
9 Informed financial consent

Key points

- Informed financial consent (IFC) occurs when patients undergoing treatment as a private patient receive relevant cost information about their treatment prior to the treatment taking place. IFC is important as it allows patients to make informed decisions.
- The latest available data show that currently around 85 per cent of hospital medical services provided to privately-insured patients do not have an associated gap payment, suggesting that most patients do not have a problem with IFC. Nevertheless, it is undesirable for any patients to incur gap payments without IFC.
- Survey data collected by Ipsos Australia are the only information source that is available to consider the provision of IFC and out-of-pocket expenses. These data are dated (2007 is the latest) and subject to potential sample-selection and self-reporting bias and should be interpreted with caution. These data suggest that a greater percentage of in-hospital services involve a gap than is actually the case.
- The 2007 Ipsos data for pre-planned admissions show that the IFC rate was:
 - lower in private hospitals (around 80 per cent) than public hospitals (about 90 per cent)
 - higher in Tasmania, South Australia, and inner regional areas across Australia (around 90 per cent in each case)
 - among specialists, lowest for paediatricians (around 60 per cent).
- The data also show that, at a national level, the IFC rate was relatively stable between 2004 and 2007, and for a range of disaggregations.
- At a national level, the average gap for people who did not provide IFC was around \$800 and relatively stable between 2004 and 2007. However, few conclusions can be made when disaggregating further, due to small sample sizes.
- The medical profession has sought to promote best practice with respect to IFC in recent years, including through educational campaigns. In addition, individual specialists are using internet-based packages to inform patients about their likely out-of-pocket expenses.

The terms of reference ask the Commission to examine aspects of informed financial consent (IFC) for privately-insured patients. IFC occurs when patients receive relevant cost information, including notification of likely out-of-pocket

expenses (gaps), desirably prior to agreeing to treatment. It is preferable for this information to be provided in writing.

The provision of relevant cost information prior to treatment is desirable as it allows patients to make more informed decisions about whether to continue to receive treatment from the particular practitioner(s) and to understand the full cost implications. However, it is not feasible for written notification to be provided in all circumstances, such as in many emergency cases.

Excesses and copayments are not considered out-of-pocket expenses because they are due to the patient's choice of insurable cover. An excess is the amount that a patient agrees to pay towards the cost of hospital treatment in exchange for a lower insurance premium. A copayment is a set amount that insured patients pay for each day they are in hospital in exchange for a lower insurance premium (PHIO 2009).

For the year to September 2009, there was no gap payment for 85 per cent of hospital medical services provided to privately-insured patients (not including hospital accommodation services) (PHIAC 2009a). For the remaining 15 per cent of services that did involve a gap, 4 percentage points involved known-gap agreements. In known-gap agreements there is a legal requirement for IFC to be provided. Thus, it could be argued that no more than 11 per cent of services should lack IFC. For the year to September 2009, this represented approximately 730 000 medical services (PHIAC 2009a).¹ Of this 11 per cent, the Australian Society of Anaesthetists (sub. 9) noted that 1–3 percentage points involve emergency cases, for which it is not always realistic to expect IFC. Nevertheless, it is undesirable for any non-emergency patients to incur out-of-pocket expenses without IFC, and desirable for as many emergency patients to receive IFC as is practicable.

The Private Health Insurance Ombudsman (sub. 26) noted that there has been a gradual decline in complaints received regarding IFC over recent years. The Private Health Insurance Ombudsman received 76 complaints about medical gap issues in 2007-08 (of which almost all concerned IFC), which was 39 fewer than the previous year, suggesting that the provision of IFC has been improving. However, there still seems to be a number of patients that do not receive relevant cost information prior to treatment.

Aside from analysing the provision of IFC and out-of-pocket expenses, this chapter discusses some potential impediments to the provision of IFC, available IFC data

¹ In 2008-09, there were 3 052 375 acute hospital episodes and 6 151 724 medical services involving privately-insured patients, therefore privately-insured patients are on average treated by approximately two medical service providers per episode of hospitalisation (PHIAC 2009a, 2009b).

sources and possible data developments, and best-practice examples of IFC provision.

9.1 Potential impediments to the provision of informed financial consent

Key impediments to IFC can include short lead times prior to treatment, treatment involving multiple service providers, and the complexity of some health insurance policies.

Short lead times and multiple providers of services

It is generally more difficult for specialists or other service providers to obtain IFC from patients for whom there is a short amount of time between the decision to undertake surgery and the actual admission for surgery (short lead time). This is because there is less available time to provide financial information to patients enabling them to provide IFC in advance of the procedure.

This issue is not as pertinent for those specialists and service providers who discuss in person the available treatment options with a patient, and thus have an opportunity to also provide financial information. However, IFC can be more of an issue for ‘downstream’ specialists and service providers who have less contact with patients prior to surgery (for example, anaesthetists and surgeon’s assistants). Internal polling conducted by the Australian Society of Anaesthetists supports this view. The Australian Society of Anaesthetists (sub. 9) noted that its polling shows that, while 93 per cent of anaesthetists believe they can obtain IFC within five days of treatment, only 25 per cent believe they can obtain IFC when there are only two days between the allocation of the task and the treatment date.

In this framework, emergency admissions can be considered to have no lead time and this makes it very hard for specialists and service providers to obtain IFC. Indeed, as the Australian Health Service Alliance (AHSA) (sub. 1) noted, it may not be appropriate for specialists to obtain IFC if it delays the treatment of an emergency patient.

Health insurance policies

The level of insurance benefit payable can be difficult for patients to ascertain and this can hinder the ability to obtain IFC (Australian Medical Association, sub. DR55). A patient’s out-of-pocket expenses are derived from the payable health

insurer benefit, in conjunction with treatment charges and the Medicare benefit. Some health insurance policies provide a higher benefit if certain requirements are met, but only the minimum allowable benefit (25 per cent of the Medicare Benefits Schedule fee) if these requirements are not met. These requirements can include the relevant doctor being registered with the fund and accounts being ‘correctly’ processed. Uncertainty about the level of payable benefit could also make it difficult for the doctor to provide the patient with an accurate estimate of out-of-pocket expenses. Despite these potential issues with estimating likely private health insurance benefits, many specialists do provide indicative private health insurance and Medicare returns to show likely out-of-pocket expenses.

