INFORMED FINANCIAL CONSENT
in the
PRIVATE HEALTH SYSTEM

(November 2012)
Executive Summary

HaDSCO has identified issues with the process of obtaining informed financial consent (IFC) from patients at private hospitals. The agency receives complaints when complainants are surprised to receive bills for out-of-pocket costs, as they were under the impression that these services were either covered by their private health insurance policy, or included in other payments they had made. The issue is particularly prominent when third party providers have been engaged in the complainant’s treatment, as the relationship between these providers and the complainant is unclear.

This project sought to provide clarity regarding the responsibilities of different parties to disclose information about the financial consequences of treatment, and to obtain informed financial consent from the consumer. A second objective was to identify tools and resources which can assist in the complaints resolution process by educating consumers and providers on their roles in the IFC process. Some useful publications have been attached to this report which can be used to fulfil this education objective. The third objective of the project was to engage with and establish long-term relationships with key stakeholders to assist in handling IFC-related complaints.

The project utilised a literature review to determine the legal and industry standards for meeting the requirements of IFC in Australia. Useful resources for consumers and providers were identified through this process. A number of providers were contacted to analyse the steps taken to obtain IFC from consumers, and determine whether these were sufficient. Other stakeholders were also engaged with to determine the practical requirements and implications of IFC in the private health system, and identify any previous research done in this area. Government agencies with similar functions to HaDSCO were contacted to determine their perspective on resolving IFC-related complaints.

This research identified that IFC should operate as a process of shared decision making, in which the provider is responsible for disclosing the information in a manner that facilitates consumer understanding, whilst the consumer is responsible for actively considering the information to make an informed decision. IFC can be considered as an aspect of the overarching ethical principle for informed consent to treatment, and a component of medical providers’ duty to disclose information to their patients. Guidelines and codes of conduct, rather than a statutory standard, are used to provide practical requirements for the types, and manner, of information that should be conveyed to patients.

Written tools such as consent forms, cost estimates, and information brochures are useful additions to the dialogue between the consumer and provider regarding their financial liability for a treatment episode. However, care should be taken to avoid the risk of these written forms detracting from the essential face-to-face, patient-specific conversation.

Three main areas of focus for further research and action on this project have been identified at the conclusion of this report. These include the process of third party providers obtaining IFC from inpatients in hospitals, consumer choice with regard to the provision of these ancillary services, and maintaining a relationship with the Health Consumers’ Forum.
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Disclaimer

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written consent. When reproduced, content must not be altered in any way.
1 Background: purpose of the project

HaDSCO has identified that IFC in private health is an area that requires more clarity, both in terms of the complaints resolution process and understanding by consumers and providers. The agency receives a number of complaints from consumers regarding bills they have received for services provided in private hospitals. These consumers are often unaware that they will be liable to pay out-of-pocket expenses for these services. It has become clear that there is an issue with obtaining quality informed financial consent (IFC) from patients in private hospitals, which gives rise to a lack of patient satisfaction and causes these complaints.

Obtaining IFC in the private health system is complicated by the lack of clarity regarding the responsibilities of each party involved in a treatment episode. An obvious issue is that private health insurance policies are complex and diverse, making it difficult for consumers and providers to accurately predict the likely out-of-pocket expenses of a treatment episode. The issue is most prominent when third party providers are involved, as different insurance entitlements may apply than those for the main treatment service and provider.

1.1 Objectives

The purpose of this project is three-fold. The main objectives are summarised as follows.

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<th>Objectives of IFC project</th>
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1.2 Complaints received by HaDSCO

Between 2008 – 20 August 2012, HaDSCO received 165 complaints involving financial consent issues. Of these cases, 18 were closed in negotiated settlement, conciliation, or investigation.

