NOTICE OF LODGMENT

AUSTRALIAN COMPETITION TRIBUNAL

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Lodgment and Details

Document Lodged:	Applicant's Statement of Facts, Issues and Contentions
File Number:	ACT 5 of 2021
File Title:	RMSANZ APPLICATION FOR REVIEW OF AUTHORISATION AA1000542 DETERMINATION MADE ON 21 SEPTEMBER 2021
Registry:	VICTORIA – AUSTRALIAN COMPETITION TRIBUNAL

REGISTRAR

Dated: 4/04/2022 9:00 AM

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.

IN THE AUSTRALIAN COMPETITION TRIBUNAL **File No: ACT 5 of**

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

APPLICANT: **REHABILITATION MEDICINE SOCIETY OF AUSTRALIA AND NEW ZEALAND LTD**

APPLICANT'S STATEMENT OF FACTS, ISSUES AND CONTENTIONS

PART A: BACKGROUND FACTS

The Applicant

1. The Rehabilitation Medicine Society of Australia and New Zealand Ltd (**RMSANZ**) is the peak body representing rehabilitation physicians and trainees in Australia and New Zealand.

2. The World Health Organisation defines rehabilitation medicine as the area of medicine which focuses on interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment, following an injury, surgery, disease or illness, or because their functioning has declined with age.[1]

3. Rehabilitation physicians are experts in rehabilitation, managing patients of all ages (including children) who suffer from medical, musculoskeletal, neurological and congenital disorders with an emphasis on maximising functional ability and quality of life. As such, they are integrally involved in the management of patients following surgery (or other primary treatment) through the patient's post-operative and post-hospitalisation phases.

4. Rehabilitation physicians are specialist physicians who are fellows of the Australasian Faculty of Rehabilitation Medicine (**AFRM**), itself a Faculty of the Royal Australasian

[1] https://www.who.int/news-room/fact-sheets/detail/rehabilitation

College of Physicians (**RACP**). Rehabilitation medicine has been recognised as a speciality by the medical board of Australia since 1976. Training to qualify as a rehabilitation physician takes 4 years to complete after the second post graduate year (a total of 6 years of training) and has an extensive qualification process.

5. Rehabilitation consultations assist in patient flow through the hospital system, so that patients can be moved from acute care beds to sub-acute beds in order to create improved capacity in the acute hospitals and emergency departments.

6. Rehabilitation physicians assist patients to achieve optimal quality of life and improve clinical outcomes following illness, injury or complex procedures and treatments, such as orthopaedic surgery, spinal surgery, cardiac surgery, transplant medicine and vascular surgery.

7. Rehabilitation physicians have developed individual Rehabilitation Medicine departments and stand-alone hospitals in both the public and private sector, to offer rehabilitation to those with permanent or temporary disability due to illness, injury or complex surgery and treatments.

8. Specialists and general practitioners refer patients to rehabilitation physicians to manage their rehabilitation needs and to gain opinions on the benefits of accessing rehabilitation facilities with specialised equipment such as hydrotherapy, body weight supported treadmill training, driver training programs and simulators as well as robotics.

9. Rehabilitation physician work closely with orthopaedic surgeons (for matters including fractures, joint replacement, deformity correction), neurologists (for matters including strokes, MS and Parkinson's disease), neurosurgeons (for matters including spinal injuries, brain tumours and head trauma), oncologists and cardiothoracic surgeons (among others).

10. On average, rehabilitation commands approximately 10% of the Australian bed base for hospitalised patients.

11. The RMSANZ advocates for rehabilitation in the home where appropriate, and academic rehabilitation physicians have been researching patient outcomes and the safety of home-based rehabilitation since 2004.

12. The RMSANZ has devised rehabilitation in the home programs in the public sector since 2004.

13. In 2009-2012 rehabilitation physicians in Australia developed rehabilitation in the home programs under a funding arrangement with the Council of Australian Governments National Partnership Agreement on Hospital and Health Workforce Reform (**NPA-HHRWR**), producing reports that consider the health outcomes and cost effectiveness of in-patient rehabilitation programs.[2]

The Application for Authorisation

14. This proceeding concerns an application for Authorisation submitted by Honeysuckle Health Pty Ltd (**HH**) on behalf of itself and nib health funds limited (**nib**) (together, **Authorisation Applicants**), pursuant to s88(1) of the *Competition and Consumer Act 2010* (Cth) (**CCA**) (**Application**).