The Australian Society of Anaesthetists (sub. 9) noted that a lack of available benefits schedules can hinder the proper provision of IFC. Health insurers usually update the schedules of their more common ‘gap-cover’ type insurance policies every November. However, the Australian Society of Anaesthetists suggested that the updated schedules are not always available from the time at which they are activated, and in some cases may even take up to a month to be published. If this were the case, it would make it difficult for practitioners to calculate the expected level of benefit that a patient would receive around this time of the year. The Private Health Insurance Ombudsman stated that they have not received any complaints from medical practitioners or consumers regarding the timely updating of schedules (Private Health Insurance Ombudsman, pers. comm., 28 August 2009).

9.2 Informed financial consent data sources and their suitability

The Australian Government Department of Health and Ageing has commissioned three surveys on IFC in Australia. These were conducted by Ipsos Australia in September 2004, September 2006 and May 2007. The surveys asked patients who had recently made a private health insurance claim for an episode of hospitalisation about the costs they incurred and the information they received about those costs prior to treatment (Ipsos Australia 2005, 2007a, 2008). This is the best available dataset to consider IFC and out-of-pocket expenses in the way stipulated by the terms of reference. However, the surveys have some major limitations that will be discussed below.

Ipsos has also estimated rates of IFC and out-of-pocket expenses for privately insured patients in its biennial report *Ipsos Healthcare and Insurance Australia Report* (Ipsos Australia 2007b) and in a member experience survey for Medibank Private (2009). However, the latter survey was restricted to privately insured patients who were treated in private hospitals.

The Private Health Insurance Administration Council (PHIAC) collects industry data on the out-of-pocket expenses incurred by privately-insured patients. The data include information on 'known-gap' agreements, where:

... the medical practitioner agrees to accept a payment by the insurer in part satisfaction of the amount owed and the patient has provided informed financial consent so that the gap or out-of-pocket expense to be paid by the insured person is known in advance. (PHIAC 2009a, p. 2)

The provision of IFC is a legal requirement of known-gap agreements and therefore quantification of this segment can provide some information on the provision of IFC. However, it cannot be considered an ideal measure of IFC as there is no verification of whether the provision of IFC actually occurred. Furthermore, this data source can at most be considered a lower bound on the provision of IFC, as it does not include any estimates of IFC where a known-gap agreement is not in place.

Ipsos survey methodology

The samples for the 2004, 2006 and 2007 Ipsos surveys were drawn from individuals who had made a recent insurance claim for hospital treatment as a private patient, and whose claim had been settled prior to 1 September 2004, 15 September 2006 and 1 May 2007 respectively. Each survey involved the distribution of 10 000 questionnaires, with the 2004, 2006 and 2007 surveys receiving a response rate of 41, 46 and 42 per cent respectively. Public hospital episodes and episodes covered by small health insurers were oversampled to improve the accuracy of estimates relating to these groups. The sample population was subsequently weighted so that it was representative of the population.

The Ipsos surveys have a number of limitations that need to be considered when interpreting the results. A potential limitation of the surveys is that individuals may have been more likely to respond if they did not receive sufficient information to provide IFC or incurred significant out-of-pocket expenses. If such sample-selection bias existed, it would result in rates of IFC being underestimated and out-of-pocket expenses being overestimated.

A further limitation is that the surveys are based on patient perceptions and recollections, and are not an audit of actual occurrences. While in hospital, patients may be treated by a number of different practitioners, may receive a large amount of healthcare information and may be worried about a range of other issues aside from treatment costs. All these factors may lead to some patients incorrectly recalling the gap they incurred and whether they provided IFC. Study participant Mark Sinclair (sub. 8) noted that he has had cases as an anaesthetist where he obtained written consent from patients regarding costs, yet was later told that the patient did not

realise that they would have out-of-pocket expenses. The Private Health Insurance Ombudsman (sub. 26) also noted that in the investigation of some IFC complaints they have found that IFC was provided by the patient, even though the patient did not later recall this being the case. However, the Private Health Insurance Ombudsman noted that they believe patients recollections to be a ‘good guide’, though not always accurate (Private Health Insurance Ombudsman, sub. 26, p. 5).

The possibility of sample-selection and/or self-reporting bias was tested by comparing Ipsos results with data collected by PHIAC. This PHIAC data, measuring medical gaps, is based on data submitted by health insurers for every hospital admission by a privately-insured patient. The results for 2007 suggest that the Ipsos surveys significantly overestimated the number of services where a gap was paid and the average gap payment (table 9.1).

It is important to distinguish between IFC for individual services and IFC for a patient’s whole episode of hospitalisation. IFC rates for individual services measure the provision of IFC by each service provider or specialist. In contrast, IFC rates for a patient’s whole episode of hospitalisation measure whether IFC is obtained by all individual specialists or service providers by whom a patient is treated in an episode of hospitalisation. As private patients are almost always treated by more than one specialist or service provider in an episode of hospitalisation, the IFC rate for the whole episode of hospitalisation should always be less than the IFC rate for individual services. PHIAC does not publish data on the proportion of patients with no gap for the whole episode of hospitalisation. However, it would be expected that the proportion of patients in the population with no gap in 2007 for the whole episode of hospitalisation was also greater than the figure suggested by the Ipsos survey data.

Table 9.1 Comparison of Ipsos and PHIAC data, 2007

	<i>Units</i>	<i>Ipsos</i>	<i>PHIAC^a</i>
Share of services with a gap payment ^b	%	28	18
Share of patients with a gap payment (whole episode) ^c	%	42	na
Average gap across all services ^b	\$	131	23
Average gap across all services where a gap occurred ^b	\$	465	126

^a PHIAC data is for 2006-07, as it is the closest to the sample period of the 2007 Ipsos survey. ^b This includes all in-hospital services except hospital accommodation. ^c This excludes test-related specialities such as pathology, radiology, ultrasound and x-ray. **na** not available.

