Australian Government
Private Health Insurance Ombudsman

Submission by the Private Health Insurance Ombudsman to the Productivity Commission Study of the Performance of Public and Private Hospitals

Introduction

The Private Health Insurance Ombudsman (PHIO) is a Commonwealth Government statutory agency whose role is to protect the interests of consumers in relation to private health insurance. The main functions of the office include the provision of an independent complaints handling service that operates Australia wide, advice and recommendations to industry and government regarding issues of concern to consumers with private health insurance and consumer education and advice services including the website PrivateHealth.gov.au.

One area of complaint investigated by the PHIO is the lack of Informed Financial Consent (IFC) given to private patients by public and private hospitals, as well as medical practitioners. Informed Financial Consent is the process of enabling a consumer to give consent to incurring out-of-pocket costs, prior to receiving treatment. The ability to give IFC is an important consumer right and the PHIO has worked with government and industry over a number of years to improve the rate of IFC by healthcare providers to private patients. Accordingly, this submission provides comment on issues relating to IFC and the questions posed in Chapter 6 of the Issues paper.

Provision of Informed Financial Consent to Private Hospitals

The PHIO's investigation of complaints relating to the provision of IFC to private hospitals has enabled the office to obtain a good understanding of the systems in place in private hospitals to facilitate IFC. In 2002, the then Ombudsman took up the issue of the provision of Informed Financial Consent for private hospital admissions with the private health industry. Complaints to the office showed that on too many occasions, consumers were receiving significant out-of-pocket expenses of many thousands of dollars for private hospital admissions which were not fully covered by their health insurer. There were a number of reasons why people were not adequately covered, including waiting periods, policy restrictions, non-payment of premiums or not holding an appropriate level of health insurance cover.

The Ombudsman took the view that there needed to be systems in place to allow for membership eligibility checking between fund and hospital to ensure the member could be advised, prior to undergoing treatment, of any out of pocket costs they would be liable to pay that would not be covered by their insurer. This would allow the member to proceed with treatment with a full understanding of the financial cost to themselves, or if they could not afford the expense, to discuss alternative treatment options with their doctor.

At the time, many private hospitals had membership verification systems, but not all were effective or enabled staff to seek proper IFC from patients. In October 2002, the Ombudsman released the report "*Membership Verification and Informed Financial Consent*", which contained a number of recommendations, including that all heath insurers move to 24/7 electronic availability of membership verification. The report also recommended that all private hospitals provide members with an itemised quotation and provided a suggested format for hospitals to use.

Prior to this, many private hospitals were requiring patients to sign general disclaimers that purported to make them responsible for any amounts not paid by their insurer. The Ombudsman took the view that this was unacceptable and that there could be no proper informed financial consent unless the member knew the amount of out-of pocket expense they were consenting to incurring. The Ombudsman noted that "*no patient should be rendered an account for any amount that they had not knowingly approved following full financial disclosure prior to their admission to hospital*." This continues to be the PHIO's view.

Since that time, the majority of insurers and private hospitals have electronic systems in place to allow for eligibility checking and informed financial consent to be provided to consumers prior to admission. In general, these processes work well. This is reflected in the level of complaint to the PHIO about issues relating to the lack of IFC by private hospitals, which has declined over time (see graph at Attachment A).

As noted in the PHIO's 2008 "*State of the Health Funds Report*":

"Funds and [private] hospitals now have good membership eligibility checking systems in place that enable consumers to give IFC to any out-of-pocket costs associated with a hospital admission. As a result, the PHIO intervention is required to resolve complaints about unexpected hospital gaps in only a small number of cases. This is supported by the finding of Ipsos Australia's 2007 Consumer Survey on Informed Financial Consent that "*gaps without prior IFC accounted for only 2% of the reported hospital accommodation and theatre episodes."*

IFC is an important consumer right, but there are occasions when IFC is not possible or can be problematic. The most common situation where it is not possible relates to emergency admissions. In a recent complaint investigated by the PHIO, the complainant was injured in an accident and was taken by ambulance to hospital. It was not until he was in theatre that it became evident that a plastic and reconstructive item number would need to be used for his surgery. His health insurance policy had a restriction on plastic and reconstructive surgery and he subsequently received an account for $6,000 from the hospital, which was not covered by his health fund.

In this situation, it was impossible for hospital staff to provide a cost estimate to the patient or for him to consent to incurring this expense. The PHIO was able to negotiate a resolution of the matter with the fund and hospital. This case demonstrates the difficulty of providing IFC in some exceptional circumstances.