15. The Applicant participated in the ACCC's public consultation with respect to the Application, making a submission dated 3rd February 2022 and attending the pre-determination conference.

16. Broadly, the Application relates to a proposal pursuant to which:

    a. HH would establish a collective buying group, to be comprised of nib and various other private health insurers (**PHIs**), the precise identity of whose members is yet to be determined, for the purpose of negotiating commercial terms with Australian hospitals (**Hospital Conduct**);

    b. HH would establish a collective buying group, to be comprised of nib and various other private health insurers (**PHI**), the precise identity of whom is yet to be

[2] See, for example, https://rmsanz.net/wp-content/uploads/2021/09/180503-FINAL-Positon-Statement-on-Rehabilitation-following-TKR-compressed.pdf

determined (but excluding Medibank Private Ltd (**Medibank**), BUPA Hi Pty ltd (**BUPA**), Hospital Contribution Fund of Australia Ltd (**HCF**) and HBF Ltd's Western Australian operating entity (**HBF**) (each a **Major PHI**), with the purpose of negotiating commercial terms with individual medical specialists with respect to the commercial basis on which each specialist would treat policyholders of each member of that buying group (**Specialist Buying Group**); and

c. HH would establish a collective buying group, to be comprised of nib and various other PHIs, the precise identity of whom is yet to be determined, with respect to an area of practice referred to by the Authorisation Applicants as the Broad Clinical Partners Program (**BCPP**) (**BCPP Buying Group**) (together with the Specialist Buying Group, **Specialist Conduct**);

d. HH would provide services to each of the collective buying groups, broadly involving:

   I. negotiating contracts with private hospitals on behalf of each of the collective buying groups;

   II. negotiating contracts with individual medical specialists on behalf of each of the collective buying groups; and

   III. collecting and disseminating data amongst each collective buying group with respect to the performance of contracting counterparties under their contracts.

(**Proposed Conduct**)

17. In essence, the Specialist Conduct would be given effect through the entry into contracts between each participating PHI and each medical specialist, known as a Medical Purchaser Provider Agreement (**MPPA**).[3]

[3] As discussed further below, PHIs currently offer to reimburse specialists at applicable rates under contracts which govern the basis on which that reimbursement will be made. That is, that the payment is made as long as the specialist agrees to a cap on the fees charged to the patient. These capped arrangements are discussed in more detail below, but relevantly include "no gap" patient charges. These PHI contracts are known as "gapcover" arrangements.

18. Each MPPA (discussed in further detail below) governs the basis on which a specialist is remunerated by a PHI for services provided to patients in hospitals, either as in-patients or, where applicable, as day patients.

19. The scheme known as BCPP involves specific MPPAs tailored to relate to a whole episode of care which typically involves more than one specialist.[4]

20. For example, orthopaedic work typically involves more than one medical specialist (an orthopaedic surgeon, and one or more of either an anaesthetist, a rehabilitation physician, a geriatrician, a vascular physician, an ICU specialist, a pain physician, a vascular surgeon etc) all providing in-patient services as required to the same patient over a course of treatment.

21. In the case of BCPP, the intent of the Authorisation Applicants is that each of the relevant specialists will enter into a specific form of MPPA which governs all of the services provided by the specialist for that entire episode of care (**BCPP MPPA**).

22. At present, the Authorisation Applicants have identified orthopaedics as clearly falling within BCPP, but the scope of the scheme – or courses of conduct which might be captured by the scheme – is not closed.

Private healthcare in Australia - overview

23. Private healthcare in Australia comprises two elements, being hospital cover and extras.

24. In principle, hospital cover provides cover for patients' in-patient and day-patient care in hospitals, with the precise scope of the cover depending on the level of private cover taken out by the patient. For the most part, private healthcare does not extend to care provided outside of a hospital premises (**out-patient care**), with the exception of some extras, such as physio.[5]

[4] As discussed further below, a BCPP MPPA is – at least at present – an alternative to the standard gapcover schemes and standard MPPAs offered to specialists and involves more complex and tailored terms.
[5] The cost of out-patient care costs is the responsibility of the patient and is subsidised to a specified level under the Medical Benefits Scheme (discussed below). If a specialist or general practitioner charges a patient an amount greater than the fee prescribed under the Medical Benefits Scheme, then the patient is responsible for any additional amount.