Source: Ipsos survey data (unpublished); PHIAC (2007b).

A further limitation of the Ipsos surveys is that the most recent survey was conducted in 2007, and thus the effects of any measures undertaken since 2007 to increase the levels of IFC or to reduce out-of-pocket expenses cannot be assessed.

Due to a lack of other suitable data sources, Ipsos survey data will be the primary data source used to calculate statistics relating to IFC and out-of-pocket expenses in this chapter. However, all results should be considered in light of the aforementioned data limitations.

9.3 Rates of informed financial consent

Reporting rates of informed financial consent

Rather than reporting the proportion of all patients who received sufficient information to provide IFC, this section will define the IFC rate to be the proportion of patients who either had no gap or who received information and provided IFC on any gap for their episode of hospitalisation. This measure of IFC recognises that while patients value receiving information to provide IFC, they also value not incurring any out-of-pocket expenses. This is the measure that is used by Ipsos Australia (2005, 2007a, 2008) in its three reports on IFC.

As previously noted, it is important to distinguish between IFC for individual services and IFC for episodes of hospitalisation. In this chapter the reported IFC rates are based on episodes of hospitalisation that include all of the relevant aspects of the episode (for example, hospital costs, medical costs, surgeon's assistants and prostheses). If IFC is not provided for one (or more) component of the service, then IFC is not provided for the entire episode of hospitalisation. However, IFC rates for individual services can be useful for analysing which specialists or service providers are least likely to obtain IFC. Therefore, the IFC rates used for analysing the provision of IFC for service providers and specialists are for individual services.

Emergency admissions

The Ipsos survey asked respondents whether their admission to hospital was pre-planned or an emergency, with 22 per cent of respondents in 2007 indicating that their admission was the latter.²

As previously mentioned, it would be expected that the provision of IFC would be less prevalent for emergency admissions. However, Ipsos data suggests that in 2007, IFC was more likely to have occurred in emergency admissions than in

² Ipsos Australia provided no further guidance as to the definition of pre-planned and emergency admissions besides noting that maternity/obstetrics admissions were to be considered pre-planned.

pre-planned admissions (table 9.2). This difference is due to a greater percentage of emergency admissions not incurring any gap payment. When only considering privately-insured patients who incurred a gap, the proportion who provided IFC is nonetheless similar in pre-planned and emergency admissions. While this result is unexpected, any financial information that is provided to a patient in an emergency situation is likely to be different to information provided in a pre-planned context, as the patient may not be in a reasonable position to evaluate their treatment options. For this reason, only pre-planned admissions are considered in the analysis of IFC and out-of-pocket expenses, unless otherwise stated. Specialists who deal with an emergency situation for a patient who had a pre-planned admission cannot be removed from the sample.

Table 9.2 Informed financial consent rates for pre-planned and emergency admissions, 2007^a

	<i>Pre-planned</i>	<i>Emergency^b</i>
	%	%
Informed financial consent	80	88
Informed financial consent (no gap) ^b	54	72
Informed financial consent (gap)	26	16
No informed financial consent	20	12
Total	100	100

^a Test-related services are excluded in the calculation of total IFC rates. ^b Ipsos Australia provided no further guidance as to the definition of pre-planned and emergency admissions besides noting that maternity/obstetrics admissions were to be considered pre-planned. ^c This includes patients who were unsure whether they incurred a gap.

Source: Ipsos survey data (unpublished).

Rates of informed financial consent

Ipsos survey data show that, in 2007, the rate of IFC was approximately 80 per cent (table 9.3). Between 2004 and 2007, there was a small increase in the IFC rate, from 78 to 80 per cent.

Table 9.3 Informed financial consent rates, 2004–2007^a

	2004	2006	2007
	%	%	%
Informed financial consent	78	81	80
Informed financial consent (no gap) ^b	52	55	55
Informed financial consent (gap)	25	26	26
No informed financial consent	22	19	20
No informed financial consent for one service ^c	16	14	15
No informed financial consent for multiple services ^d	6	5	5
Total	100	100	100

^a Only patients who considered their admission to be pre-planned are included. Maternity/obstetrics admissions are considered pre-planned. Test-related services are excluded in the calculation of total IFC rates. ^b This includes patients who were unsure whether they incurred a gap. ^c Patients did not provide IFC to one service provider. ^d Patients did not provide IFC to multiple service providers.

Source: Ipsos survey data (unpublished).

In 2007, of the 20 per cent of admissions where IFC was not provided on all gaps, 15 percentage points involved just one service provider failing to obtain IFC, while 5 percentage points involved more than one service provider failing to obtain IFC.

Informed financial consent rates by type of hospital provider

In 2007, the IFC rate in public hospitals was approximately 88 per cent compared to 80 per cent in private hospitals (table 9.4). This notable difference seems to be primarily attributable to fewer privately-insured patients incurring gaps in public hospitals. Between 2004 and 2007, the ratio of IFC rates between private and public hospitals remained relatively stable.

The proportion of hospital admissions for which IFC was not provided on hospital accommodation costs was 2 per cent or less for both public and private hospitals, suggesting that a lack of IFC for accommodation costs is not an issue for either sector.

Table 9.4 Informed financial consent rates by hospital provider^a

	<i>Private hospitals</i>			<i>Public hospitals</i>		
	<i>2004</i>	<i>2006</i>	<i>2007</i>	<i>2004</i>	<i>2006</i>	<i>2007</i>
	%	%	%	%	%	%
Informed financial consent ^b	77	80	80	85	90	88
IFC (no gap) ^c	51	52	53	67	76	76
IFC (gap)	26	28	27	18	14	12
No informed financial consent	23	20	20	15	10	12
No IFC (medical) ^d	21	19	19	14	9	11
No IFC (accommodation) ^d	2	2	2	1	0	1

^a Only patients who considered their admission to be pre-planned are included. Maternity/obstetrics admissions are considered pre-planned. Test-related services are excluded in the calculation of total IFC rates. ^b Due to rounding, in 2007 the IFC rate for private hospitals appears not to differ from the overall IFC rate (table 9.3). ^c This includes patients who were unsure whether they incurred a gap. ^d The medical IFC rate and accommodation IFC rate may not sum to the total IFC rate, as some patients may not have provided IFC for both. They may also not equate due to rounding error.