Some scenarios that have given rise to complaints relating to informed financial consent include:

(i) No discussion or mention of costs prior to treatment
(ii) Consumers being under the impression that the treatment was fully covered by their private health insurer and feeling that they should have been warned of the potential out of pocket expenses prior to receiving treatment.
(iii) Consumers being told that their ‘top cover’ private health insurance would leave no out-of-pocket fee, only to receive an account after receiving treatment
(iv) Consumers being unaware of additional costs (such as those associated with third party providers,) that would be charged on top of the original cost estimate they consented to.
(v) Consumers being unaware of specific restrictions, exclusions or limits in their private health insurance cover and the hospital failing to clarify with the health fund prior to admission.
(vi) The providers failing to conduct an eligibility check to determine whether the consumer’s health insurance policy is sufficient for the proposed treatment
(vii) Consumers believing that they have previously been bulk-billed or charged a reduced amount for a service but now receiving a larger bill.
(viii) A consumer being quoted the wrong rebate amount or given an incorrect cost estimate.
(ix) A consumer being transferred from public to private hospitals without being notified of the financial consequences or the hospital conducting a health insurance check.
(x) Consumers electing to be private patients in public hospitals and then surprised when they receive accounts for fees such as an excess and diagnostic imaging.
(xi) A specialist provider supplying incorrect information to hospitals regarding the prostheses to be used in consumers, resulting in consumers receiving incorrect quotes for costs of these prostheses
(xii) Consumers receiving accounts for services they do not believe they consented to or received.
(xiii) Consumers who receive accounts for out-of-pocket expenses associated with Ambulance services
(xiv) A provider was made aware of the consumer’s state of financial hardship but did not inform the consumer of a cheaper treatment option/alternative provider.
The main objectives sought by consumers with IFC-related complaints are for the provider to waive, refund, or reduce the fee. Some consumers also seek to register their concern with HaDSCO, to receive an apology or explanation from the provider, to improve access to information, and/or a policy change or development.

2 Informed financial consent: definition

Informed financial consent can be defined as the provision of cost information to patients, including notification of likely out-of-pocket expenses, by all relevant service providers, preferably in writing, prior to admission to hospital or treatment.\(^1\)

It is recognised as sound ethical, professional and business practise, which “indicates respect for individual patients and their rights, avoids negative perceptions of private medical practice, and makes it more likely that patients are willing and able to settle their accounts following treatment.”\(^2\)

The provider is required to sufficiently explain his or her fees to the patient to enable the patient to make a fully informed decision about costs.\(^3\) IFC should involve a dialogue between the provider and consumer with the end result being that the consumer understands the likely out-of-pocket costs of their treatment episode.\(^4\) Ideally, IFC should be a process of shared decision making, which includes an active two-way relationship between the consumer and provider. The provider is responsible for open disclosure and facilitating the consumer’s understanding, whilst the consumer is responsible for actively analysing the information and coming to a decision.

While IFC is required for all medical services, it is most important in the private hospital context due to the complex array of health services provided for any given treatment episode, and the tendency for inpatients to have a lesser appreciation for their potential gap fees.\(^5\)

To achieve IFC, the consumer must be provided with information regarding all likely out-of-pocket expenses, by each and every service provider associated with the relevant treatment episode. This will ensure the consumer is aware of:\(^6\)

- the potential fee to be charged by the principle provider;
- the potential fee for other service providers involved the procedure; and
- the likely Medicare and/or private health insurance payment associated with that episode of treatment.\(^7\)
3 Operation of the private health industry

3.1 Market participants

The other main participants in the private health industry include;
- private health insurers;
- health services providers (such as private hospitals and specialist doctors);
- consumers;
- insurer industry groups;
- consumer groups; and
- Australia Government agencies or independent statutory bodies.8

These participants are summarised below:

<table>
<thead>
<tr>
<th>Market participants</th>
<th>Regulatory bodies and advocacy groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private health insurers EG: HBF</td>
<td>Private Health Insurance Ombudsman</td>
</tr>
<tr>
<td>Insurer industry groups</td>
<td>Private Health Insurance Administrative Council</td>
</tr>
<tr>
<td>Health services providers EG: private hospitals and specialist doctors</td>
<td>Australian Competition and Consumer Commission</td>
</tr>
</tbody>
</table>
| Consumers                                  | Consumer representative groups EG: Consumers' Health Forum (ACT)
                                              | Health Consumers' Council (WA)           |
|                                            | HaDSCO and equivalent complaints resolution bodies inter-state. |
3.2 Purchaser-provider agreements

Private health insurance funds can enter contracts directly with private hospitals and medical providers through purchaser-provider agreements. These agreements enable health insurers to negotiate the price of services so their members receive a pre-agreed rebate for that service. Medical gap insurance is permitted in circumstances where gaps were not completely eliminated. Health insurance funds were more successful in contracting with private hospitals than with doctors, who were opposed to these arrangements.