25. Each PHI pays an amount in respect of a patient's in-patient or day-patient costs (both hospital charges and those of the treating specialist(s)) up to an agreed amount,[6] on a fee for service basis.

26. Hospital cover is sold as one of four defined product categories, being basic, bronze, silver and gold, with the coverage – and price – increasing through the categories.

27. Palliative care, mental health treatments and rehabilitation are considered basic non – optional services and are provided for in each category of hospital cover.

28. Private insurers provide access to rehabilitation units and wards in both public and private hospitals for those who are referred to a rehabilitation physician by their treating doctor.

29. The treating rehabilitation physician submits a rehabilitation plan to the PHI, indicating the condition which requires rehabilitation, the goals to be achieved and the expected time of discharge.

30. PHI funding is available for inpatient rehabilitation and day rehabilitation services provided in hospital rehabilitation units only, which includes medical supervision of the patient, medical coordination of the allied health team and all allied health and nursing service costs.

31. There are currently no private health insurance products that fund medical supervision, co-ordination or leadership of rehabilitation in the home programs, as the *Private Health Insurance Act 2007* (Cth) (**PHIA**) does not allow PHIs to pay for rehabilitation consultations that take place in a consultation suite or at the patient's home.

32. Private health insurance enables patients to be able to choose their doctor, obtain timely medical interventions (especially for elective surgery), choose their preferred hospital and to have continuity of care with a specialist doctor and treatment team.

[6] In the case of the specialist, agreed under gapcover arrangements or an MPPA and in the case of the patient, agreed under the terms of their insurance policy.

*The Medical Benefits Scheme (**MBS**)*

33. The MBS is a key component of the Australian Medicare system. It establishes a Schedule which lists a range of professional medical services, and allocates a unique item number to each service, along with a description of the service. In broad terms, these include consultation, diagnostic, procedural and therapeutic services.

34. Medicare provides subsidies to patients for services provided by eligible health professionals.

35. The MBS sets out a fee (known as the Schedule fee) for each unique medical service, together with the rate(s) at which the benefit for that service is to be calculated, as well as providing guidance on the clinical and administrative conditions under which benefits can be claimed.

36. Relevantly, under the MBS, Medicare reimburses each patient who holds private health insurance for 75% of the Schedule fee for each in-patient or applicable day-patient service provided to them. PHIs are required to reimburse the patient for the remaining 25% of the Schedule fee.

37. In practice, under gapcover arrangements and standard MPPAs, the patient assigns their right to the Medicare component to the PHI, and the PHI pays both the Medicare component, and an additional component to the specialist as one lump sum amount.

38. Importantly, the Schedule fee reflects a fee-for-service determined by the Australian Government. However, this fee is a government subsidy, and is often substantially lower than the prevailing market fees for the services provided by specialists.

39. The extent of any difference between the MBS Schedule fee and the actual fee charged by the specialist – for which the patient is liable – is known as the “out of pocket” or “gap” amount.

40. Since amendments to the statutory regime governing PHIs in 1995 and 2000 (discussed further below), PHIs have been allowed to enter – and have entered– into either MPPAs

or gapcover arrangements with specialists under which they agree to pay the specialist an amount greater than the 25%, in return for the specialist agreeing to either:

a. charge the patient no extra fees for episodes of care (known as "no-gap" contracts);

b. a known fixed amount extra fee for the patient (known as "known-gap" contracts); or

c. charge the patient an amount agreed between the PHI and the specialist under a standard MPPA.

However, no-gap and known gap contracts were not actually introduced until 2000.

41. In the case of a "no gap" gapcover contract, the insurer sets a schedule of fees based on the Medicare schedule fee and the specialist agrees to be reimbursed by the insurer at the insurer's scheduled fee for each applicable service provided by the specialist, and the specialist agrees not to charge the patient any additional, or out of pocket, amount. This fee is greater than the Schedule fee for that service.

42. In that sense, the traditional gapcover arrangement reflects a purely financial arrangement, in that they have no bearing on the specialist's clinical approach to the treatment of the patient. Such arrangements are ubiquitous.