Source: Ipsos survey data (unpublished).

Informed financial consent rates by jurisdiction

There is notable variation in the IFC rates between jurisdictions (table 9.5). In 2007, Tasmania and South Australia had the highest rates of IFC among jurisdictions. In contrast, after excluding the ACT and Northern Territory (due to insufficient sample sizes), New South Wales had the lowest IFC rate. Between 2004 and 2007, the IFC rates did not change significantly for any jurisdictions (figure 9.1).

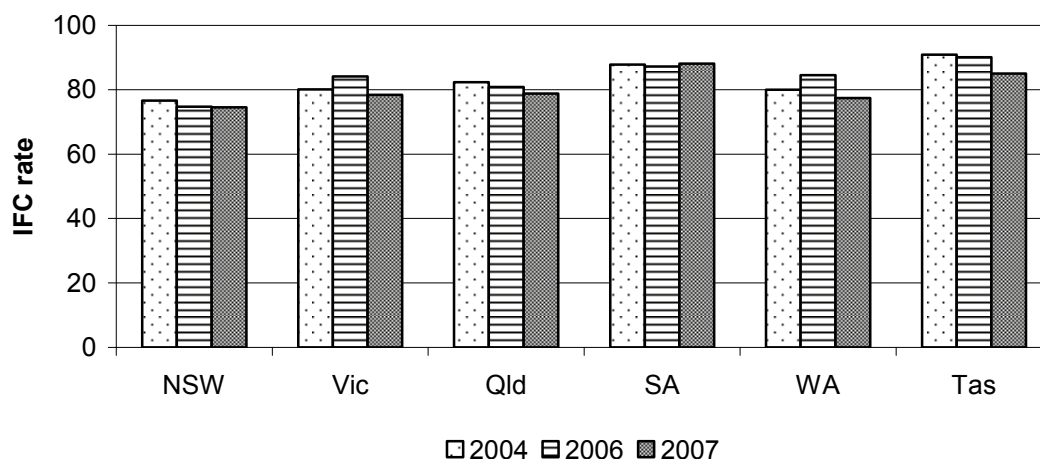
Table 9.5 Informed financial consent rates by jurisdiction, 2007^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>SA</i>	<i>WA</i>	<i>Tas</i>
	%	%	%	%	%	%
IFC	77	80	82	88	80	91
IFC (no gap) ^b	53	53	58	63	48	72
IFC (gap)	24	27	25	25	32	18
No IFC	23	20	18	12	20	9
No IFC (medical) ^c	22	18	16	11	17	8
No IFC (accommodation) ^c	2	3	2	1	5	1
No. of observations	1037	889	540	269	287	103

^a Jurisdiction refers to the patient's jurisdiction of residence. According to the AIHW (2009a) approximately 98 per cent of separations occur in hospitals that are in the patient's jurisdiction of residence. Only patients who considered their admission to be pre-planned are included. Maternity/obstetrics admissions are considered pre-planned. Test-related services are excluded in the calculation of total IFC rates. The sample sizes for the ACT and Northern Territory were very small (52 and 8 observations respectively) and thus are not published. ^b This includes patients who were unsure whether they incurred a gap. ^c The medical IFC rate and accommodation IFC rate may not sum to the total IFC rate, as some patients may not have provided IFC in both. They may also not equate due to rounding error.

Source: Ipsos survey data (unpublished).

Figure 9.1 Informed financial consent rates by jurisdiction^a



^a Only patients who considered their admission to be pre-planned are included. Maternity/obstetrics admissions are considered pre-planned. Test-related services are excluded in the calculation of total IFC rates.

Source: Ipsos survey data (unpublished).

Informed financial consent rates by location

In 2007, inner regional hospitals had the highest IFC rates (86 per cent), compared to outer regional hospitals (76 per cent) and major city hospitals (80 per cent)

(table 9.6). For private hospitals, the IFC rate was notably higher for hospitals located in inner regional areas (85 per cent) compared to outer regional and major city areas (71 and 79 per cent respectively). For public hospitals, the IFC rate was also highest for hospitals located in inner regional areas (95 per cent), however this result was not significantly different from the IFC rate for public hospitals located in outer regional areas.

One possible explanation for these results may be that specialists in inner regional areas have relatively strong community relationships, making it easier to provide financial information to patients. In comparison, patients may be less likely to personally know their specialists in major cities and outer regional areas (possibly because specialists do not reside in the area), making the provision of IFC more difficult.

Between 2004 and 2007, the IFC rate for hospitals located in major cities increased slightly. This was largely due to an improvement in the IFC rate for private hospitals in major cities.

While the improvement in the IFC rate for public hospitals in inner regional areas was significant it was offset by a slight decrease for private hospitals. The changes between 2004 and 2007 for the inner and outer regional areas were not significant.

Table 9.6 Informed financial consent rates by location and type of provider^a

	<i>Major cities</i>			<i>Inner regional</i>			<i>Outer regional</i>		
	<i>2004</i>	<i>2006</i>	<i>2007</i>	<i>2004</i>	<i>2006</i>	<i>2007</i>	<i>2004</i>	<i>2006</i>	<i>2007</i>
	%	%	%	%	%	%	%	%	%
Private hospitals	75	79	79	87	88	85	72	77	71
Public hospitals	85	89	85	83	94	95	93	93	89
All hospitals	76	79	80	87	89	86	80	82	76

^a Location based on ABS (2005) Australian Standard Geographical Classification. Data for remote and very remote classifications are not published due to insufficient sample sizes. Only patients who considered their admission to be pre-planned are included. Maternity/obstetrics admissions were considered pre-planned. Test-related services are excluded in the calculation of total IFC rates.

Source: Ipsos survey data (unpublished).

Informed financial consent rates by medical specialist

Disaggregating IFC rates by specialist and service providers confirms that a lack of IFC is more commonly associated with medical practitioner charges than with hospital accommodation charges (table 9.7). In 2007, the IFC rate was highest for hospital accommodation (98 per cent) and orthopaedic surgeons (95 per cent). In

contrast, the IFC rate was lowest for paediatricians (61 per cent) and test-related services (77 per cent). The IFC rate remained relatively stable across all specialties between 2004 and 2007.

