of data from the health industry, primarily from health funds. This information is published periodically on their website. Since September 2000 PHIAC has published data on the rate and dollar value of gaps paid by medical consumers for in-patient private medical treatment. This has shown a steady decrease in the rate of gaps as shown in the table below. The March quarter 2009 revealed an Australia-wide rate of gaps at just 15.1% - the lowest on record[9]

Rate of No-Gaps – Private in-patient medical services – PHIAC data										
March Quarter	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
No-gap Rate	60%*	69%	76.3%	81.0%	82.0%	80.6%	82.6%	82.7%	84.0%	84.9%

** September 2000*

While the above table does not directly reflect IFC practice and rates, it does indicate the proportion of medical services where a gap is payable by the patient and therefore where IFC should occur. It can be seen that while in September 2000 40% of medical services incurred a gap payment for the patient, by March 2009 84.9% of services are gap-free. This means that for just 15.1%of services was there any need for IFC to occur.

PHIAC also publish data on the dollar benefits received by consumers from health funds and whether they are paid through a Gapcover scheme or Agreement or not. This data can also provide indirect evidence relevant to the IFC debate. While all health funds provide a higher level of benefits through a Gapcover scheme, there are significant differences between the funds. One important difference is whether the fund offers a '*known-gap'* insurance product or simply a '*no-gap only'* product. With a known-gap product health fund members can receive the full level of Gapcover benefits from the fund where the fee charged by the medical provider is above the level listed in the fund's own Gapcover schedule. This facility allowing a patient co-payment but retaining eligibility for full health fund benefits for medical treatment recognizes the fact that doctors set their fees independently and in some instances will charge more than the fund's Gapcover schedule listed fee. One of the requirements of the funds is for full written IFC to have occurred for benefits to be paid through their known-gap scheme. The table below shows the rate of known-gap utilization since March 2001.

[9] Quarterly Gap Payment & Medical Benefit Statistics March 2009. From www.phiac.gov.au/for-industry/industry-statistics/quarterly-gap-payment-medical-benefit-statistics/ Accessed July 2009

Known-gap and No-gap - PHIAC data									
March Quarter	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
Known Gap	3.5%	4.1%	3.5%	4.9%	5.1%	5.2%	5.1%	4.9%	4.5%
No Gap	69%	76.3%	81.0%	82.0%	80.6%	82.6%	82.7%	84.0%	84.9%
Total	**72.5%**	**80.4%**	**84.5%**	**86.9%**	**85.7%**	**87.8%**	**87.8%**	**88.9%**	**89.4%**

The known-gap product ensures that there is a higher likelihood of the fund member receiving full fund benefits for medical treatment. At the same time it ensures full pre-hospital written IFC. By combining the no-gap and known-gap rate the PHIAC data demonstrate that by the March quarter the full IFC compliance rate must be at least 89.4%. This is now at an all-time high. Of the remaining 10.6% of services there will be a gap required to be paid by the patient for their medical services. If the emergency services are excluded from this group (approximately 1-3%) this reduces the cohort of patients with a gap and requiring additional IFC to between just 7-9%.

It should be noted that four of the major funds (covering approximately 30% of the population) only offer a no-gap only product. With this type of insurance where the doctors' fees are above the level of the health fund's Gapcover schedule the full Gapcover benefits will not be provided to the fund member. This will significantly reduce the amounts paid by the health fund but significantly increase the amount paid by the individual consumer.

ASA Surveys

The ASA conducted a series of surveys of members (anaesthetists) over the past 2 years to initially benchmark IFC practice and then measure the response to the IFC campaign undertaken by the ASA and AMA. These surveys certainly have limitations but arguably cover a much greater number of services than the IPSOS surveys. The surveys were conducted as e-polls where members were emailed a request to complete the electronic survey form. The table below summarises the important findings over the three surveys completed.