43. Table 1 below identifies some differences between the Schedule fee and the typical gap component paid by some PHIs under "no gap" gapcover agreements, including nib and members of the AHSA buying group (being the PHIs predicted by the Authorisation Applicants to join in the Proposed Conduct) as well as BUPA (being an example of a Major PHI), together with the fees recommended by the AMA to its members[7], by reference to rehabilitation services provided to in-patients or day-patients.

[7] https://feeslist.ama.com.au/ (subscription only). The Australian Medical Association publishes a guide for its members reflecting its view as to what a fair fee is for each relevant service. This guide is made available to subscribing AMA members under the caveat that the AMA does not represent that the fee list is accurate or current (or that it will be suitable for a specialist's purposes) and on the condition – among others – that each specialist makes their own decisions as to what fees they will charge and that they satisfy themselves in each individual case as to the fee that it is fair and reasonable, having regard to their own practice cost experience and the particular circumstances of the case and the patient (see https://feeslist.ama.com.au/terms , cl 9)

MBS Item	Service Description	Schedule fee	nib no gap fee[8]	AMA recommended fee	BUPA no-gap fee[9]	AHSA no-gap fee[10]
110	Initial consultation	$159.35	$185.35	$ 355.00	$191.00	$170.00 - $194.80
116	Follow up consult	$ 79.75	$ 92.75	$ 164.00	$ 95.60	$ 85.00 - $ 93.50
119	Brief consult	$ 45.40	$ 52.80	$ 88.00	$ 54.45	$ 46.00 - $ 53.50
880	Case conference	$ 51.40	$ 59.65	$ 97.00	$61.65	$ 54.00 - $ 61.60
830	Discharge case conference	$146.90	$170.60	$300.00	$176.20	$154.60 - $176.80

Table 1

44. Almost all rehabilitation physicians operating in private and public hospitals utilise "no-gap" gapcover arrangements (i.e. where the patient faces no out of pocket costs).

45. When receiving referrals for a patient, rehabilitation physicians are generally unaware of the patient's PHI. As a result, rehabilitation physicians – in a practical sense – typically have "no gap" gapcover arrangements in place with all PHIs, so that they are able to access "no gap" benefits for their consultations with privately insured patients.

46. Neither gapcover arrangements nor standard MPPAs offer incentives, request the promotion of any rehabilitation products or affect the clinical independence of rehabilitation physicians, and they do not incentivise the physicians toward quality targets or clinical guidelines developed by the PHI.

PHI contracts with hospitals

47. PHIs typically negotiate contracts with hospitals (both private and public) with respect to the charges that will be levied by the hospital for services provided by that hospital to a patient that holds applicable insurance issued by that PHI. These negotiations lead to

[8] https://www.nib.com.au/docs/medigap-schedule-of-benefits-jan-2022
[9] https://www.bupa.com.au/-/media/Dotcom/Files/For-Provider/Bupa-Medical-Gap-Scheme-Schedules-1-December-2021_v2.xlsx?la=en&hash=FFA1AA715A7330AB36CD573696123071DA5D6F0B
[10] https://www.ahsa.com.au/web/doctors/agc/schedules (different schedules apply for different States and Territories and the cited benefits reflect the range offered across Australia)

contracts between private hospitals and PHIs, which cover costs for inpatient and day-patient care and also include other terms that cover broader service matters.

The legislative landscape

48. Prior to 1995, the private health insurance regime was regulated by various statutes, including the *National Health Act* 1953 (Cth) and the *Health Insurance Act* 1973 (Cth).

49. In 1995, the *Health Legislation (Private Health Insurance Reform) Amendment Act 1995* (**Reform Act**) was passed, introducing the ability for PHIs to enter into MPPAs and pay medical benefits in excess of the Schedule fee for a practitioner's services. Prior to that time, each PHI was restricted to paying medical benefits up to a maximum of the difference between the Medicare rebate and the Schedule fee.

50. The Reform Act was designed to focus on strengthening consumer rights and to address the following concerns:

    a. to reduce the cost of private health insurance premiums and reduce the increasing cost of private health hospitalisation and treatment;

    b. to provide better value for those who take out private health insurance; and

    c. to encourage a wider range of private health insurance products so that consumers are offered more choice about the type of cover which best suits their needs which, it was intended, would be achieved by enabling health funds to enter into contracts with hospitals and doctors.[11]

51. Following passage of the Reform Act, the Senate referred to the Senate Standing Committee on Public Affairs (**Committee**) the task of monitoring the implementation and operation of the Reform Act during its first 12 months of operation.