Table 9.7 Informed financial consent rates by medical practitioner or service provider, 2007^a

<i>Medical specialist/service provider</i>	<i>Sample size</i>	<i>Patients that used provider</i>	<i>Patients using provider that had a gap</i>	<i>IFC rate</i>
		<i>%</i>	<i>%</i>	<i>%</i>
Paediatrician	226	8	45	61
Tests/pathology/radiology/ ultrasound/x-ray etc.	977	31	24	77
Anaesthetist	2 478	78	30	86
Specialist's or surgeon's assistant	832	24	26	88
General surgeon	530	17	25	92
Oncologist	271	8	15	93
Obstetrician/gynaecologist	440	14	32	94
Cardiologist	200	6	9	94
Orthopaedic surgeon	418	13	45	95
Hospital (accommodation)	3 194	100	5	98

^a These results should be interpreted with care as they do not necessarily provide an accurate indication of which specialties have the lowest IFC rates. In particular, the sample sizes in the Ipsos survey for a number of medical specialists or service providers were too small to make robust conclusions about rates of IFC. Only patients who considered their admission to be pre-planned are included. Maternity/obstetrics admissions are considered pre-planned.

Source: Ipsos survey data (unpublished).

When comparing rates of IFC for different service providers, it is important to recognise that it can be more difficult for certain types of specialists to provide sufficient information to enable their patients to give IFC. As mentioned previously, specialists who have less direct contact with patients prior to surgery may find it relatively more difficult to provide IFC. This could explain the lower rates of IFC for anaesthetists, surgeon's assistants and test-related specialists.

Ipsos survey data show that the IFC rates for different specialties are not notably higher for admissions where the patient saw the admitting doctor at least five days prior to the procedure taking place (table 9.8), but rather are broadly similar to the results for the full sample.

Table 9.8 Informed financial consent rates for patients with a lead time of at least five days, 2007^a

<i>Medical specialist/service provider</i>	<i>Sample size</i>	<i>Patients that used provider</i>	<i>Patients using provider that had a gap</i>	<i>IFC rate</i>	<i>Difference from full sample^b</i>
		%	%	%	%
Paediatrician	200	10	48	59	-2
Tests/pathology/radiology/ultrasound/x-ray etc	713	33	26	76	-1
Anaesthetist	1 753	80	32	85	-1
Specialist's or surgeon's assistant	622	28	26	88	0
General surgeon	362	17	25	94	2
Oncologist	185	9	16	92	-1
Obstetrician/gynaecologist	358	17	34	94	0
Cardiologist	138	6	9	95	1
Orthopaedic surgeon	317	15	45	95	0
Hospital (accommodation)	2 189	100	5	97	-1

^a Only patients who saw the admitting doctor at least five days prior to surgery are included. These results should be interpreted with care as they do not necessarily provide an accurate indication of which specialties have the lowest IFC rates. In particular, the sample sizes in the Ipsos survey for a number of medical specialists or service providers were too small to make robust conclusions about rates of IFC. Only patients who considered their admission to be pre-planned are included. Maternity/obstetrics admissions were considered pre-planned. ^b Difference from full sample IFC rates (table 9.7).

Source: Ipsos survey data (unpublished).

9.4 Out-of-pocket expenses

The terms of reference ask the Commission to report the average out-of-pocket expenses for patients who do not receive sufficient information to provide IFC. The Commission has also been asked to report the range (the minimum to maximum) of these costs, and to categorise the data by type of provider (public/private hospital and medical specialty).

As was the case for IFC rates, out-of-pocket expenses are reported for the whole episode of hospitalisation. The exception is that out-of-pocket expenses for individual specialties are reported for individual services. In this context, the average gap with no IFC is defined as the average gap incurred by privately insured patients who do not receive sufficient information to provide IFC for at least one gap.

In particular, as previously noted, results should be considered in light of the limitations of the Ipsos surveys. Estimates regarding the average gap with no IFC should be interpreted with care. This is because disaggregated groups other than

private hospitals, New South Wales and Victoria, major city hospitals, hospital accommodation and anaesthetist services have very small sample sizes.

The Ipsos survey data show that in 2007, the overall average gap with no IFC was \$847 (table 9.9). This is marginally greater than the average gap incurred by all privately-insured patients that had a gap, but the difference is not significant. In 2007, the out-of-pocket expenses incurred with no IFC ranged from \$5 to \$19 827.

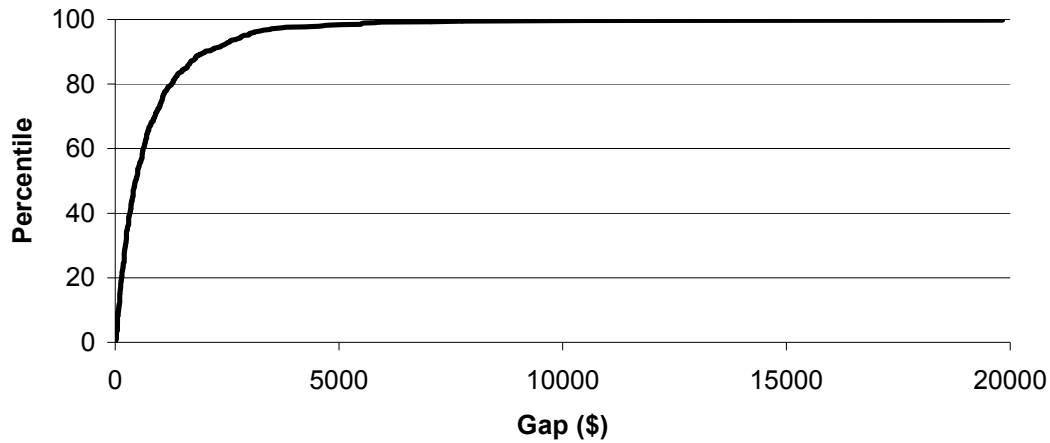
Table 9.9 Average gap^a

	<i>Units</i>	<i>2004</i>	<i>2006</i>	<i>2007</i>
Proportion of patients incurring a gap	%	48	45	45
Average gap for patients incurring a gap	\$	755	684	817
Average gap for patients who did not provide IFC	\$	816	756	847
Minimum	\$	2	4	5
Maximum	\$	8 547	7 881	19 827

^a Only patients who considered their admission to be pre-planned are included. Maternity/obstetrics admissions are considered pre-planned. Test-related services are excluded in the calculation of average gaps.
Source: Ipsos survey data (unpublished).