This new health care environment transformed health insurance funds from passive bill payers to active purchasers of health services on behalf of their members. The protection of consumers depended on whether their health insurer had a contract with the hospital at which they were being treated, so the following consumer protection measures were implemented:

(i) The Private Health Insurance Administrative Council (PHIAC) began disseminating information to consumers who were considering purchasing private health insurance to enable them to make informed choices about private health insurance (Annexure 6);

(ii) The “Private Patients’ Hospital Charter” was published to inform potential members of what they could reasonably require from health funds (Annexure 4) and

(iii) All purchaser provider agreements were required to contain a provision to the effect that the provider must inform the consumer of the amount they will be liable to pay in respect of their treatment.

3.3 Gap-cover arrangements

In response to the medical profession’s concern that purchaser-provider agreements would compromise their service delivery, the Government gave legislative approval for private health insurance funds to offer gap insurance schemes without requiring a formal contract to be entered with medical practitioners.

These are called “known gap” agreements when the consumer pays part of the medical fee, and “no gap” agreements when the cost is entirely covered by insurance.

In the absence of a purchaser provider agreement, the Private Health Insurance Act 2007 enables health insurance rebates to doctors and private hospitals to be withheld if there has not been informed financial consent.
3.4 Doctors’ fees & out of pocket charges

As a private patient, Medicare pays 75% of the Medicare Benefits Schedule (MBS) fee for the medical service provided, and the private health insurer pays the remaining 25%.15 Out-of-pocket, or ‘gap’ payments may arise because providers are entitled to charge more than the MBS fee for their services. To address the issue of out-of-pocket charges, private health insurers enter into “gap cover arrangements” with willing providers, through which they can cover more than 25% of the MBS fee. These can be “no gap” arrangements, in which the consumer pays no out-of-pocket fee for that service, or “known gap” arrangements, where the consumer will be given advance notice of the out-of-pocket fee.

It is important that consumers are aware of the relationship between their provider and private health insurer, as this will influence the potential rebate and out-of-pocket charges for a treatment episode.

A useful overview of the services covered by Medicare compared to private health insurance funds is available via the Private Health Insurance Ombudsman website, at: http://www.privatehealth.gov.au/healthinsurance/whatiscovered/

3.5 Regulatory bodies

The main bodies responsible for regulation of the private health insurance industry are the Private Health Insurance Administrative Council (PHIAC), and the Private Health Insurance Ombudsman (PHIO). The PHIAC is an independent statutory body responsible for regulating the private health insurance industry, whilst the PHIO manages complaints involving private health insurance. There are also State-based agencies that deal with complaints, such as HaDSCO in Western Australia, as well as the Australian Competition and Consumer Commission (ACCC,) which deals with complaints in the context of the Competition and Consumer Act (CCA).

4 IFC as a component of general informed consent

Informed consent to treatment is a fundamental ethical principle, underpinned by respect of patient autonomy and self-determination, which entitles an individual to choose what is done to their body.16 It is the foundation of modern medical practice which seeks to empower patients and enable shared decision making and patient-centred care.17

The level of fees and charges is one factor that is relevant to a patient’s decision of whether or not to receive medical treatment. Providing information regarding the treatment’s financial implications is therefore a necessary component of the overall duty of a medical practitioner to inform.
4.1 Definition of informed consent

The Western Australian Department of Health’s Consent to Treatment Policy (the Policy) defines informed consent as a patient’s agreement for a health professional to provide treatment.\(^{18}\) The Policy sets out the four steps to the consent process as follows:

<table>
<thead>
<tr>
<th>4 steps of informed consent</th>
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<tr>
<td>1</td>
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<td>3</td>
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<td>4</td>
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4.2 Legal distinction between information disclosure and the defence to trespass

It is important to recognise the legal distinction between consent to medical treatment which negatives trespass, and the principle of “informed consent” which relates to the appropriateness of information provided prior to medical treatment.\(^{19}\)

The former refers to the requirement to advise a patient in broad terms of the nature of the procedure to be performed on them.\(^{20}\) Failure to do this will expose a provider to liability in tort for the action of trespass, or for the crime of assault.\(^{21}\)

The latter requires the practitioner to provide their patient with sufficient information to enable the making of a fully informed, independent decision as to whether to undergo medical treatment or not.\(^{22}\) This is relevant to the question of whether a practitioner has fulfilled their duty of care to the patient and is considered part of the law of negligence.\(^{23}\)
4.3 Legal duty to inform the patient about the proposed treatment

