Guidance and information

Safety standard exemption for recumbent bicycles

In February 2000 the Product Safety section of the Commission was asked by a potential manufacturer and importer of recumbent bicycles, about how the mandatory standard for pedal bicycles applied to the recumbent type.

While some recumbent cycles were exempt, many fell within the definition of products caught by the mandatory standard for pedal bicycles. These bicycles, because of their inherent design, did not meet some specifications in AS/NZS 1927:1998. Recumbent bicycles are for a specialised market and are available through limited outlets.

What is a recumbent bicycle?

Recumbent bicycles are pedal-powered bikes and have a low-slung, full seat and back support designed to take all the body weight and thereby remove any stress from the neck and arms. They may have forward handlebars or steering equipment on either side within easy arm reach. Their pedals are usually toward the front of the bike. They sit lower on the road than other pedal bicycles and the rider is usually in a semi-reclined position looking straight ahead and at about eye level with someone sitting in a car.

Case for exemption

Unlike other pedal bicycles, recumbent ones vary widely in design and shape. with differing ergonomics. Yet it would seem that their design has been well considered and that it is reasonable to assume they are made to be fully utilitarian for the user and safe to ride.

Also, because they are for a small, specialist market, they are more likely to be of high quality than, say, mass-produced types of bicycles at the bottom end of the market where quality is sometimes compromised.

The initial examination of the various types of recumbent bicycles presented to the Commission established that some were exempt from the standard because they were tandems, collapsible or designed for use as competitive bicycles. Other recumbents have three wheels (tricycles) and therefore do not fall within the definition of 'bicycle'.

From the Commission's initial investigation, there appeared to be a prima facie case for exempting recumbent bikes that fell within the

mandatory standard for pedal bicycles. Accordingly, the Commission made a submission to the Consumer Affairs Division of Treasury, requesting consideration of exemption for all recumbents.

The subsequent investigation by the Consumer Affairs Division led to the Minister for Financial Services and Regulation, Mr Joe Hockey, signing a Gazette notice in July this year effectively exempting recumbent bicycles from the mandatory safety standard for pedal bicycles.

Report to the Senate on health funds and providers

The Commission's *Report to the Australian Senate on anti-competitive and other practices by health funds and providers in relation to private health insurance for the period ending 30 June 2000* was tabled in the Senate on 8 November 2000.

It is the Commission's second report in response to an order agreed to by the Senate on 25 March 1999, during consideration of the Health Legislation Amendment Bill (No.2) 1999. It covers the period 1 January to 30 June 2000.

The reporting period was marked by the lead up to the introduction of the Government's Lifetime Health Cover. This has resulted in an unprecedented influx of new members to health funds in the June 2000 quarter.

Various matters came to the Private Health Insurance Ombudsman's and the Commission's attention, indicating some new fund members may not have been adequately informed about some aspects of the products they were encouraged to purchase during the Lifetime Health Cover campaign. Issues were raised about advice provided by call centre staff, as well as some funds' advertising and promotional activities. The Commission would expect the funds to honour any representation made to consumers. The Commission has also instituted proceedings against Medibank Private in the Federal Court, Melbourne, for false, misleading and deceptive advertising of its health insurance products.

No or known gaps

The report notes that contracting between health funds and private hospitals via hospital purchaser provider agreements (HPPAs) is effectively ensuring that fund members are able to have a no, or at least known, gap for hospital accommodation services.

Hospitals have raised various concerns with the Commission about the conduct of health funds. Although many of these reflect the competitive process, health funds still have to be mindful, in their dealing with private hospitals, not to act unconscionably. The Commission considers this a serious issue and is currently investigating allegations of unconscionable conduct by a health fund towards a small private hospital. In addition, the Commission considers that a code of practice may address some of the hospitals' concerns with the contracting process. The Commission understands that after some delays, the code is being finalised.

Health funds have continued to develop and expand contract-based, no-gap/known-gap arrangements on the model of AXA Australia Health Insurance's Ezyclaim. This transaction-by-transaction medical purchaser provider agreement (MPPA) process provides practitioners with the freedom to participate in no-gap arrangements on behalf of patients or visits selected by the practitioner. AXA reported it had 3000 doctors registered to use Ezyclaim, and the Australian Health Service Alliance said its member funds now have agreements with 2700 practitioners around Australia. HCF reported that, for the months of May and June 2000, 70 per cent of medical services to HCF members were provided with no-gap payment for the members.

The Health Legislation Amendment (Gap Cover Schemes) Act 2000, which became effective in August 2000, allows health funds to set up no-gap or known-gap arrangements without the need for a negotiated agreement between funds and doctors.

The Commission acknowledges that gap cover schemes may provide a useful alternative to contract-based arrangements for some practitioners. It also acknowledges the instrumental role of the AMA in developing this further option for creating no-gap or known-gap arrangements. However, aspects of the AMA's

preferred model for these schemes appear more focused on practitioners' interests than on effectively addressing community concerns about the medical gap, specifically the capping of the medical gap by health funds and the provision of information enabling fund members to choose a doctor for whom they would not have to pay a gap.

The Commission has always had some difficulty with the AMA's negotiating with health funds on these issues, particularly on pricing and capping issues. Any threat of a boycott or attempt to induce a boycott by the AMA, or any other craft group, of schemes that do not meet its preferred model would be thoroughly investigated by the Commission.

Informed financial consent

The Commission's view is that all doctors should provide financial information to patients and obtain informed financial consent. Patients surely have a right to know their financial obligation before committing to a service. The Commission believes that for informed financial consent to be meaningful, the lead practitioner should have the responsibility for obtaining informed financial consent from patients for all doctors involved.

Meaningful informed financial consent requires patients to have quality information and to know about the likely costs of various specialists before making an appointment. In this way they can make a truly informed choice about the best specialist for their needs.

Some funds are developing a list of medical practitioners who participate in the fund's no-gap/known-gap arrangements for their members to access. The Commission supports these initiatives. In the Commission's view, such lists will provide valuable information for fund members about participating practitioners and the extent of members' exposure to out-of-pocket expenses.

Financial interests

The Commission is of the view that all medical practitioners should disclose to patients any financial interest they may have in products or services they recommend or provide. This issue will become increasingly important with the amalgamation and vertical integration currently taking place in the medical sector.

The report is available from all Commission offices or from Robert Booth on (02) 6243 1143 for $10 postage paid. It is also available on the Commission's Internet website at <http://www.accc.gov.au>.

ACCC issues plain-language procedural guidelines

Two new guides that explain in clear, everyday language the Commission's powers under s. 155 of the Act have been published by the Commission. To enforce the law and act effectively as a regulatory authority the Commission needs to gather and use information. The two new publications explain its powers to do this.

The Commission likes to get information through cooperation, but sometimes it needs to use its mandatory powers under s. 155. This is usually done by notice, but occasionally Commission staff are authorised to enter premises to inspect and copy documents.

The guide, *Section 155 of the Trade Practices Act*, outlines the scope of the powers, how and when they are used, the formal requirements of s. 155 notices, how to comply, and the limits to the Commission's s. 155 powers.

Collection and use of information explains how information gathered in enforcement activities is used by the Commission. It is emphasised that the Commission recognises the importance of confidentiality and that it cannot use the information other than in the performance of its duties. The Commission must comply with statutory requirements relating to confidential information.

Information collected by the Commission for a particular purpose may be used for other functions or in other contexts.

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