52. In September 1996, the Committee published a report titled *The Review of The Health Legislation (Private Health Insurance Reform) Amendment Act 1995* (**1996 Report**).

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[11] *Health Legislation (Private Health Insurance Reform) Amendment Bill 1994*, Minister's Second Reading Speech, Senate *Hansard,* 28 February 1995, p.1069.

53. Critically, the Committee observed that "*…it is important that all parties, including government, recognise that sectional interests should not be put ahead of the interests of patients and health fund contributors.*"[12]

54. The Committee acknowledged the argument that contracts with third parties that imposed obligations could seriously compromise the professional independence of doctors or could adversely affect judgements about patient care, but did not consider that it was in a position to properly assess those concerns given the limited uptake of those contracts at that time.[13]

55. Ultimately, the Committee recommended that:

> "…the provisions relating to the implementation of medical purchaser-provider agreements under the *Health Legislation (Private Health Insurance Reform) Amendment Act 1995* proceed, subject to the recognition of the right of the medical profession to treat patients according to their clinical needs, the right of the profession to collectively negotiate contracts, subject to authorisation by the ACCC, and the right to public scrutiny of contracts as provided for in later recommendations."

56. The Committee concluded that:

> "…the concerns of the medical profession in relation to any possible impact of the Reform Act in respect of a doctor's freedom to treat patients need to be addressed appropriately. The Committee, therefore, considers that any contracts offered by funds should contain an unambiguous undertaking to refrain from interfering in the clinical treatment of patients so that the profession may be assured that the doctor-patient relationship is respected at all times and the funds will refrain from interfering or attempting to influence a doctor's treatment of a patient[14]"
>
> and
>
> "…an effective doctor-patient relationship is one in which the doctor's primary obligation is to the welfare of the patient. It is therefore essential that the professional independence of doctors should be preserved. The Committee believes that this independence will not necessarily be threatened by contracts entered into between doctors and funds, provided that the agreements respect the primacy of the doctor-patient relationship, and refrain from interfering in, or attempting to influence, a doctor's treatment or care of a patient. The Committee considers that as few contracts have been concluded to date, a proper assessment of whether contracts pose a threat to the right of doctors to treat consumers according to their clinical needs cannot be made at this stage of the inquiry."[15]

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[12] 1996 Report, para 2.47
[13] 1996 Report, para 3.14
[14] 1996 Report, para 3.31
[15] 1996 Report, para 3.34

The *Health Legislation Amendment (Gap Cover Schemes) Act 2000* (GCSA)

57. The new MPPAs were largely unsuccessful with a senate committee reporting that fewer than 100 medical practitioners across Australia had signed up to the new agreements after two years of operation.[16]

58. The failure of MPPAs led to the introduction of the GCSA which had a stated objective of controlling medical fees without contracted arrangements. The then Federal Health Minister stated:

> "'This Bill amends the National Health Act 1953 (NHA) and the Health Insurance Act 1973 (HIA) to provide for gap cover schemes. The purpose of these schemes is to enable registered health benefits organisations to provide no gap and/or known gap private health insurance without the need for contracts."[17]

59. Despite the Minister's statement that gapcover arrangements do not require contracts, research has demonstrated that up to five parties are involved in gapcover transactions, all having various contracts and legal relationships with each other that collectively determine the fate of the Medicare rebate at the heart of each transaction.[18]

The *Private Health Insurance Act* 2007 (Cth) (PHIA)

60. In 2007, the PHIA came into law, replacing the prior regime that had governed private health insurance in Australia (at that time, mainly contained in the *National Health Act* 1953 (Cth), the *Health Insurance Act* 1973 (Cth) and the *Private Health Insurance Incentives Act* 1998 (Cth)), and introducing a comprehensive regulatory regime for the private health insurance sector.

61. Significantly, the PHIA did not alter the GCSA, which remain in force today as the enabling legislation for the ubiquitous gapcover arrangements.