A patient cannot properly consent to treatment if they have not been provided with all the relevant information that will influence their decision.24

Australian law requires medical practitioners to provide their patients with all the relevant information about the proposed treatment to put the patient in a position which enables them to make an informed decision about whether or not to undergo that treatment. The information to be provided includes details of material risks and alternative treatments, as well as other types of information needed to enable patients to make an informed decision about their health.25

To make a decision, the patient must be capable of reasoning and making a choice to consent or refuse treatment. The provider should take reasonable steps to ensure that the patient understands, retains and believes the information.26 Whether the practitioner has taken “reasonable” steps to ensure the patient understands, will be assessed by reference to the time when the decision was made, not with the benefit of hindsight.27

4.3.1 Objective test

Medical practitioners must exercise reasonable care to give their patient such information that a reasonable person in the patient's position would, in the circumstances, want to be given before making a decision whether or not to undergo treatment.28 That is, they are required to provide all the information that a reasonable person in the patient's position would attach significance to in deciding whether or not to undergo the proposed treatment.29

Whilst this is an objective test, the practitioner is required to reasonably consider the individual characteristics of the patient, rather than just provide information that a reasonable doctor would consider relevant.30 It is clear that the type of information to be provided extends beyond information of material risks inherent to the treatment, and is likely to include information regarding costs and the likely out of pocket expenses of the proposed treatment.31

4.3.2 No statutory standard

In their 1989 report into the law of negligence, the Law Reform Commissions recommended against legislating the requirements of information disclosure for informed consent. This opinion is also shared by Australian courts and the medical profession, who are reluctant to clearly set out an explicit list of the types of information required to be provided to a patient.32

A statutory standard of information provision may be too rigid and narrow for the wide range of scenarios that arise.33 Instead, it has been recommended that the National Health and Medical Research Council (NHMRC) develop guidelines to outline the practical requirements for providing information.34 Other industry and professional
bodies have also established guidelines and codes of conduct outlining the types of and methods for communicating and disclosing information to patients.

4.3.3 NHMRC Guidelines for provision of information

Resulting from these recommendations, the NHMRC has produced two sets of guidelines; *Communicating with Patients: Advice for Medical Practitioners* and *General Guidelines for Medical Practitioners on Providing Information to Patients*. Whilst not legally binding, these guidelines provide a flexible and practical overview of the types, and manner of presenting, information to patients. They are intended to assist medical practitioners and the community to utilise effective communication methods in the exchange of appropriate information between patients and doctors.\(^{35}\)

They do not set mandatory standards of behaviour, but aim to foster better communication to enable patients and doctors to collaboratively make the best decisions about medical care. The guidelines can be considered in court when determining whether a doctor has acted reasonably in fulfilling their duty to provide information.\(^{36}\)

Below is a summary of the types of information and manner of presentation as outlined in the *General Guidelines for Medical Practitioners on Providing Information to Patients* (Annexure 1):

<table>
<thead>
<tr>
<th>Type of information</th>
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<tbody>
<tr>
<td>Possible or likely nature of illness</td>
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<tr>
<td>Proposed approach of the intervention</td>
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<tr>
<td>Alternative interventions</td>
</tr>
<tr>
<td>Degree of uncertainty of the outcome of the intervention</td>
</tr>
<tr>
<td>Likely consequences of not intervening</td>
</tr>
<tr>
<td>Long-term outcomes associated with the intervention</td>
</tr>
<tr>
<td>Time involved</td>
</tr>
<tr>
<td><strong>Costs involved, including out of pocket costs.</strong></td>
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</tbody>
</table>

Fig 1: Adapted from *NHMRC General Guidelines for Medical Practitioners on Providing Information to Patients*, Part D: Information to be given.
Presentation of information

<table>
<thead>
<tr>
<th>Communicate in a form the patient should be able to understand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allow the patient sufficient time to make a decision</td>
</tr>
<tr>
<td>Encourage the patient to reflect, ask questions, consult family and advisors</td>
</tr>
<tr>
<td>Repeat key information to help the patient remember and understand</td>
</tr>
<tr>
<td>Provide written information and diagrams where appropriate</td>
</tr>
<tr>
<td>Pay attention to the patient’s responses to identify their level of understanding</td>
</tr>
<tr>
<td>Use a competent interpreter when the patient is not fluent in English</td>
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</tbody>
</table>

Fig 2: Adapted from NHMRC General Guidelines for Medical Practitioners on Providing Information to Patients, Part D(2): Presenting Information.