	May 2008	**October 2007**	**April 2007**	**July 2006**
No. of anaesthetist respondents (private practice)	**427**	335	359	604
Average no. of patients per year	**954**	821	898	–
Potential patients covered	**407,000**	275,000	322,000	500,000+
Rate of gaps	**47%**	42%	45%	51%
Rate of pre-hospital IFC (where there is a gap)	**75%**	67%	65%	60%
Overall IFC compliance rate (as defined in the IPSOS surveys)	**88%**	86%	84%	80%
Patients either emergency or advised to anaesthetist <5 days	**29%**	20%		
Patients receiving fee information at any time prior to anaesthesia	**92%**	96%		
Time per patient for IFC	**5.1 mins**	5.0 mins		
Cost per patient for IFC		$5.67		

Important findings include:

- Approximately 400,000 patient episodes have been captured in the last survey
- A 25% increase in pre-hospital IFC occurred over the period of the IFC campaign (from 1st to last survey)
- Overall IFC compliance has reached nearly 90% with over 90% of patients receiving fee information prior to their treatment
- Between 20 and 30% of patients have a lead time of less than 5 days.

Collating the results of all of the available data reveals a picture where the incidence of medical gaps is reducing, now down to a record low level of just over 15% in Australia. Further data demonstrates that a further 5% of services are already covered by mandatory IFC through the known-gap schemes. After allowing for emergency services the proportion of services where IFC is required but currently not mandated is between 7-9%. This figure is from 'hard' PHIAC data and not derived from consumer surveys and then extrapolated to the wider population. The ASA's own polling supports this picture of recent improvement in the provision of IFC.

Other Considerations

The Role of Health Funds
Many aspects of health fund practices and their insurance products lead to continuing consumer expectations of no out-of-pocket expenses associated with their medical treatment episodes despite the knowledge of the funds that the contrary is true. Health insurance products are unnecessarily complex to the point that very few consumers have any realistic understanding of the true nature of the cover and limitations provided by their insurance.

There are several specific aspects of health fund practice and product design that directly leads to unmet consumer expectation with regard to out-of-pocket expenses.

1. Health Fund Misinformation

Health funds frequently provide misleading information to consumers leading to an expectation of a 'gap-free' episode of care despite the funds' knowledge that in nearly half of all treatment episodes there will be an out-of-pocket expense[10]. The IPSOS survey in 2007 revealed that 42% of all in-patient treatment episodes involved a 'gap' payment by the patient. This fact is known to the funds but consumers are still frequently informed by their fund that there will be no gap to pay. Patients often state to doctors that they have 'top cover' or are 'fully covered' and therefore will have no gap to pay. The funds encourage this erroneous belief by consumers and many consumers who have enquired of their funds in advance of treatment episodes have been given wrong information about their likely medical costs. The usual response from the funds is that the doctor is 'charging too high' or 'not participating in our scheme'.

The ASA accepts that it is the responsibility of the doctor providing the medical service to ensure that IFC has been obtained. It is generally accepted that wherever possible this should be in writing. The ASA believes that health funds should accept similar responsibility and provide in writing an estimate of benefits available to members for a given medical treatment. The use of MBS item numbers would facilitate this process. The adoption of this provision of unambiguous information in writing from the funds will eliminate one of the major causes of unexpected medical gaps and hence greatly simplify the IFC process.

2. Design of Health Fund Products

Above MBS fee benefits are provided to consumers through a complex array of health fund products. The single biggest obstacle to good IFC practice with these products occurs with the funds offering 'No Gap only' insurance (MBF, HCF, NIB and Bupa). All funds provide a

[10] IPSOS Consumer Survey – Informed Financial Consent 2007

two-tier level of benefits for medical treatment, with payment at the higher level effectively at the discretion of the funds. Payment of higher benefits may be refused where the doctor is not 'registered' with the fund, accounts are not processed according to the individual fund's requirements, or for other miscellaneous reasons including software issues with the health fund. In all of these instances the health fund member has no choice nor any input into whether the higher level of benefit will be provided by the fund.

The ASA strongly believes that health fund members should be entitled to receive full fund benefits for all eligible services. All health funds should be required to provide a 'known gap' product. This will bring certainty to the total level of benefits available for the consumer (Medicare plus health fund), which, when combined with fee information provided by doctors will eliminate any unexpected gaps and ensure the highest possible rate of IFC. PHIAC data reveals that approximately 10% of services (~2.4 million) are not covered by the health fund Gapcover benefits and will only receive the minimum benefits legally mandated (25% of the MBS fee). It is most unlikely that consumers are even aware of this reduction in health fund benefits despite their having paid the full health fund premium.