Of the gaps where no IFC was provided, approximately 55 per cent were less than \$500, approximately 75 per cent were less than \$1000, and approximately 90 per cent were less than \$2000 (figure 9.2, figure 9.3). Only 2 per cent of gaps with no IFC were greater than \$4000. A number of these gaps over \$4000 were due to large gaps from specialist's or surgeon's assistants, while for very large gaps one was due to a large gap from a cardiologist and one was due to a large gap for hospital accommodation.

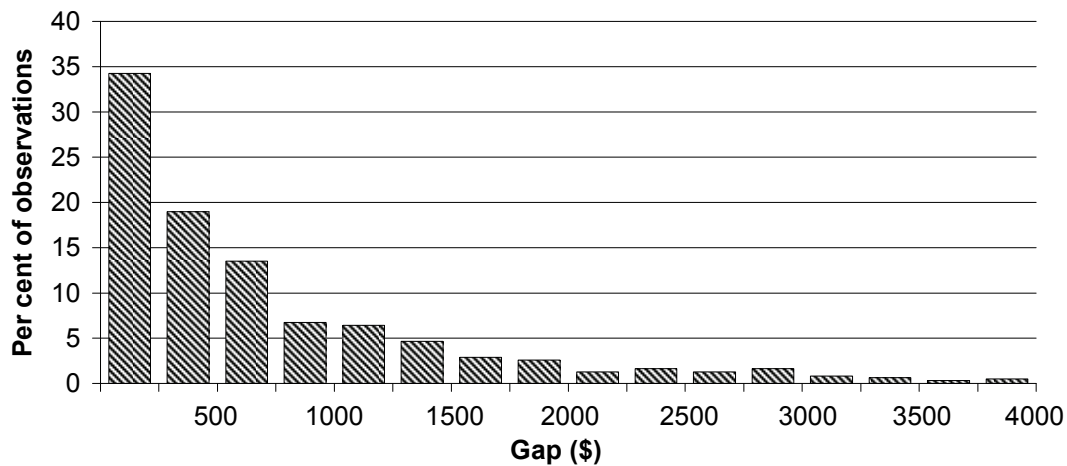
Figure 9.2 Sample cumulative distribution function of gaps with no IFC, 2007^a



^a Only patients who considered their admission to be pre-planned are included. Maternity/obstetrics admissions were considered pre-planned. Test-related services are excluded in the calculation of average gaps.

Source: Ipsos survey data (unpublished).

Figure 9.3 Distribution of gaps with no IFC, 2007^a



^a Only patients who considered their admission to be pre-planned are included. Maternity/obstetrics admissions were considered pre-planned. Test-related services are excluded in the calculation of average gaps. Gaps over \$4000 are not shown above and represent approximately 2 per cent of observations.

Source: Ipsos survey data (unpublished).

Out-of-pocket expenses by type of hospital provider

The average gap with no IFC was larger for patients in private hospitals (\$858) compared to patients in public hospitals (\$637) in 2007, however this difference was not statistically significant (table 9.10). In private hospitals, the average gap with no IFC was larger than the average gap for all patients who paid a gap and this difference was statistically significant in 2004 and 2006.

In 2007, the out-of-pocket expenses for patients with no IFC ranged from \$6 to \$19 827 for patients in private hospitals, compared to a range of \$4 to \$2030 for patients in public hospitals.

Between 2004 and 2007, the proportion of patients incurring a gap in private hospitals remained relatively stable. However, in public hospitals it fell significantly.

In 2007, the average gap for all patients with a gap was very similar in public hospitals (\$788) and private hospitals (\$818).

Table 9.10 Average gap by hospital provider, 2004–2007^a

	Units	Private hospitals			Public hospitals		
		2004	2006	2007	2004	2006	2007
Proportion of patients experiencing a gap	%	49	48	47	33	24	24
Average gap for patients that had a gap	\$	746	689	818	915	575	788
Average gap for patients who did not receive IFC	\$	820	768	858	751	536	637
Minimum	\$	2	4	6	15	15	4
Maximum	\$	8 547	7 881	19 827	4 700	3 400	2 030

^a Only patients who considered their admission to be pre-planned are included. Maternity/obstetrics admissions are considered pre-planned. Test-related services are excluded in the calculation of average gaps.

Source: Ipsos survey data (unpublished).

Out-of-pocket expenses by jurisdiction

In 2007, the average gap with no IFC was greatest for patients in New South Wales and Queensland, and smallest for patients in South Australia and Western Australia (table 9.11). In each jurisdiction, the average gap with no IFC was not significantly different from the average gap incurred by all patients experiencing a gap.

Table 9.11 **Average gap by jurisdiction, 2007^a**

	<i>Units</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>SA</i>	<i>WA</i>	<i>Tas</i>
Proportion of patients experiencing a gap	%	47	47	42	37	52	28
Average gap for patients that had a gap	\$	1 049	682	924	548	512	772
Average gap for patients who did not receive IFC ^b	\$	1 052	710	1 040	421	433	930
Minimum	\$	6	5	8	25	12	20
Maximum	\$	7 050	19 827	10 500	3 100	2 572	5 487

^a Jurisdiction refers to the patient's jurisdiction of residence. According to the AIHW (2009a) approximately 98 per cent of separations occur in hospitals that are in the patient's jurisdiction of residence. Only patients who considered their admission to be pre-planned are included. Maternity/obstetrics admissions are considered pre-planned. Test-related services are excluded in the calculation of average gaps. The sample sizes for the ACT and the Northern Territory were very small (52 and 8 observations respectively) and thus are not published. ^b These figures are based on very small sample sizes for all jurisdictions aside from New South Wales and Victoria and should be interpreted with care.