4.3.4 Private Health Insurance Code of Conduct

The private health insurance industry is self-regulated by the Private Health Insurance Code of Conduct (Annexure 2). This document requires private health insurers to promote better informed decisions in the following way:

Private health insurance code of conduct

<table>
<thead>
<tr>
<th>Ensure that Policy documentation is full and complete and accurately reflects the cover offered, including:</th>
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<tbody>
<tr>
<td>• Waiting periods;</td>
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<tr>
<td>• Exclusion;</td>
</tr>
<tr>
<td>• Restrictions;</td>
</tr>
<tr>
<td>• Co-payments and excesses; and</td>
</tr>
<tr>
<td>• How to find agreement hospitals, no gap or known gap doctors and ancillary providers.</td>
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</table>

Provide information to consumers in plain language with the aim of assisting comprehension by consumers;

Provide a verbal explanation of the contents of a consumer’s entitlements to benefits when asked by a consumer;

Ensure staff and other persons providing information are appropriately trained; and

Produce and maintain material detailing all tables of benefits available to consumers on a State-by-State basis.¹³
4.3.5 Professional industry standards

(ii) Position Statement; Code of Conduct for Members: Australian Society of Anaesthetists

4.3.6 Other publications

(ii) Informed Financial Consent Checklist: Private Health Insurance Ombudsman (Annexure 5).
(iii) Consumer Quick-Guide to Private Health Insurance: Private Health Insurance Administrative Council (Annexure 6).

5 Overcoming the barriers to informed financial consent

In the private health system, the process of obtaining IFC is complicated by the fact that there are a number of different parties that influence the level of out of pocket costs of a treatment episode. For example, a consumer may face costs from the hospital itself, the treating doctor and team of specialists, as well as allied health providers, diagnostic imaging, and pharmaceuticals. The influence of Medicare and the consumer’s private health insurance fund on costs also complicates the process of obtaining informed financial consent.

Key requirements for improving the quality of informed financial consent are:

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<tr>
<th>Improving the quality of IFC</th>
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<td>3</td>
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Fig 3: Key requirements for improving the quality of IFC
5.1 Ensure adequate and accurate information is given to consumers by providers and health insurance funds

As discussed above, a consumer cannot give IFC if they have not been provided with sufficient, accurate information regarding the financial implications of their treatment episode. This applies to information given to the consumer by both the provider and private health insurance fund.

5.1.1 Provision of information by providers

Providers, such as private hospitals or doctors, may neglect to discuss their fees or supply a cost estimate to the consumer prior to treatment. This may be because of an administrative oversight, a lack of time, or a perception that these details are not important to the patient. Furthermore, an emergency situation or a change to the treatment plan may give rise to extra costs without an opportunity for consumers to consent.

As discussed above, there are a number of professional standards and codes of conduct which set the requirements for providing information to consumers. Although these are not binding or enforceable, they help to set the standard for the provision of information.

5.1.2 Provision of information by private health insurers

Private health insurance policies are notoriously complicated, and often contain restrictions and limitations. Insurance companies may also market their products with confusing slogans such as “unlimited cover,” and “no gap,” which are subject to fine print.

Consumers can be surprised when they are charged a gap fee as they are unaware of the details of their private health insurance policy, such as the exclusions and limitations that apply to them.

Private health insurance companies should endeavour to be as transparent and candid as possible when providing information to their members, including written material on websites.

As discussed above, the industry is self-regulated by the Private Health Insurance Code of Conduct.

5.2 Assisting consumer understanding

It is more often the case that IFC-related complaints arise when consumers have been given sufficient information regarding the costs associated with their treatment, but there has been a breakdown in communication which results in the consumer agreeing to treatment without fully considering or understanding this information. This may occur because the provider merely discloses information, rather than facilitating the consumer’s understanding. Alternatively, the consumer may be unwilling to take the initiative to engage in their own medical decision-making.
This gives rise to a “disconnect” between the supply of information by providers, and the understanding and retention of this information by consumers, which can lead to complaints when consumers perceive that they have not been informed. Some recommendations for addressing this are outlined below.

