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Australian Government

Private Health Insurance Ombudsman

STANDING COMMITTEE
30 SEP 2005
ON HEALTH AND AGEING

Mr Alex Somlyay
Chairman
House of Representatives Standing Committee
On Health and Ageing
Parliament House
Canberra ACT 2600

Dear Mr Somlyay

Further to my evidence at the Inquiry into Health Funding
Public Hearing, Canberra, 21 September 2005

At the hearing on 21 September, I undertook to provide the committee with a copy of my brochure on doctor's bills. The issue of consumer information on private health insurance also came up in the committee's discussion with Helen Hopkins of the Consumers Health Forum.

I have therefore enclosed twelve copies of all of the brochures distributed by my office, for the committee's information.

I have also received a copy of a letter to you from the president of the AMA about an issue reported in the media following the hearing. For the committee's information I have attached a note, clarifying my position on this issue. (This is entirely consistent with my evidence to the committee but gives some more detail on that particular issue.) I have also sent that additional information to the AMA.

Yours sincerely

John Powlay
Ombudsman
29 September 2005

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Additional comment by the Private Health Insurance Ombudsman on the issue of doctors advising patients to change health funds.

My view is that there is nothing wrong with doctors advising patients what fund gap-cover schemes they do and do not use and the implications of this for a particular patient.

I believe that doctors have an obligation to fully disclose their fees to patients in advance of treatment, wherever possible. I would also encourage doctors, to the extent that they can, to advise their patients of their likely out of pocket costs, after Medicare and health fund benefits are taken into account. (I would always recommend that any doctor giving such advice include a caveat that the patient should check this with their fund because its unreasonable to expect doctors to know the full details of any individual's health insurance coverage.)

However, I do not consider it prudent or appropriate for any doctor to take the additional step of actually recommending that the patient transfer to a particular health fund, even if such a change might result in reduced out of pocket costs for the patient in relation to that doctor's fee. At the hearing of the House of Representatives Standing Committee on Health and Ageing on health funding I illustrated my concern about such a practice, using a case study. In that case study the actions of a group of specialist obstetricians in a small country city, who advised their patients to change to a small locally based health fund, had a significant impact on that fund and contributed to fund needing to raise its premiums by 30% in one year to cover increased benefit costs.

In my view there are a range of significant arguments against doctors engaging in such a practice. These are summarised below.

Product Endorsement

The AMA position statement on advertising and endorsement (1996) includes the following advice:

- Careful consideration needs to be given to the ethical and legal implications of endorsement by a doctor of a commercial product or service.
- The AMA advises against public endorsement of any particular commercial product or service. Whenever a doctor becomes publicly associated with a particular commercial product or service, the doctor should ensure that endorsement is not inadvertently stated or implied.
- The AMA also advises doctors against overt public endorsement of advertisements for health-related services, such as pharmacies, nursing homes and private clinics. The Association maintains that such advertising may be thought to imply a recommendation and operate to confuse patients.

This is sound advice, given the unique position of trust that doctors have, any public endorsement is likely to be given considerable weight. The same applies (to an even greater extent) to personal recommendations made by doctors to individual patients. Many patients would feel obliged to act on the doctor's recommendation.

While transfer to a recommended health fund may have a favourable outcome for the patient in terms of out of pocket costs for that doctor's fees for a particular episode of treatment, doctors wouldn't (and shouldn't need to) have a detailed understanding of other implications of changing to the fund (eg. for other doctor fees, hospital bills or allied health services).

Conflict of Interest

A recommendation to a patient to transfer to a particular health fund is usually a recommendation based on the fund's gap cover scheme. The doctor's expressed view is usually that the main motivation is to ensure that the patient will have reduced out of pocket costs and that the doctor will not gain from this. (The doctor's intention is, usually, to charge the same amount regardless of which health fund the patient is with.)

However, this ignores the doctor's interest in ensuring that he or she receives the required fee amount and the alternative that is available to the doctor, to accept a lower fee and use the patient's existing fund gap scheme. (I acknowledge that there are other features of some gap schemes that doctor's object to but I strongly suspect that most of those objections would disappear if the relevant funds paid enough.)

The doctor, therefore, has a financial interest in the recommendation to change funds. In most cases it would normally be sufficient to overcome conflict of interest concerns if the interest was disclosed but, given the doctor's position of trust, full disclosure would not be sufficient to address my concerns about this ethical issue.

Practical implications

The practical implications of doctor's recommending that patients change to a particular fund (to make use of their gap scheme) are illustrated to some extent in the case I quoted before the Committee hearing. The doctors' actions had an adverse effect on the fund involved. Because the fund allowed full portability, it resulted in immediate unfunded liabilities for the fund. (Not just for the doctor's bill but for all other doctors involved in the treatment as well as hospitalisation costs.) If such a practice became more common those gap schemes that doctor's favoured would become too costly for funds to maintain, and the funds themselves may be destabilised (as in my case study) resulting in, at a minimum, higher premiums or cuts in benefits.

As key participants in (and beneficiaries of) Australia's private health industry I consider that doctors have a responsibility not to contribute to such destabilisation of the industry.

Support for portability

The current debate on portability arises mainly from the actions of hospitals (and one group in particular) to exploit portability and advocate that patients change funds, largely for their own commercial reasons. This resulted in a large level of unfunded liabilities for the funds that accepted those members. As a result, a minority of funds have argued that in some situations full portability should not apply. (They are still nonetheless, allowing full portability.)

Actions by doctors to recommend that patients switch to a particular fund are seen as a further undue exploitation of portability.

My preferred approach to resolution of this issue

Notwithstanding the concerns indicated above, I do think there is a significant amount of overreaction in the comments by some stakeholders on these issues. The practice of doctors recommending that patients change to a particular fund at or just before treatment does not, at present, seem to be widespread. I am aware of only a few isolated instances. I included a case study on the issue in my evidence to the hearing only because it was an issue raised by other parties in their submissions and wanted to explain the concerns for the committee.

I do not support calls for legislation against doctors or the imposition of fines on this issue at this stage. As indicated at the committee hearing, I have a bias toward resolving such issues by agreement, education and voluntary compliance.

In the case of hospitals, I have prepared and gained agreement to protocols setting out what hospitals and funds should (and shouldn't) say to patients in contract dispute situations. This includes the following:

> Hospitals may also choose to communicate with current, former or potential patients. These communications may include:
> - Advice on which funds have HPPAs with the hospital
> - Advice on which funds no longer have HPPAs with the hospital
> - Advice on the potential for out of pocket expenses for treatment of members of a non-contracted fund
> - Advice on how to avoid out of pocket expenses

> The communications must not:
> - Advocate that the member transfer to a particular health fund or class of funds (e.g. those with which the hospital has a current contract/ HPPA)

I would like to see the AMA endorse a similar statement for doctors on how to advise patients about health insurance issues, clearly indicating that it is not appropriate for doctors to recommend a particular health fund to their patients.

John Powlay
Private Health Insurance Ombudsman