3. Lack of Availability of Fund Schedules

Funds usually index their respective Gapcover schedules (or equivalent) once per year at a rate unilaterally determined by the fund. Funds have often indexed below the Consumer Price Index (CPI). However a major problem arises each year, particularly around November when the new schedules become unavailable for up to a month. However over the past several years the new schedules for some funds are not available until after their activation date.

With such lack of health fund schedule information for up to a month every year, and with no certainty of indexation levels or even method of calculation, it is clearly extremely difficult for doctors to provide patients with meaningful information regarding gaps as the level of rebates will not be known. Providing detailed information about doctor's fees without corresponding information about health fund benefits does not assist consumers in gaining knowledge of their likely out-of-pocket expenses.

Conclusion Part B

The ASA fully supports the principle of ensuring that patients are fully informed about all aspects of their treatment, including relevant information about the costs involved. Private health insurance is unnecessarily complex placing consumers in the vulnerable position of a lack of knowledge of the extent of their insurance cover and the details of the limitations of their policies. Due to widespread misinformation and a lack of understanding of their insurance many consumers have been led to have an expectation of 'gap-free' medical treatment in hospital where this will not be the case.

Despite the above it is known that just under 85% of all medical services are at no out-of-pocket expense to the patient and a further 5% are covered by mandatory IFC (through the health fund known-gap products). For the remaining 10% of services where IFC should occur the ASA is not aware of any data indicating that inappropriate IFC practice is a major concern or problem for consumers. The PHIO has stated in their annual report that "*The number of complaints regarding IFC and medical gaps is now lower than at any time since the Ombudsman's office was established*"[11].

Nevertheless the ASA and the wider medical profession (led by the AMA) has undertaken major initiatives to promote good IFC practice and to provide the necessary resources for doctors to incorporate such IFC practice into their everyday interactions with patients. A major obstacle to further improvements in good IFC practice is many of the design features of private insurance products, particularly the lack of knowledge by the consumer of their extent of cover and benefits and the two-tier level of benefits provided by the funds.

[11] PHIO Annual Report 2007-08 Protecting the interests of people covered by private health insurance

Attachments:

1. ASA member Survey on the Anaesthesia Workforce and IFC July 09
2. ASA Position Statement Informed Financial Consent

ASA member Survey on the Anaesthesia Workforce and IFC July 09 **Attachment 1**

The ASA is seeking a snapshot of member views on contemporary practice issues. Please assist the ASA by completing the short survey below on a typical work week:

1. You are recognised as a:

☐ GPA ☐ Specialist Anaesthetist ☐ Trainee anaesthetist

2. Would you be best described as:

☐ Only salaried ☐ Only private practice ☐ Mixed Salaried / Private Practice

3. Select the number of sessions (half day blocks of 3-4 hours) you usually work each week:

☐ < 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ >10

4. How did you feel about your workload:

☐ Too Busy ☐ About Right ☐ Not Busy Enough

5. You did most of your sessions in:

☐ Metropolitan ☐ Regional/Rural

6. In which State did you practise?

☐ ACT ☐ NSW ☐ NT ☐ QLD ☐ SA ☐ TAS ☐ VIC ☐ WA

7. Were you rostered or available for out of hours?

☐ Yes ☐ No

8. Were you called in out of hours?

☐ Yes ☐ No

9. Would you describe the public facilities in which you work as:

☐ Highly Efficient ☐ Efficient ☐ Not Efficient

10. Which of the following do you feel contribute to the inefficiency in the public hospitals where you work:

☐ Lack of nursing staff ☐ Lack of ICU/HDU beds ☐ Lack of day-stay beds ☐ Restrictive work practices/hours ☐ Extra time/resources required for teaching ☐ None of the above

11. Would you describe the private facilities you work in as:

☐ Highly Efficient ☐ Efficient ☐ Not Efficient

12. Which of the following do you feel contribute to the inefficiency in the private hospitals where you work:

☐ Lack of nursing staff ☐ Lack of ICU/HDU beds ☐ Lack of day-stay beds ☐ Restrictive work practices/hours ☐ Extra time/resources required for teaching ☐ None of the above

13. Do you feel that you understand the ASA Gold Standard for Informed Financial Consent (IFC)?

☐ Yes ☐ No

14. How many days notice of a pending elective procedure do you need to be able to obtain IFC from patients? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Australian
Society of Anaesthetists

ASA-PS04

Attachment 2

ASA Position Statement

Informed Financial Consent

PREAMBLE

This Position Statement addresses the minimum conditions that the ASA supports before a patient is considered to be able to provide *informed financial consent.*

It does not discuss *informed consent*, which is provided by a patient prior to undergoing anaesthesia; please refer to ANZCA Professional Document PS 7 for further information.

