NOTICE OF LODGMENT

AUSTRALIAN COMPETITION TRIBUNAL

This document was lodged electronically in the AUSTRALIAN COMPETITION TRIBUNAL and has been accepted for lodgment pursuant to the Practice Direction dated 3 April 2019. Filing details follow and important additional information about these are set out below.

Lodgment and Details

Document Lodged:	Statement
File Number:	ACT 4 of 2021
File Title:	APPLICATION FOR REVIEW OF AUTHORISATION AA1000542 DETERMINATION MADE ON 21 SEPTEMBER 2021
Registry:	VICTORIA – AUSTRALIAN COMPETITION TRIBUNAL

REGISTRAR

Dated: 16/05/2022 4:42 PM

Important information

This Notice has been inserted as the first page of the document which has been accepted for electronic filing. It is now taken to be part of that document for the purposes of the proceeding in the Tribunal and contains important information for all parties to that proceeding. It must be included in the document served on each of those parties.

STATEMENT

IN THE AUSTRALIAN COMPETITION TRIBUNAL **File No: ACT 4 of 2021**

RE: **APPLICATION FOR REVIEW OF AUTHORISATION DETERMINATION MADE ON 21 SEPTEMBER 2021**

APPLICANT: **NATIONAL ASSOCIATION OF PRACTISING PSYCHIATRISTS**

Statement of	Dr Gary Alexander Galambos
Address	32 Adelaide Street Woollahra NSW 2025
Occupation	Psychiatrist
Date	13 May 2022

I, Gary Alexander Galambos, say as follows:

1. I am a member of the National Association of Practising Psychiatrists and make this statement on behalf of the National Association of Practising Psychiatrists (**NAPP**).

2. Except where otherwise stated, I make this statement from my own knowledge.

Personal background

3. I gained my Bachelor of Medicine and Surgery degree from the University of NSW in 1992 and have been practicing psychiatry as a specialist physician for over 25 years.

4. I have been a Fellow of the Royal Australian and New Zealand College of Psychiatrists (**RANZCP**) since 1999, having commenced my postgraduate training in psychiatry in 1994. For the past 25 years, I've worked mainly in the private sector in group medical practices, solo practices and psychiatric hospital care. I have served the community by practicing in clinical psychiatry, service development, leadership positions and advocacy roles.

5. I have worked in both the public and private sectors and have had patients admitted under my care to multiple hospitals since 1999, including Rozelle Psychiatric Hospital (a public hospital), St John of God Hospital Burwood, Sydney Clinic and St Vincent's Private Hospital (SVPH). The latter three are private hospitals in Sydney.

6. Between 1999 and 2013, I was a Visiting Medical Officer (VMO) admitting patients under my care to St John of God Hospital Burwood, a 100-bed private psychiatric hospital in Sydney, to all of its 6 units catering to mood and anxiety disorders, personality disorders, psychotic disorders, drug and alcohol detoxification and its mother baby unit catering to families touched by postnatal mental disorders.

7. Between 2002 and 2012, I served as the medical director of St John of God Hospital Burwood. During that time, I developed cutting-edge private services for borderline personality disorder, young adults, substance addiction, psychotic disorders and the only mother-baby unit for perinatal disorders in NSW. In that capacity, I was familiar with the negotiations of contracts with private health insurers (PHIs).

8. In 2014, I was granted Conjoint Senior Clinical Lecturer by the UNSW Medical School for teaching medical students, setting up medical student training at various hospitals, and in particular for establishing a Professorial Unit at St John of God Hospital Burwood and multiple RANZCP-accredited psychiatry training positions there.

9. For the past 10 years, I have been a VMO admitting patients under my care to a young adult private psychiatric unit at St Vincent's Healthcare Australia, a large private national hospital service. The Young Adult Mental Health Services at St Vincent's Private Hospital in Sydney (SVPH) are specifically tailored for youth aged 16-25 years old and include a 20-bed inpatient ward, day services for group therapy and a medical centre with outpatient consulting rooms.

10. This therapeutic environment is for youth with emerging complex mental disorders, and was specifically established to address the issue of youth moving between emergency departments, public adult units, paediatric units and private adult units. As I discuss further below, the need for such a unit reflects the risks associated with patients being discharged from inpatient or day patient care when it is not in their best clinical interest.

11. In 2021, I was elected Head of Department of Psychiatry at SVPH and Medical Director of the Young Adult Mental Health Services within the St Vincent's Healthcare Service. In this capacity, I have been familiar with the negotiation of contracts with PHIs.

12. A service redevelopment process has commenced to develop enhanced clinical care pathways for the inpatient program, improved integration with the consulting suites, a significantly expanded day admission program, the establishment of a dedicated outpatient neurostimulation clinic to provide youth-specific repetitive transmagnetic stimulation (rTMS) and direct-current stimulation (tDCS) treatment services and specialist-grade digital mental health care program. The need for the inpatient unit reflects the risks associated with patients being discharged from inpatient or day patient care when it is not in their best clinical interest.

13. These multiple roles have enabled me to pursue interests in teaching, lecturing, mentoring, education, service development and the training and supervision of trainee psychiatrists, career medical officers, medical students and general practitioners.

14. I have been involved in various aspects of doctor support, representation and advocacy during my professional career.

15. Between 1998 and 2014, I served as counsellor and Deputy President of the Medical Benevolent Association of NSW, a not-for-profit charity run by doctors for doctors to provide psychosocial care for medical practitioners throughout NSW and the ACT. Since 2008, I have provided professional support to doctors struggling from medicolegal issues referred by a medical indemnity insurance company, MDA National. I have provided formal supervision to general practitioners pursuing extra training and certification in mental health.

16. I have also been involved in healthcare advocacy through leadership roles within the RANZCP and Australian Medical Association (AMA).

17. Since 2008, I have served as Chair and Deputy Chair of the RANZCP Section of Private Practice Psychiatry, representing all private psychiatrists across both Australia and New Zealand.

18. I served as a general councillor on the RANZCP NSW Branch Committee between 2012 and 2019. Between 2014 and 2018, I served as the elected Chair of the RANZCP NSW Branch, representing psychiatrists and psychiatry trainees in NSW. During this time, I served on numerous committees, liaised with multiple stakeholders and advocated for mental health system reform within NSW, Australia and New Zealand.

19. I have also been a member of the RANZCP Faculty of Psychotherapy Psychiatry since 2000, the RANZCP Section of Perinatal Psychiatry since 2005, the RANZCP Section of Youth Psychiatry since 2012 and the RANZCP Section of Neurostimulation and ECT since 2013. I have been the NSW Chair of the RANZCP Section of Youth Psychiatry since 2021.

20. I have been a member of the AMA Psychiatrists Group and AMA Mental Health Committee since 2011.

Health insurance funding models

21. From my professional and advocacy roles, I have been both involved (directly or indirectly) or otherwise aware of extensive submissions, position papers and plans involving funding models, models of care, clinical guidelines and health system design and operation. I have been a member of the RANZCP's working group examining the Commonwealth Medical Benefits Scheme (**MBS**), the MBS Review Taskforce, since 2015.