Complaints to the PHIO highlight occasional errors by private hospitals in obtaining IFC from patients, but these are not widespread and tend to result from failure to follow administrative processes correctly. In general, the PHIO considers that private hospitals are able to seek IFC appropriately from patients.

Provision of Informed Financial Consent to Public Hospitals

In general, the consequences of not seeking IFC by public hospitals are not as significant for consumers, because the out-of-pocket expenses for a private (Medicare eligible) patient in a public hospital will not be as high as for a patient in a private hospital. This is because the charges in the two sectors are very different. The charges of a private hospital are intended to recover the full cost of providing the service. This means that the out-of-pocket costs of an uninsured or partly insured admission can be several thousand dollars or more.

The public system is required to charge set rates, which are determined by the Commonwealth Department of Health and Ageing (known as the default benefit). A person who elects to be treated as a private patient in a public hospital will be liable to pay their excess and sometimes a daily co-payment, as well as any gaps charged by their treating doctors. Their insurer will usually pay the default benefit. Some public hospitals waive the excess and the patient is less likely to incur gaps for medical and pathology services.

Complaints to the PHIO from people treated as a private patient in a public hospital tend to be about the cost of the excess or the daily co-payment(s) and are generally for amounts of up to several hundred dollars. The PHIO has therefore not investigated IFC processes in the public sector to the same extent as in the private sector, and cannot comment in detail on this. In some cases investigated by the PHIO, the public hospital has obtained IFC regarding out-of-pocket costs; in others, the hospital has not had the ability to obtain appropriate IFC from the patient.

One area where the provision of IFC by public hospitals can be problematic is in relation to overseas visitors who are ineligible for Medicare. The PHIO investigated a number of complaints by Medicare ineligible patients admitted to public hospitals during the 2008-09 Financial Year who had received significant out of pocket expenses following their admission, with no IFC by the hospital. Public hospitals charge ineligible patients differently from Medicare eligible patients, with a standard charge of about $1200 per day. This can soon add up to a sizeable account if someone is in hospital for any length of time and does not hold an appropriate level of Overseas Visitor Cover.

In most (but not all) of these cases, the patient could not have waited for treatment until they returned to their country of origin. Medicare ineligible patients who do not hold appropriate insurance do not have access to alternative treatment options, and public hospitals cannot turn them away if they need treatment. The provision of IFC to these people could potentially influence them not to proceed with much needed treatment; alternatively, some overseas visitors have limited understanding of English and may not understand IFC if it is provided.

In one case investigated by the PHIO, the patient was hospitalised in intensive care for several months, resulting in a bill of nearly $100,000. This patient required treatment, regardless of whether they were able to give IFC or not.
In other cases, for example removal of wisdom teeth or benign cysts, provision of IFC by the hospital would have allowed the patient to make an informed decision about whether to proceed with treatment, or to wait until they returned to their home country or obtained permanent residency.

The cases of ineligible patients investigated by the PHIO suggest that systems in public hospitals to provide IFC to ineligible patients are not always available. One hospital in South Australia advised the PHIO that it was difficult to seek IFC because the cost estimate was based on the Diagnostic Related Group (DRG), which was not available until after treatment.

Provision of Informed Financial Consent to Medical Practitioners
There has been a decline in complaints to the PHIO about lack of IFC being sought by medical practitioners over the past year, which continues the downward trend of previous years (see graph at Attachment A). The PHIO received 76 complaints about medical gap issues in 2007/08, which is 39 less than the previous year. The government has provided funding for activities to encourage medical practitioners to obtain IFC. These activities have helped to improve the rates of IFC by medical practitioners and this is reflected in the reduced number of complaints to the PHIO about this issue.

However, as indicated above, the series of consumer surveys on IFC conducted by Ipsos Australia in recent years indicates that more consumers are experiencing medical gaps where IFC has not been sought than the level of complaint to the PHIO would suggest. Consumers are understandably concerned about the possibility of impairing their relationship with their medical practitioner and might therefore be reluctant to lodge a formal complaint with the PHIO.

The 2007 Survey also found that consumers are more concerned if they incur a medical gap of over $400. (*Source: Consumer Survey, Informed Financial Consent, 2007, Ipsos Australia, p 57.*) It follows that many people may not formally complain about a gap below this threshold.

An interesting aspect of the 2007 Ipsos Survey was the finding that failure to provide IFC is less prevalent in elective admissions than in emergency admissions. The reason for this was not explored in detail in the Survey, but if IFC can be obtained in emergency situations, then even higher rates should be possible in non-emergency situations. (Source: *Consumer Survey, Informed Financial Consent, 2007, Ipsos Australia, p 3.*)

As noted earlier, the provision of IFC is not always possible in emergency situations. Complaints to the PHIO, however, only rarely concern lack of IFC in emergency situations. This may mean that patients are more accepting of gaps without IFC in these circumstances, or that doctors are not charging significant gaps in emergencies where IFC cannot be obtained.

