Submission to the Australian Government, Productivity Commission

Performance of Public and Private Hospital Systems

Introduction

I am the Principal of the eponymous Gerry Carton Consulting Pty Ltd, which has been providing advice, since 2001, to health funds, regulators, intermediaries and other organizations operating within the periphery of the private health insurance industry in Australia.

I have been employed within both the public and private health insurance systems in various capacities, as a regulator in the public service, on the board of a public hospital, and am currently a committee member of a municipal Disability Advisory Committee

More recently I have become a 'customer', in both the public and private hospital systems, as an inpatient.

The following is an anecdotal summary about my recent experience with Informed Financial Consent in the private system, and incorporates some observations which may lead to improved service to fund members.

In the early days (mid 1990s) of funds being permitted to reimburse out of pocket costs above the Medicare Benefits Schedule, I was working with a large health fund and was involved in conceptualizing how the fund might implement arrangements to best serve its members.

Until recently I believed the system was working, and I believed I was relatively empowered to deal with financial issues related to my treatment.

Informed Financial Consent; What I was told

Over recent months I have sought and received treatment for a significant condition.

I will not name the protagonists in this episode of care as I do not think it fair to single out the health fund, hospital or medical practitioners involved. (If the commission requires this information I am prepared to provide it, on a confidential basis)

For the purposes of this document I will use the Commission's definition, *viz*: Informed financial consent (IFC) is defined as being:
… 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)

I received advice from the surgeon that:

'You are required to pay a booking fee of $500 and this will need to be settled no later than one week prior to your surgery' 'This amount is non refundable and cannot be

claimed through Medicare or your health fund'. (The subsequent account was itemised as 'Booking fee')
This amount does not include the cost of hospital accommodation and theatre fees ….
The hospital will advise you of their costs.
Anaesthetist: approx $700 over and above the claimable amount
Assistant: approx $400 over and above the claimable amount

I received advice from an anaesthetist:

Estimated anaesthetist fee	*$1210.00*
Less your estimated rebate	*$402.50*
Estimated Out of pocket cost	*$807.40*

I received no further advice from an Assistant Surgeon:

Thus, I understood my approximate out of pocket costs to be:

Surgeon:	$500
Assistant:	$400
Anaesthetist:	$800
Total:	$1,700

The hospital advised that:

- *PBS Drugs not covered.*
- *'if the procedure you are having is restricted pharmacy, and pathology imaging and x-ray may attract an additional charge'*

At this point I should advise that I have Top hospital cover; no excess, deductibles or exclusions. I also hold Top ancillary cover.

Informed Financial Consent; what happened

The surgeon
Having paid the $500 seven days in advance as required, I submitted the account to both Medicare and the fund. As expected, both advised that no benefit was payable.
I have not received any other account, nor do I have any idea of the benefit paid by my fund to the surgeon.

The Anaesthetist
A gentleman other than the one who had written to me prior to admission introduced himself to me in an anteroom to the operating theatre. On reading my clinical notes he discovered several co-morbidities and decided on the method of anaesthesia. He told me I would have out of pocket costs, but I have no recollection of the amount.
I was billed for a separate attendance for this process.

My out of pocket costs were $694 against the $800 quoted by the original anaesthetist.

Assistant Surgeon
My out of pocket costs were $588.80 against the $400 advised by the surgeon. I spoke with him before surgery but costs were not discussed.

Consultant
A consultant treating a co-morbidity billed me $120 in respect of which I paid out of pocket costs of $50.

Walking frame
I was discharged home with a walking frame, the cost of which was a rental of $8 per week. The fund at first refused to pay but subsequently relented.

Pharmacy
I was required to pay $26.35 out of pocket for PBS and Non PBS scripts.

Radiology
There was also an account for in patient radiology which I refused to pay a gap on.

Observations

In my case, **I** chose the surgeon who I wished to undertake the procedure. This put me in a position where I was effectively unable to negotiate and I have no problem with that. The issue is that most people do not get to choose their surgeon, and feel they have to pay what is asked. There is no concept of negotiation; the patient is totally disempowered. It is difficult to negotiate at a time of anxiety over health matters without the possession of detailed knowledge of the technical aspects of the service to be performed or the market price of that service. There is a distinct asymmetry of information.

At two degrees of separation are the anaesthetist, assistant and the hospital. So whilst the patient gets the surgeon his GP chooses, he then gets the anaesthetist, assistant and the hospital his surgeon chooses (and sometimes owns or has an interest in!)

At three degrees of separation the patient gets the radiologists and pathologists the hospital chooses.

At each stage he is further disempowered by dealing with people he will either never see or just meet briefly..

When an assistant says he will charge me twice the out of pocket costs that the surgeon is charging, do I really have an option?

As I am being metaphorically wheeled into theatre and the anaesthetist tells me my out of pocket costs are $x, am I really getting informed financial consent and do I have an option?

Fixing the problem

The definition of Informed Financial Consent must be legislatively formalized. Perhaps rebates in respect of all relevant services should be paid to the treating surgeon on a casemix basis. The surgeon could subsequently disburse fees to the other practitioners and perhaps even the hospital.