22. From my various roles, I am familiar with different funding models and different models of hospital care in the public and private sectors including:

    a. public hospital inpatients (NSW Health funded);

    b. private inpatient admissions utilising hospital contracts between the hospital and an individual PHI (this is the most common funding method in private hospitals and comprises a mixture of Medicare and PHI subsidies where inpatients incur costs from, among other things, gaps in their insurance policies);

    c. the public local health district (LHD) public sector service subsidising uninsured inpatients requiring mother baby unit (MBU) care at St John of God Hospital, Burwood;

    d. self-funded uninsured inpatients;

    e. inpatients funded by Workers Compensation Insurers;

    f. inpatients funded by the Department of Veterans Affairs; and

    g. inpatients funded by the Royal Australian Navy (RAN) who were transferred from the Balmoral Navy Hospital to St John of God Hospital Burwood for psychiatric inpatient care under an informal arrangement.

23. In parallel, my clinical and leadership roles provided me with oversight into the various funding models for specialist care for inpatient admissions. These include:

    a. **Salaried services**: in the case of public hospital inpatients, the specialist is funded by a salary, regardless of whether they are a staff specialist or a VMO. In these cases, the hospital is reimbursed by the State Department of Health and, where a patient is privately insured, by a PHI (according to the hospital's contract with the PHI);

    b. **Medicare funding**: in the case of some public hospital outpatients, care is funded by Medicare with the hospital being reimbursed at the rate prescribed by the Commonwealth under the MBS schedule of reimbursement (**MBS Schedule**). In the case outpatients within or adjacent to private hospital facilities, care is most commonly a mix of Medicare funding and out-of-pocket expenses (more outpatients pay above the MBS Schedule Fee than being bulk billed at the rate of the Schedule Fee);

    c. **Privately insured inpatients and day patients covered by "no gap" arrangements**:[1] in these cases, the psychiatrist charges the PHI for their services under no-gap contracts between the specialist and a relevant PHI. Under no-gap contracts, the patient pays no more than their insurance premium with the PHI and the PHI reimburses the specialist according to the rates agreed under the contract between the PHI and the specialist – typically at a premium of around 15% to the MBS Schedule;

    d. **Self-funded inpatients in private hospitals**: in these cases, the psychiatrists either bulk bill them using Medicare or charge a rate above the MBS Schedule Fee such that the patient needs to pay an out-of-pocket cost;

    e. **Uninsured inpatients requiring mother baby unit care at St John of God Hospital Burwood:** these patients were subsidised by a public local health district (LHD) public sector service that funded the specialist at an agreed rate equivalent to the rate reflected in the Australian Medical Association's (**AMA**) schedule of suggested fees (**AMA rate**) (as occurs with Workers Compensation patients);

    f. **inpatients funded by Worker's Compensation Insurers**: these are also usually paid at a rate equivalent to, or in the vicinity of, the AMA rate;

[1] In the context of psychiatric inpatient treatment, I have never heard of any psychiatrist providing services under a "known gap" arrangement with a PHI (in contrast to a no-gap arrangement)

g. **inpatients funded by the Royal Australian Navy:** these were paid at a rate equivalent to the AMA rate;

h. **inpatients funded by the Department of Veterans Affairs:** the specialist receives a rate somewhere between the MBS Schedule and the AMA rate (like 'no gap' arrangements); and

i. in some cases, a combination of the various approaches described above.

Significance of independent decision-making by the treating specialist

24. Broadly, there are 3 circumstances in which a specialist negotiates a funded treatment plan with a patient. These are:

a. where the treatment plan was dependent only on doctor-patient collaborative decision-making - for example:

i. outpatient care funded by Medicare and/or the patient;

ii. private hospital inpatient care where PHIs have not incorporated any detailed parameters within which a patient could be treated other than the cost of care to the hospital;

iii. and self-funded private inpatients.

b. where the treatment plan was negotiated directly with the funder and not with the patient - for example, contracts with Workers Compensation Insurers where the treatment plan requires pre-approval from the funder before the patient can be admitted, LHDs outsourcing private care for a patient requiring treatment that they could not provide in the public sector (such as within a mother baby unit), and the RAN.

c. where the treatment plan was negotiated with the patient within parameters set by the hospital-funder contract - for example, private hospital inpatients where PHIs have incorporated parameters into the hospital contracts which dictate how a patient should be treated.

25. In my opinion, patients obtain the best mental health care outcomes and prognoses when the funding did not intrude into the doctor-patient relationship, interfere with the natural place of the specialist as the team leader (where a multidisciplinary team was required to cater to the patient's condition) or dictate any details about the medical care that would best serve the patient's immediate and long-term interests.

26. In my opinion, were PHIs to gain increased collective bargaining power to expand funding models which impact on the determination of the patient treatment plan (including as to whether or not the patient is discharged), this will be detrimental for these patients.

Compulsion to enter into contract with a PHI

27. Patients requiring hospital care usually need an admission of a duration between one and four weeks. During this time, the psychiatrist reviews and manages them, providing team leadership, oversight and direction at least twice per week. On average, the psychiatrist would perform 4-16 episodes of care or intervention per admission.

28. This number of consultations attracts high levels of accumulated out-of-pocket fees if the psychiatrist does not utilise a no gap arrangement with a PHI to minimise financial stress for the patient. As a result, close to 100% of psychiatrists are parties to no gap arrangements with PHIs. A no gap arrangement is also referred to as a Medical Purchaser Provider Agreement (**MPPA**).

29. As discussed above, no gap MPPAs (used for hospital care) typically reimburse specialists at around 115% of the MBS Schedule. Conversely, psychiatrists treating patients in non-hospital private practices (being services not covered by PHI policies) typically charge fees closer to the AMA rate for patients whom they do not bulk bill.

30. Despite the increased complexity of working in an inpatient environment compared with an outpatient setting, many psychiatrists have continued to work in these settings. Inpatient settings are more complex because they involve leading a multidisciplinary team, dealing with more severe presentations and who have a higher suicide risk. There are also, unsurprisingly, higher demands on the specialist's time when they provide inpatient care. In fact, a considerable amount of time is spent conducting liaison work during an inpatient's care that does not even attract a fee for service. In other words, there is a substantial altruistic component to any psychiatrist dedicating themselves to working as a VMO to a private inpatient hospital.

31. Whilst psychiatrists providing inpatient care generally are quite altruistic, unfortunately, over time, the discrepancy in remuneration for what is more complex and demanding work has contributed to there being fewer psychiatrists available to work as VMOs in private hospital settings than the demand for their services require.

32. In my opinion, this problem will be materially exacerbated if the PHIs are able to increase their scale (whether with large PHIs or more generally), particularly in circumstances where there is a

risk (or prospect) of a collective buying group offering incentives to psychiatrists to deliver certain commercial outcomes, which might not be in the best interests of the patient.

33. If faced with the alternative of an MPPA at a higher rate of reimbursement to the current no gap arrangement, some psychiatrists might accept that MPPA contract, even if it results in a sub-optimal patient outcome due to the conditions in that contract, and the risk of lower reimbursement if the psychiatrist does not adhere to the conditions set out by the PHI.

34. Further, any reduction in the value of the benefits currently offered under the no gap MPPAs would be likely to commercially force psychiatrists to sign up to more commercially attractive contracts.