Source: Ipsos survey data (unpublished).

Out-of-pocket expenses by location

The average gap with no IFC in 2007 was greatest for patients in hospitals located in major cities, and smallest for patients in hospitals located in outer regional areas (table 9.12). These differences could be because hospitals in major cities undertake more complex procedures, while regional hospitals tend to provide less complex procedures. The difference between the average gap with no IFC and the average gap for all patients who paid a gap was only significantly different for major city hospitals in 2004 and 2006.

Table 9.12 Average gap by region, 2004–2007^a

	Units	Major cities			Inner regional			Outer regional		
		2004	2006	2007	2004	2006	2007	2004	2006	2007
Proportion of patients experiencing a gap	%	51	48	48	34	33	33	38	36	47
Average gap for patients that had a gap	\$	804	716	867	345	461	520	686	497	536
Average gap for patients who did not receive IFC.	\$	864	799	901	364	452	581	769	471	440
Minimum	\$	2	4	6	4	6	8	40	35	5
Maximum	\$	8 547	7 881	19 827	2 082	2 220	2 790	2 400	1 550	1 669

^a Location based on ABS (2005) Australian Standard Geographical Classification. Data for remote and very remote classifications are not published due to insufficient sample sizes. Only patients who considered their admission to be pre-planned are included. Maternity/obstetrics admissions are considered pre-planned. Test-related services are excluded in the calculation of average gaps.

Source: Ipsos survey data (unpublished).

Out-of-pocket expenses by medical specialist

In 2007, the average gap with no IFC was greatest among patients treated by obstetricians/gynaecologists (\$753) and orthopaedic surgeons (\$720), and smallest for paediatricians (\$197) (table 9.13). However, it is important to remember that almost all these figures are based on small sample sizes and should be interpreted with care.

One possible reason that patients treated by some service providers incur greater out-of-pocket expenses may be that these service providers perform more complex procedures or use more expensive equipment.

The Ipsos data also suggest that between 2004 and 2007, the average gap where no IFC was provided did not change significantly for any speciality.

Table 9.13 Average gap by medical practitioner or service provider, 2007^a

<i>Medical specialist/service provider</i>	<i>Average gap amount for patients who had a gap</i>	<i>Average gap incurred by patients who did not provide IFC</i>	<i>Minimum gap incurred by patients who did not provide IFC</i>	<i>Maximum gap incurred by patients who did not provide IFC</i>
	\$	\$	\$	\$
Obstetrician/gynaecologist	828	753	39	4 000
Orthopaedic surgeon	841	720	30	2 750
Oncologist	920	677	20	5 600
Cardiologist	633	600	20	19 727
Specialist's or surgeon's assistant	536	461	7	6 000
General surgeon	518	444	12	4 200
Hospital (accommodation)	353	410	1	10 500
Anaesthetist	320	308	4	2 610
Tests/pathology/radiology/ultrasound/x-ray etc.	287	292	5	4 656
Paediatrician	207	197	16	900

^a Gap figures for most specialties are based on small sample sizes and should be interpreted with care. Only patients who considered their admission to be pre-planned are included. Maternity/obstetrics admissions are considered pre-planned.

Source: Ipsos survey data (unpublished).

FINDING 9.1

According to the Private Health Insurance Administration Council, around 90 per cent of hospital services for privately-insured patients do not have out-of-pocket expenses that require informed financial consent. Complaints data collected by the Private Health Insurance Ombudsman suggest that the rate of informed financial consent has been increasing in recent years.

FINDING 9.2

The incidence and average size of out-of-pocket expenses for privately-insured patients appear to be overstated in available survey data collected by Ipsos, due to sample-selection and self-reporting bias. Subject to this qualification, the data suggest that privately-insured patients have a higher rate of informed financial consent and lower out-of-pocket expenses in public hospitals. Few conclusions can be made about out-of-pocket expenses due to small sample sizes.

9.5 Future data improvements

The terms of reference ask the Commission to consider developments that would improve the feasibility of future comparisons. As previously mentioned, the Ipsos survey data have potential limitations of self-selection and reporting bias, which could limit their usefulness in providing information regarding IFC and out-of-pocket expenses. Therefore, future IFC surveys should focus on overcoming these limitations. A robust dataset on IFC would have the following features:

- To address self-selection bias, collection methods would ensure that the sample was representative of all patients who had utilised their private health insurance for hospital visits.
- To address reporting bias, data would not be wholly reliant on patient recollections.

One option would be to include survey questions relating to IFC in the ABS National Health Survey (NHS), as this would remove any self-selection problem and also include self-insured individuals. However, it would still rely on patient recollections and may not consist of enough people with a recent hospital episode. The NHS (ABS 2009b) reports that 53 per cent of the population hold private health insurance. Therefore, if weighting is not considered, the sample of 22 000 people in the NHS would include approximately 12 000 people with private health insurance.

According to PHIAC data the NHS is likely to contain approximately 3800 privately-insured individuals who had a recent episode of hospitalisation, including approximately 500 who were admitted to a public hospital as a private patient.³ However, to properly analyse the difference in the provision of IFC for public and private hospitals, approximately 1000 public hospital observations would be required. Thus it is unlikely that the NHS would provide a sufficient sample for an analysis of IFC to be conducted.

Another option would be to require privately-insured patients to indicate on their health insurance claim form whether they gave IFC. This information could then be provided to PHIAC and published with information it already releases on out-of-pocket expenses. This option would remove any self-selection bias as all

³ In 2008-09, there were 3 052 375 acute hospital episodes involving privately insured patients, including 435 193 acute public hospital episodes. In 2008-09, there were 9 676 645 individuals privately-insured for hospital treatment (PHIAC 2009b). This calculation does not take into account that some individuals are admitted to hospital more than once in a year. For a sample size similar to the Ipsos surveys, approximately one-third of people with private health insurance would need to have had a recent episode of hospitalisation, which is somewhat unlikely. Furthermore, to properly analyse the difference in the provision of IFC for public and private hospitals, approximately 1000 public hospital observations would be required.

privately-insured patients would complete health insurance claim forms. It would also remove some self-reporting problems, as the length of time between the hospital episode and filling out a claim form would be less than that involved in responding to the Ipsos survey.