Health funds are hamstrung by regulators and imposed bureaucratic constraints of 'technical' efficiency.

Most patients are informed by their GP that the specialist they are being referred to is one of the top specialists in the country. Again, I have no problem with that. What I do have a problem with is that health funds, in the interests of 'efficiency', generally rebate at a fixed level for each specialty and, within each specialty, for each service provided, e.g. cardiology may be based on x% above the MBS schedule fee, regardless of the expertise of the treating practitioner. The new kid on the block attracts the same level of rebate as the doyen, so it is the doyen who is less likely to settle for the fees offered.

I regard myself as an informed and empowered consumer. However my experience brought home the real level of disempowerment which must be felt more acutely by someone with little exposure to the system. From the initial referral to the settlement of the last account took about 10 months, (albeit with extenuating circumstances) involved a complex process of managing and tracking multiple accounts, receipts, claims, cheque statements and balances outstanding, and an eventual out of pocket cost over $1,800.00, even with my Top cover.

Curiously the surgeon's account will appear on the health fund records and PHIAC's published data as fully rebated, as no organization is prepared to accept responsibility or accountability for the accurate recording or publishing of data. PHIAC effectively censors (see Attachment 1) any independent examination of its data by declaring that it is confidential to only several thousand people and only for a limited period of time (parts of the reports are published annually). Contemporaneous availability of drilled down data would allow the examination of which funds are supplying differential data. This information may allow an independent source to inform existing and potential fund members of realistic expectations of out of pocket costs

Each of the major providers charged me significant out of pocket costs. One made a statement that health funds would not meet his level of fees, which, he maintained, were below the recommended AMA fee. On the one hand the government wants to help PHI consumers by giving access to every single PHI product via www.privatehealth.gov.au but then chooses to not provide valuable information regarding the medical market, AMA fee/MBS fee/health fund fee/doctor's charge. The consumer is asking, what should I be paying?

The result is that, because these entities cannot agree on prices and because the consumer can't negotiate, the consumer is punished; in my case to the tune of $1,800.

There is an opportunity for health funds to act as advocates for their members; from the initial referral, through the fee negotiation process to the account settlement, funds could lift or mitigate a considerable emotional, physical and financial burden off their members. Simply by implementing a clerical function of managing the documentation and costs on behalf of its members.

The problem here of course would be the regulators and policy makers, who see Medicare's expense ratio (costs as a % of uncapped benefits) as some sort of holy grail, and insist the health funds expense ratio should mirror that. Funds are currently driven to a large degree by the regulators' focus on overheads, and while technical efficiency is admirable, allocative or social efficiency should also be a measure. After all; it should be about the average Australian and how they fare in the system.

Other minor but annoying issues are:

- Funds are forbidden from paying a benefit where PBS drugs are prescribed on discharge. This is a relic which should have been legalized at the time funds were permitted to rebate above the Medicare schedule fee.

- Being charged for x-rays and pathology where the fund has an agreement with the hospital, but not with the in-house radiologist or pathologist.

  There is an element of third line forcing in the use of in-house radiology or pathology. Theoretically the patient can choose another, but I suspect this never happens. So while the patient may believe they are fully covered in hospital they may not be. The small print usually covers the detail.

- Perhaps most annoying was the charge for a walking frame. I understand this happens with other equipment also. Hospitals should carry this cost, and funds should be adamant that it is covered in any contract. It is ridiculous to think that a hospital is being paid a casemix fee of thousands and will not absorb the insignificant cost of allowing the patient to be discharged.

In a nutshell the take out messages, is that:

- The consumer wants help with price information - Am I paying a fair price either from my pocket or through my PHI premium, AND
- The process is unwieldy and riddled with anomalies, inconsistencies and makes unrealistic demands on the patient, AND.
- The solution is for health funds to act for their members.

Attachment 1

General PHIAC Circulars

Circular No 08/22

Contact Officers:

Paul Collins (02) 6215 7955
email: paul.collins@phiac.gov.au

PDF Format:
Circ 08/22

Replaces Circular: NA

30 September 2008

CONFIDENTIALITY OF DATA – ONUS ON INSURERS

Data and reports that are not in the public domain but are provided by PHIAC to insurers contain confidential information.

Insurers are reminded that the information is provided to assist insurers' internal analysis. The information cannot be disclosed to parties external to the insurer's business.

PHIAC included statements in data provided to insurers for the June quarter 2008 to clarify the confidentiality of data provided. These statements are:

PHIAC B REPORT

- This report contains confidential information. The report is provided to you:

  to permit you to verify the accuracy of amounts calculated in connection with the Risk Equalisation Trust Fund; and
- to inform confidential actuarial and financial assessments relevant to your business.

  The report and the information it contains may not be used for any other purpose and must not be disclosed to any third parties other than actuaries, accountants and auditors who have been informed of the confidential nature of the information, without the written authority of PHIAC.

FSR data

This report contains confidential information. The report is provided to you to assist you to assess your financial position against the financial position of directly comparable funds. The report and information it contains may not be used for any other purpose and must not be disclosed to any third parties without the written authority of PHIAC.