35. I expect that many psychiatrists would refuse to sign up to MPPAs with performance targets or other features that they would consider to be contrary to the best interests of their patients, resulting in their deciding to cease providing inpatient services in favour of outpatient practices, where they are not subject to such constraints.

36. If PHIs use disincentives to discourage specialists from continuing with existing no gap MPPAs (using, for example, financial incentives to entice specialists to transfer to conditional MPPAs), consumers are likely to be materially worse off. The reason for this, is that many psychiatrists who had been previously willing to provide mental health care for inpatients at a no gap rate (being one that was remunerated at the historical premiums to the Schedule fee) would reluctantly switch to providing only outpatient services if a failure to sign up to the proposed MPPAs resulted in their remuneration being reduced to a level below which their practices can absorb. This would result in an associated out-of-pocket expense for the consumer. This would also result in a reduced pool of psychiatrists available for inpatient care and an increased cost of psychiatric care to the community when looking at the system overall.

37. Patients cannot afford to lose the existing psychiatrist workforce willing to provide inpatient care and nor can many patients afford to pay the increased out-of-pocket expenses that would be likely to result, should PHIs be able to introduce MPPAs of the kind contemplated by the Authorisation Applicants as a result of the scale delivered by their collective bargaining.. The market demand has been growing very fast for both outpatient and inpatient psychiatric care, and currently there are crisis levels of shortage in access to psychiatric treatment.

38. The community would be much worse off if the proposed conduct had the foreseeable effect of driving psychiatrists away from inpatient care in favour of outpatient care, because inpatient

care is associated with much greater severity, acuity and risks of harm to the individual patients, to their families and to the community at large.

39. In my opinion, there is a very real risk of increased rates of deliberate self-harm, attempted suicide, completed suicide, chronic disability from the physical consequences of incomplete suicide, the adverse psychological and social consequences to the families, friends and work colleagues left behind, homicide and other forms of harm to others including domestic violence, which creates its own domino effect of psychological harm suffered by the victims as this is a risk factor that will increase the rates of trauma-related mental disorder in the community. These increased rates of morbidity and mortality also cause huge economic costs to society both directly and indirectly.

40. My mental health unit at St Vincent's Hospital represents a clear example of this potential outcome, as the unit would need to close if I were to become unavailable to take on inpatients. This situation is not unique to my private hospital. Many other private hospitals would also be likely to downscale or close.

41. In fact, it is currently not uncommon for patients in Sydney to be unable to access a private hospital bed due to the unavailability of psychiatrists to take them on, rather than due to the unavailability of beds. It is well known that the capital cities have the highest concentration of psychiatrists. The likely impact in Sydney would also be replicated in other locations. Should PHIs be able to introduce MPPAs of the kind contemplated by the Authorisation Applicants as a result of the scale delivered by their gain of increased collective bargaining, the waiting lists to access private inpatient beds would be even longer for patients suffering acute or subacute mental health problems. Longer waiting times to access inpatient care will increase the risk of adverse events occurring and also increase the demand for public sector crisis services.

Detriment of increased PHI involvement in the treatment of patients with mental health issues

42. Patients who have suffered past emotional, physical or sexual abuse typically suffer from the inability to trust others and hence may be defensive (both consciously and unconsciously) and not trust those authority figures in whom they need to place trust. This may lead to patients not fully cooperating with treatment programs. Any hint or suggestion that the clinicians involved in their care have other agendas or do not prioritise the therapeutic relationship is likely to lead to loss of confidence in the treatment process and increase the rates of drop out from treatment. The greatest concern most families have is that their loved ones will not remain in treatment to

maintain any gains made to their mental health and hence will relapse. It is vitally important therefore that the process be free from any third-party interference in order to be successful or optimal.

43. A treatment relationship is in itself an incredibly powerful yet delicate therapeutic tool that has the capacity to be a potent healing force. But, if compromised, it can re-traumatise and harm the patient. If the PHIs are permitted to interfere in the treatment process, they risk re-traumatising the patient rather than adding any value to the process.

44. It is a tragic irony that their clear lack of trust in the expertise of specialists to manage patients optimally is, of itself, detrimental to their members who seek treatment.

45. If PHIs are able reduce access to psychiatric treatment and negotiate hospital contracts that are more intrusive than is already the case, and impose MPPA contracts with increased clinical care restrictions, admission caps and stronger enticements and disincentives about how to manage a patient, this will inevitably disrupt the doctor-patient relationship.

46. In my experience, the quality of the doctor-patient therapeutic alliance and clinical outcomes have always been better when funding did not require any specific treatment approach. In my opinion, the level of detriment increases in direct proportion to the degree of intrusion into that relationship and the patients who benefited the least from treatment were those who were affected by funding that required the treatment plan to be negotiated with the funding party and not the patient.

47. A major problematic feature of funder-determined treatment plans is how the narrative is shifted from the doctor managing the patient's health problems, to prioritising time-consuming administrative tasks including the filling in of forms, waiting on the phone to speak to clerks and pleading with clerks to approve care - that is, *away* from actual patient care.

48. My experience with PHIs is that they have increasingly been attempting to impose hospital contracts that interfere with inpatient psychiatric care of vulnerable inpatients. Whilst the PHIs have had some success in introducing contracts with clauses that interfere with clinical independence, hospital administrators, hospital-based psychiatrists and those in clinical leadership roles have become more aware of these tactics. In response, hospitals and psychiatrists have been working more closely together to deflect these attempted incursions. I am concerned that the collective conduct contemplated by the Authorisation Applicants will result in the PHIs having more coercive power in their negotiations with hospitals, which will be

contrary to the best interests of the inpatients and where such developments would not otherwise have been likely.

49. If the PHIs are empowered to collectively bargain, they will have *increased* capacity to introduce these intrusive contracts, as private hospitals will be less able to resist these types of contractual conditions and because hospitals do their utmost to avoid having gaps in PHI cover. Furthermore, because increased collective bargaining is likely to enable the PHIs to *also* introduce conditional MPPAs with individual specialists (as opposed to only no gap MPPAs as is currently the case), the restrictive conditions within the MPPAs could undermine the efforts being made by psychiatrists (together with hospitals) to prevent clinically harmful hospital contract clauses being forced into hospital inpatient practices.

50. I am aware that the MPPAs that the Authorisation Applicants are developing on behalf of nib will have stipulations that the specialist will not be allowed to act in any way that will cause harm to nib including economic harm. Hence, I am concerned that the PHI will be able to undermine potential advocacy efforts to resist clinically detrimental hospital contracts. This 'dual action' of hospital contracts *and* conditional MPPAs will enable PHIs to have unprecedented power to determine how psychiatric inpatients are clinically managed. Currently, they only have a limited influence because specialists and hospitals are in a position to be able to minimise the harm that they can cause. Giving the Authorisation Applicants capacity to work collectively will effectively be giving them the power to engage in unchallenged, anti-competitive behaviour that will harm vulnerable people.

51. This detriment will be exacerbated by the inevitable recognition within the community that PHIs are effectively denying the clinician the right to disclose to the patient the degree to which the PHI is involved (directly or indirectly) in the clinical decision-making.