5.2.1 Format and nature of information and consent
Patients understand and retain information best if it is provided in both verbal and written form. Ideally, a two-way discussion of fees should occur between the consumer and provider, including any potential third party or “add-on” fees associated with the treatment episode. This discussion should be followed with written confirmation of the potential costs associated with the treatment, in a simple, readable format.

5.2.1.1 Consent forms and cost estimates
The Australian Medical Association and the Australian Society of Anaesthetists both endorse the provision of a written cost estimate of out-of-pocket costs given prior to the patient being admitted to hospital, and made subject to variations in fee estimates due to unforeseen circumstances. Cost estimates are given to the patient by the provider and should direct patients to confirm their level of cover independently with their private health insurer. This will give the consumer the opportunity to judge their financial ability to pay the gap fee before consenting to treatment, rather than being surprised by an unexpected gap payment afterwards. The AMA has produced a standard template cost estimate form (Annexure 7.) Private Hospitals have adapted their own forms for use within their organisation (example, Annexure 8).

Additionally, patients are often required to sign consent forms prior to receiving treatment or being admitted to hospital. In fact, it is a Department of Health policy that, for some types of treatment, all WA Health facilities obtain written consent using an approved consent form.

Consent forms and cost estimates are necessary and useful tools in the consent process, both for record keeping purposes and to direct the consumer’s attention to the issue of consent. It is important, however, to emphasise that the mere signing of a form is not evidence that informed financial consent has occurred. The use of generic hospital admission consent forms can in fact hinder the informed consent process, as it may encourage the idea that consent is just a provider-focussed, administrative step. Another issue is that patients often do not read these forms before signing them.

Providers and consumers must therefore both be cautious that the use of a consent form does not replace the necessary dialogue between them as they enter a decision-making partnership which blends the provider’s expertise with the consumer’s choice.

5.2.1.2 Supplying pre-admission informational materials
Private hospitals often give patients extensive pre-admission information documents as an aid to the general consent process. For example, the St John of God Admission Guide attached at Annexure 9. This material contains an overview of
hospital billing practices, and directs patients to discuss their fees in detail with both their provider and private health insurer. Another example is the SKG Radiology Inpatient and Outpatient Billing Guides, posted on their website and attached at Annexure 10.

These documents are useful, as the consumer has the opportunity to read through the information and take time to ask any questions that arise. However, once again, care should be taken to ensure that written booklets do not replace the essential face-to-face discussion of fees between the consumer and provider. Additionally, consumers may be overwhelmed by the detail and volume of the information provided and may not read it.

5.2.1.3 Tailoring the consent process to the individual consumer
Factors such as age, education level, illness, language and cultural barriers have been found to influence a consumer’s level of comprehensive and retention of information at a number of assessment points. Providers should aim to tailor the informed financial consent process to the individual circumstances of each consumer to enhance understanding and enable active participation in their own healthcare.

5.3 Encourage active consumer participation in decision-making

5.3.1 Altering the attitude that consent is just a medico-legal requirement
A significant barrier to obtaining proper informed financial consent and consent in general, is the view that “consenting the patient” is a formal, administrative procedure, necessary to cover the provider’s back against potential litigation. Viewing consent in this manner detracts from the process of “patient-centred decision making,” which relates to the broader ethical right of patients to make an informed choice as a healthcare consumer.

As discussed above, formal procedures such as generic consent forms can perpetuate the idea that obtaining informed consent is just an administrative procedure rather than a collaborative process.

5.3.2 Shifting from a paternalistic attitude to medical decision making
Despite the modern, consultative approach to healthcare, some patients and providers may still be of the view that the best treatment is given without the patient’s involvement in the decision making process. These patients are said to have an "external locus of control," whereby they perceive their health is out of their own control. Patients who believe they have control of their health ("internal locus of control," ) have been found to take on a more active role in decision-making about their health, more readily ask questions of their healthcare provider, and be more likely to recall information supplied to them.
In the context of informed financial consent, these consumers may be less likely to take the initiative to obtain and understand information about potential fees and charges. Instead, they may depend on the provider to give them all the relevant information, or acquiesce to the authority of their provider. These consumers may also be more likely to accept information on face value rather than ask questions. Consumers may believe that they have no right to choose or refuse certain services based on cost, and may simply surrender themselves to the hospital on admission. They may sign consent forms without reading them, because they feel it is unnecessary to be aware of the information they contain, or because they feel they have no choice anyway. Subsequently, these patients may be shocked when they are required to pay out-of-pocket expenses which they may have known about had they taken a more active involvement in their treatment episode.