Following the release of the Discussion Draft for this study, the Consumers Health Forum (sub. DR59) endorsed this proposal. However, the Australian Medical Association (sub. DR55) and the Australian Government Department of Health and Ageing (sub. DR69) noted that there can be significant time lags between the giving of IFC for the procedure and the submission of an insurance claim form, and thus patients may still forget whether they provided IFC. The Australian Medical Association further noted that in a significant proportion of complaints surrounding a lack of IFC, doctors have documentary evidence of IFC having been provided.

In order to address the problem of patients not accurately recalling their experiences, it might be possible for medical specialists and service providers to include as part of the billing and insurance-claim process an indication of whether documented evidence of IFC is held for the relevant item. This information could in turn be used by PHIAC to monitor rates of IFC.

FINDING 9.3

A more robust future data source on informed financial consent (IFC) could be created by requiring privately-insured patients to indicate on their health insurance claim form whether they provided IFC prior to the procedure. Alternatively, medical specialists and service providers could be required to include as part of the billing and insurance-claim process an indication of whether documented evidence of IFC is held for the relevant item. This information could be collected and reported by the Private Health Insurance Administration Council.

9.6 Best-practice examples of IFC

The terms of reference ask the Commission to identify best-practice examples of where IFC is provided for every procedure. Emphasis is to be put on best-practice examples that occur in specialties where a lack of IFC is most common. The Commission requested examples in the Issues Paper and Discussion Draft but only a limited number of examples were provided.

Table 9.7 suggests that patients are most likely to pay a gap without IFC when using the services of a paediatrician, an anaesthetist, a specialist's or surgeon's assistant or when undergoing diagnostic tests such as pathology, radiology, ultrasound and x-ray. However, as previously mentioned, these results should be interpreted with

care as they do not necessarily provide an accurate indication of which specialties have the lowest IFC rates.

In recent years, a number of medical specialist groups have undertaken education campaigns regarding IFC, demonstrating their desire to improve the rates of IFC provision. These included the following campaigns (Australian Medical Association, sub. 28):

- The Australian Medical Association’s campaign called ‘Let’s talk about fees’, which provided doctors with materials to read and share with patients.
- The Australian Diagnostic Imaging Association’s campaign, which involved the creation of a website where members publish fee information.
- The Australian Society of Anaesthetists’ IFC campaign, which included among other initiatives:
 - publishing a newsletter on IFC
 - mailing out an ‘IFC campaign kit’ to anaesthetists that contained resources on how to improve IFC in anaesthetic practice
 - holding IFC educational meetings for anaesthetists in capital cities and major regional centres.

These education campaigns can be seen to complement the best-practice examples outlined below.

Meditrust

Meditrust is an organisation that helps anaesthetists to provide patients with information prior to their procedure. This information is delivered through a website or toll-free phone number and includes the expected out-of-pocket expenses (box 9.1).

It may be more difficult for anaesthetists than other specialists to obtain IFC from patients. This is because an anaesthetist often needs to make separate contact with the patient aside from the patient’s contact with their surgeon, which can be especially difficult when there is a short lead time prior to the procedure. Meditrust’s system facilitates this anaesthetist/patient contact and may remove the necessity for a meeting before the day of surgery.

Box 9.1 **Meditrust and IFC**

The Meditrust system provides information to patients in the following way:

- The anaesthetist provides the surgeons with whom they regularly work a note that lists the different procedures specific to that surgeon.
- Any patient to be treated by the anaesthetist receives a copy of the note from the surgeon indicating the procedure they will undergo.
- The patient enters a surgeon-specific password into the Meditrust website.
- Patients select their procedure and private health insurer from lists.
- Patients are presented with information relevant to the anaesthetic for that specific procedure. This includes information relating to:
 - administration of the anaesthetic itself
 - an estimated total fee, the rebate and expected out-of-pocket expenses.
- Patients are provided with the anaesthetist's phone number to contact if they have any questions.
- The anaesthetist receives an email notifying them that the patient has accessed the information and has provided IFC.

Mark Sinclair (an anaesthetist who uses Meditrust) noted in his submission that:

... patients who are not 'computer literate' and/or do not have Internet access are given a toll-free phone number to ring. A Meditrust staff member asks for the names of the relevant surgeon and anaesthetist, and the information is mailed to the patient as a hard copy, free of charge. (sub. 8, p. 2)

Source: Dr. Mark Sinclair (sub. 8, p. 2)

Sportsmed SA

Sportsmed SA is a South Australian healthcare provider specialising in sports medicine, orthopaedics, podiatry and physiotherapy. Sportsmed SA's hospital admissions only relate to orthopaedic cases.

Aside from emergency admissions that occur on weekends, Sportsmed SA claims that they obtain IFC for all orthopaedic surgeon and hospital accommodation fees. When surgery is recommended for a patient, they are given a 'comprehensive financial quotation for the operation, hospital fees and incidental charges at the time of booking' (Sportsmed SA 2009, p. 11).

Sportsmed SA's hospital is collectively owned by ten orthopaedic surgeons, who have their private practices on site (Sportsmed SA 2009). This collective ownership,

coupled with a well functioning administrative process for providing financial information, enables Sportsmed SA to obtain IFC in all cases.

South Australian public hospitals

In South Australia, Rights of Private Practice agreements require that salaried doctors in public hospitals only bill the full Medicare Benefits Schedule fee (SA Department of Health, sub. 4). Therefore, privately-insured patients in public hospitals should not incur any out-of-pocket expenses in relation to treatment performed by salaried doctors. Visiting medical officers are able to sign up to such agreements, but not all do so . These doctors are able to charge as they wish, leaving open the possibility that IFC is not provided on all out-of-pocket expenses in SA public hospitals.

FINDING 9.4

The medical profession has sought to promote best practice for informed financial consent in recent years. This has included educational campaigns for practitioners and internet-based packages to inform consumers of their likely expenses.