52. If MPPAs that have conditions attached about how to manage patients become commonplace, this will introduce homogenised care in the place of person-centred care. Examples of homogenised care include target percentages for admissions or treatment outcomes, requiring patients to be discharged to home treatment where the clinician's reasonable independent assessment is that inpatient treatment is in the patient's best interests and requiring the specialist to have regard to clinical or treatment guidelines formulated by the PHIs rather than by recognised specialist bodies.

53. The inducements and disincentives that will inevitably introduce these MPPAs into common practice if the Authorisation Applicants are granted their increased collective bargaining power include:

    a. paying specialists larger amounts for entering into the conditional MPPA than are presently offered under the no gap arrangements;

    b. paying specialists much lower amounts than are presently offered under future non-conditional MPPAs such as no-gap MPPAs;

    c. allowing or enabling the differential remuneration between the conditional MPPAs and non-conditional MPPAs to grow to the point that the specialist feels compelled to enter into the conditional MPPA;

    d. requiring specialists to enter into a conditional MPPA if they wish to obtain admitting privileges at a hospital where the Authorisation Applicants have contracted those hospitals to only accept specialists who are willing to enter into a conditional MPPA;

    e. discontinuing a specialist from a conditional or non-conditional MPPA if the PHI deems the specialist to have caused any harm to the PHI; and

    f. a condition of the MPPA being that the PHI may publish information about the specialist on a public website that is favourable or unfavourable depending on the specialist's degree of compliance with the conditional MPPA and the outcomes measures that are selected by the Authorisation Applicant.

54. The MPPAs will also be detrimental to patients by compelling specialists to share highly sensitive and previously confidential information about a patient's demographics, health status, symptoms, management, response or non-response to treatment and outcome measures with the PHI (or HH) in much greater detail than is currently the case. Currently, the only clinically related information that the specialist is required to provide the patient's PHI is generic clinical information in the form of the specialist ticking various categories in a certificate that is provided upon a patient being admitted to a private hospital. For a psychiatrist, this involves ticking which category of disorder the patient is suffering from (for example: mood, anxiety, personality, substance use, cognitive, psychotic disorder or other), the categories of treatment modality required (e.g. individual psychotherapy, group psychotherapy, pharmacotherapy, counselling, other) and the category of the follow-up care (such as GP, specialist, community

health centre, etc). Should the Authorisation Applicants be granted the collective bargaining power that they are seeking, they will use that power to introduce MPPAs with much wider data-collection parameters.

55. Honeysuckle Health is a data analytics company that proposes to use this information to, adopting its terminology, "enhance" patient care, although It has not been revealed how HH proposes to actually use this data. As such, I remain concerned that its use, without strict guidelines or controls, could be contrary to the best interests of patients (as well as contrary to the interests of clinicians).

56. I recently (early 2022) became aware of an instance of HH phoning a patient of mine who was recently discharged from a psychiatric hospital, with an offer of a promise to enhance her psychiatric care.

57. This was done without any consultation or discussion with me. The patient did not understand who HH was – I understand that they simply called themselves "Honeysuckle Healthcare" – so she assumed they were a healthcare provider.

58. The patient agreed, and the next day received a phone call from a person who questioned her about her recent inpatient admission. The patient was highly distressed after this conversation. She felt invaded and her privacy breached. It had been a very sensitive admission as she had disclosed to me a sexual assault that she had not previously disclosed. She said she did not want further contact with anyone else from HH.

59. I am concerned that scenarios like this will become commonplace in the future if the PHIs gain the collective bargaining power that permits them to play a much larger role in any individual patient's healthcare. In my opinion, this example reveals the detriment that is likely to occur from increasing the power and role of PHIs in the clinical arena.

60. I am also concerned that any increased collective bargaining capacity may give PHIs the power to determine what services are or are not funded and that if clinicians are not free to develop tailored programs to care for each distinctive complex group, patients that would be categorised as falling under discrete special needs types would suffer.

61. If specialists are not confident that they can safely treat patients who are high risk due to risk of suicide, for example a chronically suicidal person with borderline personality disorder or an unpredictable person with a manic or psychotic disorder, then they would be reluctant to admit

such a patient under their care. This would be highly likely if the increased collective bargaining power led to PHIs homogenising inpatient treatment programs even more than they have already managed to do.

62. It is my understanding that nib and Cigna Health, who have established HH, are for-profit corporations. I am concerned that assertions as to improved patient satisfaction, health outcomes and reductions in healthcare costs to patients are purely speculative, remain unsupported by clinical evidence and should be viewed with scepticism by the Tribunal.

63. My opinion is based on my personal experiences in dealing with PHIs. Some of these are briefly described below.

64. In May 2004, I was medical director of the only mother baby unit in NSW at St John of God Hospital Burwood, a unit which caters to families where postnatal depression, psychosis, bipolar disorder and anxiety strikes when they have the responsibility to care for a baby under one year of age.

65. At that time, one of the largest PHIs in Australia decided – without warning or consultation – to *stop* paying the cost of board for the babies who needed to be cared for by their mentally ill mothers, who were being supported by mental health nurses and mothercraft nurses. The PHI said their contract stipulated that they only had to pay for the person with the mental illness - the mother. The baby didn't count as they asserted that the baby could not be mentally ill. They informed us that if it was the mother who was sick, they would only pay for *her* healthcare, and not the baby's.

66. I was outraged at the depth of the insensitivity, the lack of compassion and the apparent ignorance - the supposed lack of understanding that the babies were also suffering emotional distress having a mentally ill mother who sometimes was unable to meet the emotional needs of their baby or who were at risk of infanticide

67. Payment for boarding the babies was eventually reinstated after some months of negotiation and pleading. It took many months to convince the PHI that the babies were in fact unable to survive or thrive without their mothers' care. I cannot help but wonder whether families would have continued to suffer this situation with other PHIs being likely to join in on the exclusion exercise of funding the inpatient care of distressed babies if the PHIs were able to collectively bargain rather than events like this being sporadic and quickly stamped out by market forces.

Impact on clinicians

68. I am also aware of clinicians who have chosen to opt out from treating a person whose funding is dependent on an arrangement which they consider intrudes into the doctor-patient relationship and which limits the effective or optimal treatment of the patient

69. Allowing PHIs to collectively bargain, such that they have enough power to force specialists into contracts that may discourage them from advocating on behalf of their own patients, will cause even greater harm to the consumer.

70. Some specialists will feel compelled to enter into MPPAs because it is the only financially viable way of providing inpatient mental health care, although many patients will be unable to receive treatment from the optimal specialist for their disorder and many others will be faced with a reduced pool of specialists from which to choose.

71. Vulnerable consumers will also be challenged by PHIs that will possess increased bargaining power to introduce and amend more prohibitive insurance products onto the market, specifically with increased restrictions placed upon the treatments that their members may receive during episodes of hospital care. It has been my experience that some PHIs opportunistically try to restrict treatments and I am concerned that increased collective bargaining power will escalate such occurrences.

72. If collective bargaining leads to the introduction of conditional MPPAs, I infer that PHIs will subsequently introduce mandatory auditing of patient medical records kept by those specialists in their private practices. The basis for this inference is the obligation, at cl 10.3 of the template MPPA provided to the ACCC, that:

    "Without limiting the Provider's independence as set out in clause 10.2, the Provider agrees to follow clinical guidelines as nib may reasonably require from time to time, for the purpose of nib administering the Fund and the payment of claims under the Fund."