6 Competition and Consumer Law Issues

6.1 The Australian Consumer Law

The Australian Consumer Law (ACL) is administered and enforced by the ACCC. While the ACL does not contain a provision that deals explicitly with informed financial consent, it places an obligation on providers and private health insurers to be open about prices. The following are some provisions which may be relevant to dealings between consumers and providers, or consumers and private health insurers.

6.1.1 Misleading and deceptive conduct

Misleading and deceptive conduct occurs when an insurer “engage[s] in conduct that is misleading or deceptive or is likely to mislead or deceive.”

Examples of “conduct” which may be misleading or deceptive include:

(i) advertisements;
(ii) promotions;
(iv) quotations; and
(v) statements;

which create a misleading overall impression among the audience about (for example) the price, value, or quality of consumer goods or services.

For example, the ACCC reported that the most common cause of complaints in the private health insurance industry in the year 2010-11, was allegations of misleading or deceptive conduct relating to the advertising and sale of insurance products.

Silence can also amount to misleading or deceptive conduct, such as a provider or health insurer’s failure to disclose facts or important details that are relevant to a
decision, or a change in circumstance that means information already provided is now incorrect.\textsuperscript{56}

When considering whether conduct was misleading or deceptive, the intention of the person who engaged in the conduct is not relevant. The question is looked at objectively by asking whether the conduct would likely mislead or deceive a person from the “class” of people to which it is made.

\textbf{6.1.2 False and misleading representation as to price}\textsuperscript{57}

It is unlawful for a business to make false or misleading representations about goods or services when supplying, offering to sell, or promoting them. Section 29 of the ACL contains a list of specific matters about which a business must not make false or misleading representations, including the price of goods or services. The particular circumstances of the consumer are relevant to determining whether a representation is considered false or misleading.

\textbf{6.1.3 Unconscionable conduct}

Unconscionable conduct may arise if 1 party to a contract or transaction is under a special disability, which is taken advantage of by the other party, either knowingly or where the circumstances suggest that they ought to know.

A “special disability” may include sickness, age, poverty, infirmity, drunkenness, and illiteracy, lack of education, assistance or explanation.

Under the ACL, the following considerations may point to whether unconscionability has occurred:

- (i) the respective bargaining strengths of parties;
- (ii) whether the consumer is required to comply with unnecessary conditions;
- (iii) undue influence or unfair tactics by the provider;
- (iv) the price of substitute goods or services available from third parties;
- (v) consistency with which the provider engages in similar transactions with other consumers;
- (vi) the provider’s compliance with any relevant industry code;
- (vii) the presence of negotiation and good faith.

\textbf{6.2 Exclusive dealing and third line forcing}

“Third line forcing” is a type of exclusive dealing prohibited by s47(6) of the Competition and Consumer Act (CCA) below:
Section 47 CCA

Exclusive dealing

(6) A corporation also engages in the practice of exclusive dealing if the corporation:

(a) supplies, or offers to supply, goods or services;

(b) supplies, or offers to supply, goods or services at a particular price; or

(c) gives or allows, or offers to give or allow, a discount, allowance, rebate or credit in relation to the supply or proposed supply of goods or services by the corporation;

on the condition that the person to whom the corporation supplies or offers or proposes to supply the goods or services or, if that person is a body corporate, a body corporate related to that body corporate will acquire goods or services of a particular kind or description directly or indirectly from another person not being a body corporate related to the corporation.

Third line forcing is the supply of goods or services on condition that the purchaser buys goods or service from a particular third party, or a refusal to supply because the purchaser will not agree to that condition. Making a contract conditional upon the consumer contracting with a third party is therefore a breach of the CCA. The contracting party (EG the hospital or provider) can apply to the ACCC to authorise this “forcing” conduct if it is deemed to be in the public interest.

7 Areas for further action

There is scope for further research and action to be taken in the following areas:

7.1 Obtaining IFC between hospital inpatients and third party providers

The issue of obtaining IFC for treatment by third party providers still needs to be looked at in more detail. Specifically, it would be useful to develop some practical steps of how the process can be improved in a hospital setting once patients are already admitted.