In terms of IFC not being sought by medical practitioners, the most common complaints to the PHIO relate to anaesthetists, assistant surgeons, pathologists and radiologists. This is not surprising, given that these doctors do not always have contact with the patient prior to the procedure and provision of IFC can be problematic.

Ipsos Surveys

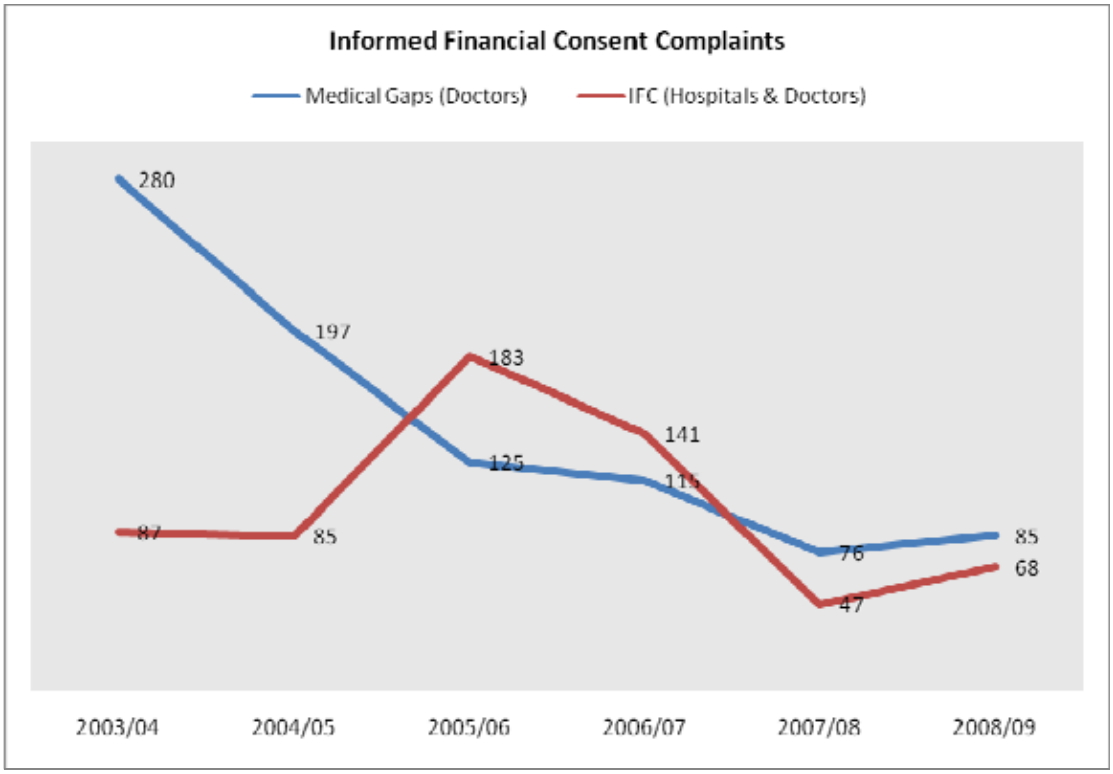
PHIO believes the Consumer Surveys on Informed Financial Consent provide good insight into this issue. The methodology used in the surveys is rigorous and the surveys are the only source of reliable data PHIO is aware of in relation to IFC. The surveys are based on the patient's recall of IFC given to them. It is likely that this is not always accurate, but it is a good a guide. PHIO's investigation of IFC complaints does show that in some instances, IFC was provided by the patient, even though they do not recall this being the case.

PHIO complaints data is a source of information about complaints regarding IFC and out of pocket expenses. There has been a gradual decline in these complaints in recent years, which suggests that initiatives to improve rates of IFC have had some impact.

Although the PHIO does not receive large numbers of complaints about IFC, PHIO complaints data provides a useful tool for measuring an increase or decline in complaints about this issue.

The PHIO would be happy to provide the Commission with any additional data or information that may be useful in relation to complaints about IFC.

30 July 2009



Notes (1) Almost all medical gap complaints concern IFC

(2) The increase in complaints about IFC (Hospital and Doctors) in 2005/06 reflects increased scrutiny of this issue by the PHIO and the introduction of wider jurisdictional powers