73. Further, nib's insistence that all members of a multidisciplinary team (being those treating an "episode of care") within a hospital are party to an MPPA creates an unprecedented, additional layer of pressure and coercion to participate in prioritising the adherence to the requirements of hospital contracts, insurance policies and conditional MPPAs which in effect creates a per patient budget that prioritises the costs of care above tailored person-centred care. The true

way to benefit patient care is to prioritise the doctor-patient relationship rather than to force members, hospitals and specialists into conditional contracts.

74. Many specialists will likely choose the easier path of simply managing patients according to the general clinical care pathways stipulated in the MPPA rather than risk the significant financial consequences of deviating from the agreed stipulations. If the Tribunal were to increase the number of PHIs that can join HH, there will be clear market pressure to sign on to contracts that have the very real potential to influence clinical care *en masse* and give unprecedented access to a data analytics company to highly sensitive and personal clinical information of Australian patients with mental disorders.

75. While the documentation of “best practice guidelines” may be a reasonable approach for an ‘average’ hypothetical patient (a so-called ‘textbook case’), it is inappropriate to include a guideline in a legal contract with a healthcare provider (be it a hospital contract or a conditional MPPA with a specialist), because:

    a. most patients have some, but not all, the symptoms or features of any specific mental disorder;

    b. mental disorders can present very differently from patient to patient;

    c. any particular mental disorder may be the result of quite different underlying causes or mixes of aetiologies;

    d. many patients present with more than one mental disorder and it takes specialist expertise to assess which diagnosis (or diagnoses) may be the dominant condition/s warranting maximum targeting for treatment; and

    e. different presentations, causes and comorbidities require that a clinical determination be made about which treatment modalities need to be used, emphasised or deemphasised.

76. Therefore, including any guidelines for how clinicians should treat patients with a particular mental disorder in a legal contract that contains conditions in the form of financial enticements and disincentives, is likely to be contrary to the best interests of the patients.

77. Ultimately, it is my opinion that the proposed conduct would, if authorised, be highly detrimental to the practice of medicine and in particular psychiatry because psychiatric care depends so much on trust in the therapeutic relationship.

78. The Authorisation Applicants, in their proposed MPPAs with specialists, wish to determine which outcome scales and measures should be used by hospital inpatient teams including psychiatrists to guide the management of patients with mental disorders.[2]

79. These outcome measurements could potentially be used not only to determine what treatment a patient requires, but also to determine when that patient has reached a desired completion point in a treatment episode, thereby warranting discharge. This would have the effect of overriding the current approach to assessing outcome measures, which is to use the Centralised Data Management Service (CDMS).

80. The CDMS is part of the *National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private Psychiatric Services*. It has been implemented by most private psychiatric hospitals throughout Australia for the purpose of obtaining information to support improvements in the quality, effectiveness and efficiency of the services they provide.

81. Since 2001, the Australian Government, private health insurers, and over forty private hospitals with psychiatric beds have contributed to the funding necessary to support the CDMS. This system is not overly bureaucratic, cumbersome or burdensome. It has been very useful for benchmarking and quality control. However – critically – it is not used to actually determine what treatments a patient requires or when they have reached a satisfactory level of remission – these matters are all clinically determined by the doctor-patient in collaboration.

82. I am concerned that if the Authorisation Applicants are able to collectively bargain, thereby empowering them to choose their own preferred outcome scales rather than the measures that have been the preference of the industry stakeholders for the past 20 years, they might choose outcome scales that are highly onerous to implement for complex patients, which would make those patients less attractive for private hospitals to take on. In my opinion, this outcome is even *more* likely where there is a financial incentive for the PHIs to pursue such a course.

83. In my opinion, any outcome that linked outcome measures to funding could result in the potential for massive harm to occur to patient care. If the Authorisation Applicants are

[2] Letter from Minter Ellison to ACCC of 9 August 2021

successful in introducing collective bargaining for the PHIs in question (both with and without any of the major PHIs), I consider that it would give those PHIs the power to:

- determine what constitutes desired health outcomes;
- homogenise these measures rather than prioritise collaborative decision-making between doctors and patients to decide what outcomes to work towards; and
- use these measures as leverage to control specialists whose performance data they will publish on public websites.

Recent unsuccessful attempts by PHIs to introduce material changes to their contracts

84. In order to attempt to predict the likely impact of conditional MPPAs on healthcare, it is useful to examine how PHIs have attempted to use hospital contracts in recent years to try to control and homogenise healthcare, in a manner which I consider would disrupt the optimal mental health care of inpatients.

85. From my observations as to how PHIs have approached negotiating hospital contracts, they have attempted to interfere in standard healthcare practices by:

    a. interfering in decisions around referral and admission - specifically, they seeking to reduce referrals and admissions;
    b. seeking to influence the types and amounts of treatments occurring during an admission (for example, by seeking to introduce treatment schedules, demanding that clinicians explain why they are deviating from the schedules that hey were seeking to introduce, and generally seeking to influence the type of care that could be provided by healthcare providers);
    c. seeking to override existing established quality assurance processes (for example, by attempting to introduce their own preferred generic treatment schedules);
    d. seeking to Influence when and why a patient gets admitted to a hospital and the duration of the admission;
    e. overriding trauma-informed, person-centred healthcare (for example, through attempting to minimise the relevance of psychiatric treatment, medical interventions, nursing care and individual counselling in favour of intensive group-based therapy programs conducted by allied health clinicians such as social workers, psychologists and occupational therapists. This oversimplification of inpatient care contravenes the biopsychosocial approach that is considered standard best practice in mental health care, where biological, psychological and social factors are all utilised in a package tailored to the individual patient's needs).

86. The PHIs have tried to introduce clauses in hospital contracts that interfere with standard healthcare practices and are in defiance of the *Guidelines for Determining Benefits for Private Health Insurance Purposes for Private Mental Health Care 2015 Edition,* Private Mental Health Alliance (PMHA) (the Guidelines)[3] which state:

    "The Guidelines cannot be prescriptive and, at present, are primarily intended to provide guidance for hospitals and private health insurers in determining health insurance benefits for private patient hospital–based mental health care. This includes same–day, half–day, overnight and services that substitute for traditional admitted patient treatment, as well as community and outpatient services, where applicable." (Introduction, Page 3 of 24)

87. The Guidelines were developed by the Collaborative Care Models Working Group of the PMHA in 2015. The PMHA consists of the Australian Medical Association (AMA), Private Healthcare Australia, APHA, the Private Mental Health Consumer Carer Network (Aust) and the Australian Government Department of Health the Department of Veterans Affairs. A related group, part of the PMHA, titled the Collaborative Care Models Working Group includes the Royal Australian and New Zealand College of Psychiatrists (RANZCP), Australian College of Mental Health Nurses, the Australian Psychological Society, the Australian Association of Social Workers and Occupational Therapy Australia. All stakeholders in the mental health field support these guidelines being non-prescriptive.