INFORMED FINANCIAL CONSENT

The ASA defines informed financial consent as the dialogue (verbal or written) undertaken between a medical practitioner or his/her representative and a patient so that the patient understands the potential fee for the medical procedure, the potential rebate for the services from Medicare and/or the patient's private health insurer. The patient is expected to be able to broadly identify his or her expenses associated with the procedure that will most likely not be reimbursed.

The provision of written material to the patient about anaesthetic fees is likely to improve the rate of retention of this information.

The provision of this important information about anaesthesia fees should ideally be available to patients prior to their admission to hospital.

Providing for informed financial consent for patients is sound, ethical, professional practice. Ultimately it is also good business practice and will result in fewer disputes over accounts, lower debt recovery costs and fewer bad debts.

The ASA has available a patient information brochure, *Anaesthesia and You*, which includes a form for notating the anaesthetist's estimated fee, estimated rebates and the estimated gap payable by the patient.

WHO SHOULD INFORM THE PATIENT?

The treating anaesthetist is ultimately responsible for obtaining informed financial consent. On some occasions it may be suitable for informed financial consent to be obtained on behalf of the anaesthetist by another anaesthetist, another practitioner or by administrative staff. On such occasions there must be clear instructions from the anaesthetist to the person obtaining consent and the anaesthetist should, where practical, affirm the financial consent during the pre-anaesthesia consultation.

Some anaesthetists may provide general information on their fees and charging practices to other practitioners (e.g. surgeons) for patients' information. However, this does not remove the responsibility of the anaesthetist to obtain the patient's informed financial consent where practicable.

COMMUNICATING WITH PATIENTS

Many patients will be unfamiliar with what is involved with their anaesthetic procedure. In some instances, patients may have wrongly assumed that the fee for the anaesthetic service is included in the fee for the hospital or medical procedure or is fully covered by their health fund.

Patients may also be apprehensive over the pending medical procedure, unwell, distressed, disoriented, unconscious, or affected by more than one of these conditions. Discussing financial implications with some patients at this time may be impractical and unworkable. This is a matter for the anaesthetist's

judgement in each case. Under such circumstances, the anaesthetist should arrange to discuss his or hers fees with the patient as soon as practical after the patient's condition has sufficiently improved.

UNEXPECTED CHANGES TO FEES

Anaesthetic fees derived from the Relative Value Guide (RVG) are partly based on the time taken to complete the medical procedure. Accordingly, the anaesthetist may only be able to estimate a range of fees based on the expected time to undertake the procedure. Similarly, if the planned procedure is changed during surgery, this may also result in a change to the final fee charged by the anaesthetist.

Any information about expected charges, provided to the patient prior to treatment, should include advice that the estimate is not guaranteed and the cost to the patient may increase if the planned procedure takes longer than expected or other procedures are required.

HEALTH INSURANCE INFORMATION

For most private patients, the amount they will have to pay themselves will be determined by the difference between the fees charged by the anaesthetist and the applicable rebates from Medicare and/or the patients' private health insurer

Private health insurance arrangements are complex and may depend on individual patients' circumstances

Any information given to patients about likely health insurance rebates should therefore include a suitable disclaimer and advice that they should check their entitlement to private health insurance benefits with their health fund.

LEGAL OBLIGATION

When anaesthetic services are provided under a negotiated agreement or designated "gap cover scheme" operated by a health fund under the Health Legislation Amendment (Gap Cover Schemes) Act 2000, the anaesthetist is obliged, where practical, to provide to the patient a written estimate of fees or the likely patient out-of-pocket expenses as well as seek written patient acknowledgement of that informed financial consent.

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