7.2 Consumer choice in private hospitals regarding treatment by third party providers

The question of consumer rights to choose to access treatment from different third party providers than the ones provided in hospitals needs further exploration. For example, the exclusive dealing and third line forcing issues can be looked into further with the aid of the ACCC.
7.3 Maintain contact with Consumers’ Health Forum

The Consumers’ Health Forum is currently undertaking a project looking at IFC in the private health system. They will soon be engaging a consultant to specifically look at the issue in the context of diagnostic imaging providers, so it would be useful to maintain this contact and receive updates on their progress with that project.

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1 “Private Health Insurance:” Australian Government, Department of Health and Ageing.
2 AMA position statement on Informed Financial Consent – August 2006.
4 Above, n 2.
5 Above, n 2.
7 Above, n 2.
8 ACCC Report to the Australian Senate on anti-competitive and other practices by health funds and providers in relation to private health insurance, 2011.
9 The Health Legislation (Private Health Insurance Reform) Amendment Act 1995 amended the National Health Act 1953 to his effect.
11 Gath, S.
12 Sheahan, M.
13 National Health Act 1953 ss 73BD(2)(d) and (c) (repealed).
14 Above, n 10.
15 Above, N 1.
16 Bernat J & Peterson L.
17 Laine C & Davidoff F.
18 Consent to Treatment Policy for the Western Australian Health System 2011.
19 White B, McDonald F & Willmott L.
21 Schloendorff v The Society of the New York Hospital 211 NY 125 (1914) as adopted in Secretary, Department of Health and Community Services (NT) v JWB and SMB (Marion’s Case) (1992) 175 CLR 218.
22 Ipp Report [3.35].
23 Ipp Report [3.44].
24 Rogers v Whitaker (1992) 175 CLR 479.
26 Ipp Report [3.46] and Stobie v Central Birmingham Health Authority (1994) 22 BMLR 135 (QBD)
27 Ibid.
28 Ipp Report [3.54]
29 Ipp Report [3.47] and [3.51]
30 Ipp Report [3.53]
31 Ipp Report [3.51]
32 Ipp Report [3.52] and [3.55]
33 Ipp Report, Recommendation 1.
34 Ipp Report, Recommendation 1 and 2.
36 Ipp Report, Recommendation 3.
37 Private Health Insurance Code of Conduct of Australia 2012, Part E.
38 Murphy, J.
39 Ibid.
40 Above, n 2.
41 Treatment including surgical, medical, obstetric, radiology, oncology and endoscopy requiring general/regional anaesthesia or intravenous sedation, invasive procedures or treatment where there are known significant risks or risk of complications, sterilisation of a minor or represented person, the application of electroconvulsive therapy, administration of medications with known high risk complications or new unusual medications which may have risks, drugs administered under the Special Access Scheme, and participation in clinical trials and medical research: Western Australian Department of Health Policy on Consent to Medical Treatment, 3.1
42 Lavelle-Jones et al.
43 Bernat et al; and Quill TE.
45 Sokol D.
46 Bernat et al; and Quill TE et al.
47 Charles C et al.
48 Lavelle-Jones et al.
49 Ibid.
50 Schedule 2, Competition and Consumer Act 2010.
51 ACCC report to the Australian Senate, 2011.
52 Section 18, Schedule 2, Competition and Consumer Act 2010.
53 Ibid.
54 ACL Guide for Businesses and Legal Practitioners: “Avoiding unfair business practices”.
55 ACCC report to the Australian Senate on anti-competitive and other practices by health funds and providers in relation to private health insurance
56 ACL Guide for Businesses and Legal Practitioners: “Avoiding unfair business practices”.
57 Section 29, Schedule 2, Competition and Consumer Act 2010.
8 Annexures

Annexure 1
- NHMRC General Guidelines for Medical Practitioners on Providing Information to Patients

Annexure 2
- Private Health Insurance Code of Conduct
- Private Health Insurance Code of Conduct brochure

Annexure 3
- Private Practice Standards for physiotherapy practices 2011.

Annexure 4
- Private Patients Hospital Charter

Annexure 5
- Private Health Insurance Ombudsman Checklist

Annexure 6
- PHIAC consumer quick guide to private health insurance

Annexure 7
AMA template cost estimate form

Annexure 8
- Mount Hospital IFC1
- Mount Hospital IFC2

Annexure 9
- SJOG admission guide

Annexure 10
- SKG Inpatient Billing Guide
- SKG Outpatient Billing Guide
9 References

*Australian Competition and Consumer Act 2010: Schedule 2*


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