88. Annexure A to this Statement contains de-identified excerpts from clauses that PHIs have submitted in contract negotiations with private hospitals, in order to provide examples of the types of clauses they have unsuccessfully tried to introduce that, in my opinion, would have interfered with standard healthcare practices. I have also set out, at Annexure A, why I consider this to be the case. These have been de-identified due to commercial-in-confidence obligations.

---

[3] [https://nla.gov.au/nla.obj-299533756/view]

Conclusion

The three negative ways mental health care provision can be modified by PHIs if they are permitted to form an anticompetitive collective buying group

89. Firstly, Psychiatrists would become compelled to shift from the existing no gap contracts into conditional MPPAs with PHIs. That's because any reduction in the differential value of the benefits currently offered under the no gap MPPAs would be likely to commercially force psychiatrists to sign up to more commercially viable contracts if they wished to continue to provide inpatient care.

90. Secondly, hospital contracts would intrude more into inpatient clinical care. Currently, hospital administrators and psychiatrists have been able to minimise PHIs imposing contracts with conditions interfering with inpatient psychiatric care. The concurrent introduction of conditional MPPAs with specialists will have restrictive stipulations that those specialists cannot act in any way that will cause harm to nib (including economic harm). This will give PHIs the capacity to undermine any advocacy efforts that could otherwise have resisted hospital contracts that were not in patients' best interest. This 'dual action' of hospital contracts and conditional MPPAs will enable PHIs to have unprecedented power to determine how psychiatric inpatients are clinically managed. Furthermore, nib's potential insistence that all members of a multidisciplinary team within a hospital are party to an MPPA creates an unprecedented further layer of pressure and coercion to prioritise the requirements of hospital contracts.

91. Thirdly, the increased bargaining power of PHIs would enable them to introduce more prohibitive insurance products onto the market, specifically with increased restrictions placed upon the treatments that their members may receive during episodes of hospital care. The increased power to determine clinical care will be magnified by their capacity to make insurance policies concordant with the hospital contracts and MPPAs with specialist teams. For example, the PHIs might choose to offer cheaper insurance policies for members who will agree to restrict their choice of hospital and specialist providers to those who have signed up to their BCCP associated contracts. The problem with this last scenario is that it limits the choice of hospitals and specialists to patients, and it reduces the options for specialists where they can have the independence to practice high quality medicine. It gives power to the PHIs to prioritise financial return over healthcare standards.

The three adverse impacts on patients if PHIs modify mental health care provision through anticompetitive collective buying power

92. Firstly, it is inevitable that enticements and disincentives to secretly manage patients in the ways the PHIs want them managed will eventually disrupt the doctor-patient relationship. Compromising trust in the therapeutic relationship will re-traumatise patients especially those with histories of childhood abuse or neglect. Other ways to break trust in the therapeutic relationship are giving a data analytics company access to the highly sensitive, personal clinical information of Australian inpatients with mental disorders and shifting their specialist's attention from patient care to prioritising bureaucratic tasks.

93. Secondly, clinical independence will be compromised by the introduction of homogenised care in the place of person-centred care. That will occur if PHIs are given the power to introduce contracts that require target percentages for admissions or treatment outcomes, the specialist to follow treatment guidelines formulated by the PHIs and patients to be discharged to home treatment even if their treating clinician's reasonable assessment is that inpatient treatment is in their best interests. There was nothing in the draft MPPA preventing a PHI from introducing mandatory auditing of patient medical records kept by specialists in their private practices.

94. Thirdly, negative workforce consequences would result if some psychiatrists choose to move from inpatient to outpatient care provision due to unpalatable MPPAs being their only option. The community cannot afford to lose the existing psychiatrist workforce willing to provide inpatient care, which is associated with much greater severity, acuity and risk than outpatients. Hence, the waiting lists to access private inpatient beds would be even longer for patients suffering acute or subacute mental health problems.

95. This would increase the risk of adverse events occurring and also increase the demand for public sector crisis services. Another negative consequence would be that PHIs would have the power to determine what services are or are not funded and may choose to deny the establishment of services for more complex clinical groups.

96. Furthermore, if specialists were to become unconfident about being able to safely treat inpatients who are at high risk of suicide due to newly imposed restrictions around inpatient care, they would become reluctant to continue to admit such patients.

Date: 16 May 2022

Dr Gary Galambos, Conjoint Senior Lecturer, UNSW
Consultant Psychiatrist

IN THE AUSTRALIAN COMPETITION TRIBUNAL **File No: ACT 4 of 2021**

RE: **APPLICATION FOR REVIEW OF AUTHORISATION DETERMINATION MADE ON 21 SEPTEMBER 2021**

APPLICANT: **NATIONAL ASSOCIATION OF PRACTISING PSYCHIATRISTS**

ANNEXURE A

SAMPLE CLAUSES PROPOSED BY PHIs

1. The following material contains examples of contractual provisions proposed by PHIs, together with my explanation as to the likely harm that would arise from those clauses.

2. An example of contract clauses that a health insurer tried to introduce into a hospital contract relating to referral and admission processes and inpatient procedures include:

   Overnight Mental Health Threshold Requirements means that the overnight mental health service includes:

   (a) the decision by the Member's treating psychiatrist to Admit the Member, either prior to Admission or where the treating psychiatrist is unavailable prior to Admission, before 12:00pm on the day following Admission

   (c) On any particular day, the therapeutic time requirement referred to in item XXX of this Part XXX will be deemed to have been met where:

   (i) Mental Health Therapy is available on that day, for not less than the time specified in item XXX; and

   (ii) the Member's treating psychiatrist, or other member of the treating multidisciplinary team in consultation with the treating psychiatrist, determines that it is clinically inappropriate for the Member to receive Mental Health Therapy (or the specific number of hours of Mental Health Therapy), or the Member refuses to participate in Mental Health Therapy, on that day, as documented in the Records of Treatment.

(d) a copy of the schedule of Mental Health Therapy included in the Records of Treatment and otherwise made available to XXXX at the time of audit, including documentation of the clinical rationale for any variations made to the schedule;

(f) multidisciplinary case conferences, as demonstrated by the following documented in the Records of Treatment… and where a Member's Episode of Care is seven days or more, occurring:

(iii) at a frequency of at least once every seven days, unless a multidisciplinary case conference is due to be held on a public holiday, in which case the frequency is extended such that the multidisciplinary case conference is held on the next day that is not a public holiday;

Overnight mental health services:

(d) Where a mental health service does not satisfy each of the Overnight Mental Health Threshold Requirements only because a date, the author's name or designation was not included in a document in the Records of Treatment on a particular day as required by the Overnight Mental Health Threshold Requirements, the daily Charge for a mental health service referred to in item XXX or XXX is the overnight mental health service rate otherwise applicable under the relevant item reduced by 5%.

(a) (iv) for any day on which the Member does not attend at least four hours of Mental Health Therapy (commencing the first full day after the Member's Admission, unless the Member's Admission commences before 12pm, in which case commencing on that day), the Charge is 50% of the rate referred to in paragraph XXX or XXX, as applicable XXX

3. These proposed clauses sought to micromanage any patient's admission using multiple conditions backed up by financial penalties for non-compliance as the lever. The language used in these clauses are not the way doctors, nurses and allied health clinicians approach patient care.

4. In the proposed item (a), the PHI demanded that admission occur within 24 hours of the referral taking place. This narrow parameter would have created a bureaucratic burden that would have made many referrals unable to be accommodated. This would have caused more stress on referring general practitioners, external psychiatrists and consumers and families in states of crisis. It would also have impacted negatively on referrals from public hospital emergency departments, short stay mental health units and acute admission units.

5. In proposing a clause like this, the PHI adopted a surgery practice type model of care rather than a psychiatric specialist practice model. A surgeon usually refers a patient for inpatient care who

they have already consulted on as an outpatient. In inpatient psychiatric care, it is more typical for the inpatient psychiatrist to have not met the patient previously. Hence, the insurer attempted to apply a model of care that was not fit for purpose.

6. Strictly defined parameters like those that were proposed by the PHI would lead to private hospital mental health resources being channelled away from those with severe mental disorders to simpler, less onerous patients, as the former cohort is likely to require more person-centred care. The cohort with more severe disorders would be more likely to need exclusions from any homogenous process that the PHI was postulating.

7. Should PHIs be able to force private hospitals to accept such clauses, it would likely lead to many more premature discharges because patients would be asked to leave by the hospital due to non-compliance with the PHIs contractual regulations. It would undermine private hospital psychiatric care and drive more patients into a public system that has poor capacity to manage consumers not requiring crisis care. The distortions to standard clinical care of mental disorders are multiple in number and their nature is difficult to predict. .

8. I have also observed PHIs propose hospital contract clauses during contract negotiations that relate to the type and duration of treatments and who can provide them. They can be divided into:

    - The types and specific amounts of treatments that must be used.
    - Decisions around who can be employed on the multidisciplinary team.
    - Requisite details of explanations provided for any deviations from the expected inpatient care**.**

9. An example of contract clauses that a PHI tried to introduce into a hospital contract relating to the types and duration of treatments and who can provide them include:

    Overnight mental health services

    (a) If a rate for a mental health service provided to a Member who is Admitted for one or more Admitted Days at:

    (iii) subject to item XXX of this XXX, for each day on which the Member attends at least 4 hours of Mental Health Therapy, the Charge:

    (i) for any day on which the Member does not attend at least four hours of Mental Health Therapy (commencing the first full day after the Member's Admission, unless the Member's

Admission commences before 12pm, in which case commencing on that day), the Charge is 50% of the rate referred to in paragraph XXX or XXX, as applicable XXX,

provided that the maximum Charge reduction under this item XXX will not exceed 50% of the total amount for all Admitted Days in the Member's Episode of Care calculated in accordance with the applicable rate referred to in paragraph XXX, or XXX,

(b) On any particular day, in determining whether the Member attended at least four hours of Mental Health Therapy for the purpose of items XXX and XXX, the following will be taken into account:

(i) consultation time with the Member's treating psychiatrist (as indicated by the MBS item number);

(ii) participation in specialised group therapy programs and one-to-one counselling/therapy sessions, as set out in the Member's documented schedule of planned Mental Health Therapy, where evidence in the Records of Treatment (or otherwise made available for review at the time of the relevant Onsite Audit) demonstrates that the Member attended the programs/sessions;

(iii) where there is documentation in the Records of Treatment of Mental Health Therapy provided by a career medical officer, medical registrar, medical fellow or equivalent, this will be considered to amount to 30 minutes of Mental Health Therapy on any particular day;

(iv) where there is documentation in the Records of Treatment of Mental Health Therapy provided by a Mental Health Nurse, 20 minutes will be allocated per interaction between the Member and a Mental Health Nurse, up to a maximum of 60 minutes per day, but this does not include bedside nursing care (for example, provision of medication and taking observations).

10. The following Worked example was provided:

    A Member is Admitted for overnight mental health treatment at a XXX Hospital, with a length of stay of 10 days. Each of the Overnight Mental Health Threshold Requirements is satisfied, but on days 2, 3 and 4 no Mental Health Therapy is provided. There is also no document in the Records of Treatment that it was clinically inappropriate for the Member to receive Mental Health Therapy on those days, or that the Member refused to participate in Mental Health Therapy. In accordance with item XXX, the Charge for days 2, 3 and 4 is 50% of the rate referred to in item XXX

11. These clauses are inconsistent with the PMHA Guidelines regarding the types and specific amounts of treatments to be used as per the following quotes from the Guidelines:

- *"Consideration must be given to the most appropriate... recovery oriented treatment options" (Page 4)*

- *"Choice and access to a range of treatment options in consultation with the patient and where nominated and clinically appropriate their family or carers" (Page 7)*
- *"Comprehensive individualised care, access to treatment and support services able to meet specific needs during the various stages of the individual's illness" (Page 7)*
- *"There will be situations where evidence does not exist for the level of complexity of some mental health problems and the nature of some forms of psychotherapeutic treatment" (Page 7)*
- *"At all times, in the selection of treatment options, the focus needs to be on individual needs and restoration or stabilisation of function, taking into account environmental factors for the patient, patient preferences and the patient's support systems" (Treatment and care options, Page 9)*

- *"It is expected that program modules designed to develop/increase skill levels or to prevent relapse will be conducted...where possible and clinically appropriate" (Page 10)*

12. The PHI that proposed these clauses attempted to dictate the elements of an inpatient program by weighting them based on their commercially driven preferences and threatening penalties for non-compliance. If successful, this would materially distort the types of interventions that the hospital service could provide, despite their weightings being to the contrary of evidence-based interventions, individualised care, patient preference and other medical interventions.

13. It is most concerning that the PHI would unilaterally wish to develop its own definition, strictly defined parameters and thresholds for what they consider "mental health therapy". In my opinion, it is inappropriate for a PHI to determine these definitions, parameters and thresholds around standard medical practice. It should collectively be developed by specialists overseen by regulatory bodies such as Medical Colleges, the Federal Government's regulator, AHPRA, the state-based Medical Boards, the AMA, hospital-based clinical leaders and healthcare hospital accreditation systems.

14. Should a PHI be able to introduce such clauses, private hospitals would need to respond by diverting clinical teams to prioritise the collection of documentary evidence to protect hospital income against periodic PHI-instigated audits characterised by disproportionate financial penalties for minor absences of information that the PHI would have stipulated as necessary. These intrusions distract attention away from clinical priorities and divert limited resources from

patient care. It would ultimately result in closer scrutiny by hospital administrators to put more energy into complying with bureaucratic requirements rather than actually providing high quality patient care.

15. An example of a contract clause that a health insurer tried to introduce into a hospital contract relating to decisions around who can be employed on the multidisciplinary team is:

    Definitions

    Mental Health Nurse means a Health Professional with postgraduate study in mental health nursing at Graduate Certificate, Diploma or Masters level or solely qualified in the area of mental health nursing.

16. What the PMHA Guidelines say about who can be employed on the multidisciplinary team:

    - *Registered and Enrolled Nurses and Nurse Practitioners registered with AHPRA (p 13)*
    - *Mental Health Nurses credentialed by the Australian College of Mental Health Nurses (ACMHN) (p 13)*
    - *Appropriately trained mental health professionals will make up the majority (minimum 60%) of the staffing numbers (p 13)*

17. If a PHI could restrict the types of clinicians a healthcare service can employ based on their own narrow definitions, it would remove a hospital's independence to determine the composition of clinical temas and staffing formula generally based on the clinical needs of the subpopulation it serves. This would likely lead to greater inefficiencies and could cause patient harm.

18. An example of contract clauses that a health insurer tried to introduce into a hospital contract relating to details of explanations provided for any deviations from the expected inpatient care is:

    Overnight mental health services

    (a) If a rate for a mental health service provided to a Member who is Admitted for one or more Admitted Days at:

    (iii) subject to item XXX of this XXX, for each day on which the Member attends at least 4 hours of Mental Health Therapy, the Charge:

(A) where during the Episode of Care the mental health service satisfies each of the Overnight Mental Health Threshold Requirements, the rate referred to in paragraph XXX or XXX, as applicable; or

(B) where during the Episode of Care the mental health service does not satisfy each of the Overnight Mental Health Threshold Requirements, 50% of the rate referred to in paragraph XXX or XXX, as applicable; and

(i) for any day on which the Member does not attend at least four hours of Mental Health Therapy (commencing the first full day after the Member's Admission, unless the Member's Admission commences before 12pm, in which case commencing on that day), the Charge is 50% of the rate referred to in paragraph XXX or XXX, as applicable,

provided that the maximum Charge reduction under this item XXX will not exceed 50% of the total amount for all Admitted Days in the Member's Episode of Care calculated in accordance with the applicable rate referred to in paragraph or

(b) On any particular day, in determining whether the Member attended at least four hours of Mental Health Therapy for the purpose of items XXX and XXX, the following will be taken into account:

(i) consultation time with the Member's treating psychiatrist (as indicated by the MBS item number);

(ii) participation in specialised group therapy programs and one-to-one counselling/therapy sessions, as set out in the Member's documented schedule of planned Mental Health Therapy, where evidence in the Records of Treatment (or otherwise made available for review at the time of the relevant Onsite Audit) demonstrates that the Member attended the programs/sessions;

(iii) where there is documentation in the Records of Treatment of Mental Health Therapy provided by a career medical officer, medical registrar, medical fellow or equivalent, this will be considered to amount to 30 minutes of Mental Health Therapy on any particular day;

19. The PMHA Guidelines concerning details of the specific biopsychosocial ingredients of inpatient care state:

    - *"Hours per patient day will be an average of 4 hours, with the aim of achieving 4.2 hours, per patient day over 7 days" (p. 14)*

20. The PMHA Guidelines encourage thinking in terms of averages over 7 day periods rather than the unreasonable expectation that every patient is sufficiently mentally fit to attend a minimum

of 4 hours per day. It is more helpful and appropriate to think about averaging a patient's attendance and associated therapeutic interventions over each week of admission with a view to reflecting need, capacity and impact on fellow inpatients.

21. An example of contract clauses that a health insurer tried to introduce into a hospital contract relating to overriding existing, established quality assurance processes are:

    Overnight mental health services:

    (e) Where a mental health service does not satisfy each of the Overnight Mental Health Threshold Requirements only because a multidisciplinary case conference does not occur at the frequency required by the Overnight Mental Health Threshold Requirements (Due Date), the daily Charge for a mental health service referred to in item XXX or XXX is 50% of the overnight mental health service rate otherwise applicable under the relevant item, only for those days after the Due Date.

22. The following Worked example was provided:

    A Member is Admitted for overnight mental health treatment at a XXX Hospital, with a length of stay of 10 days. There is no multidisciplinary case conference during the Member's Admission documented in the Records of Treatment, but all other Overnight Mental Health Threshold Requirements are satisfied, and the Member attended more than four hours of Mental Health Therapy on each day. In accordance with item XXX, the daily Charge for days 8, 9 and 10 is 50% of the rate referred to in item XXX

23. The PMHA Guidelines regard quality assurance processes to:

    - *"engage in recognized quality assurance processes, including review of services against the National Safety and Quality Health Service Standards 2nd Ed, by an independent accreditation agency" (Page 5)*

24. Auditing of clinical processes and outcome measures is beyond the expertise of PHIs. It would also raise a serious conflict of interest whereby a PHI could exert an excessive degree of control over patient care. Should PHIs have excessive bargaining power, they would use it to compromise the integrity of clinical services.

25. An example of a contract clause that a health insurer tried to introduce into a hospital contract relating to influencing when and why a patient gets admitted to a hospital and the duration of the admission is:

    Criteria 1

A psychiatric service is provided to a member who meets the relevant admission criteria set out in the Mental Health Guidelines:

High risk of harm to self and others

Incapacitating symptoms of distress

The needs to establish the nature of a disorder, initiate or stabilise complex treatment modalities

Significant problems in initiating treatment, or continuing treatment in another setting.

26. The PMHA Guidelines regard decision-making about referral for inpatient care in the following terms:

- *"Treatment in the most facilitative environment appropriate for the individual patient" (Page 7)*

- *"The following factors need to be considered when selecting the most appropriate setting for care delivery: patient acuity, level of distress and disability; level of social supports in the home; geographical considerations" (Choice of setting, Page 8)*

27. If PHIs are given increased bargaining power, they would be able to demand that thresholds be met, second opinions be sought and other measures be implemented that would delay and disrupt access to inpatient clinicians chosen by patients' in collaboration with their general practitioners. It would be a dangerous precedent for insurers to define what mental disorders are coverable by their policy and the level of acuity that they are willing to fund for inpatients.

28. This example illustrates the consequences of restrictive clauses that would narrow the parameters for which a PHI would fund an admission. The focus and priority of clinical staff would shift from accurately communicating the patient's needs to ensuring the supporting documentation reflects the PHI's requirements. This would cause a detrimental impact on the quality of patient care.

29. An example of a contract clause that a health insurer tried to introduce into a hospital contract relating to overriding trauma-informed, person-centred healthcare is:

Overnight mental health services

(b) On any particular day, in determining whether the Member attended at least four hours of Mental Health Therapy for the purpose of items XXX and XXX, the following will be taken into account:

(iv) where there is documentation in the Records of Treatment of Mental Health Therapy provided by a Mental Health Nurse, 20 minutes will be allocated per interaction between the Member and a Mental Health Nurse, up to a maximum of 60 minutes per day, but this does not include bedside nursing care (for example, provision of medication and taking observations).

30. The PHI attempted to impose a clause on the hospital that defined therapeutic hours in ways that excluded physical health interventions and monitoring. This would have compromised nurses engaging in those roles.

31. Additionally, any PHI insisting on the group psychological therapy component of a psychiatric admission to the exclusion of individual specialist care and other medical care needs of inpatient is neglectful of the clinical care of psychiatrists who are ultimately medicolegally responsible for the healthcare of the patient

32. Any PHI demanding that patients must wholly pay for other medical expenses beyond the treatment of a mental disorder solely because they are in a mental health setting is a 'contractual technicality' rather than good medical practice. It is an approach that would be inconsistent with the Position statement 91 of the Royal Australian and New Zealand College of Psychiatrists titled Private health insurance policies for psychiatric care in Australia[4], which states:

- *"patients who are admitted to a private psychiatric hospital for treatment of a mental disorder should have their coexisting physical health needs treated at the same time, where possible*"

[4] [https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/private-health-insurance-policies-for-psychiatry]