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[16] https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/1996-99/health/report/c03

[17] https://www.legislation.gov.au/Details/C2004B00655/Explanatory%20Memorandum/Text

[18] Faux et al, Medicare Billing, Law and Practice: Complex, Incomprehensible and Beginning to Unravel. J Law Med. 2019 27(1):66-93

62. Chapter 4 of the PHIA imposes various obligations imposed on PHIs. Relevantly, clause 172-5(1) provides that:

> *"Medical purchaser-provider agreements*
>
> (1) If a private health insurer enters into an agreement with a *medical practitioner for the provision of treatment to persons insured by the insurer, the agreement must not limit the medical practitioner's professional freedom, within the scope of accepted clinical practice, to identify and provide appropriate treatments."

63. This approach reflected the ongoing concern – previously identified by the Committee – of ensuring the primacy of the welfare of the patient in the context of any commercial arrangement.

64. This was reflected in the course of the Minister's second reading speech prior to the passage of the PHIA, where the then Minster for Health and Ageing stated that:

> "The bill also ensures that the contracts that doctors have with insurers may not limit the clinical freedom of doctors to choose the most appropriate treatment for their patients."[19]

The difference between gapcover, the standard MPPAs and the BCPP MPPA

65. As described above, gapcover arrangements are offered by PHIs to every specialist (other than pathologists) and the governing terms of these arrangements (including as to the amount of the PHI's contribution over and above the Schedule fee in the case of "no gap" or "known gap" arrangements are published by each PHI on their website.

66. A specialist may elect to service a patient outside of gapcover, on a patient by patient and service by service basis. When this happens, the PHI will not contribute any more than 25% of the Schedule fee towards the patient's costs (although, for reasons discussed below, there is a commercial disincentive for specialists to do so).

67. Under standard MPPAs, a specialist agrees to the terms of the MPPA for all patients, and relinquishes the right to charge amounts to patients that fall

[19] House Hansard, 7 December 2006, page 6, *Private Health Insurance Bill* 2006, Second Reading Speech

outside the fees agreed under the MPPA, although critically, clinical independence is not affected – the restriction is purely financial.

68. In contrast to existing gapcover arrangements and standard MPPAs discussed above, the specific MPPAs contemplated for being used in accordance with the BCPP require the specialist to comply with its terms for every applicable service provided during its term; the specialist has no discretion whether to comply or not – both with respect to the fees that can be charged and also with respect to any other obligations imposed under the MPPA in the BCPP framework.

69. The terms of standard MPPAs and BCPP MPPAs are not publicly available.

The current landscape for the provision of private health care in Australia

70. There are currently 35 PHIs in Australia[20], with the three largest insurers – the Major PHIs – accounting for approximately 62% nationally and nib accounting for approximately 10% nationally.

71. The balance of the market is made up of smaller insurers who also negotiate with the assistance of collective buying groups.

72. The largest of the existing collective buying groups – and, according to the Authorisation Applicants, the forecast source of many of the likely participants in the buying group to be established by them – is the Australian Health Service Alliance (**AHSA**), a not for profit organisation.

73. Presently, AHSA represents 23 of the 35 PHIs operating in Australia,[21] together accounting for approximately 19% of the national PHI market.[22]

74. The funds represented by AHSA each offer gapcover arrangements and standard MPPAs, none of which include performance targets.

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[20] See https://www.privatehealth.gov.au/dynamic/insurer. However, several of these are related entities of others e.g. nib owns G U Health and HBF owns CUA Health. As such, the list understates the degree of concentration in the market.

[21] https://www.ahsa.com.au/web/fundlist

[22] fhttps://www.ahsa.com.au/web/doctors/forms/registration__direct_credit_authority

The ACCC Determination

75. On 8 April 2021, the Authorisation Applicants amended their application to revise the scope of the Proposed Conduct (**Revised Application**) and, particularly, the identity of the PHIs which could participate in the Specialist Conduct.

76. Under the Revised Application, the Authorisation Applicants excluded from their application the provision of contracting services to the Major PHIs, ***other than*** with respect to MPPAs for the purposes of the BCPP[23].

77. However, the scope of the Proposed Conduct was stated to expressly include the provision of contracting services to *all* PHIs (including the Major PHIs) with respect to MPPAs to be used as part of the BCPP.

78. The scope of courses of care (or specialities) which *could* be covered by the BCPP is not limited in any way.

79. On 21 April 2021, the Authorisation Applicants further amended their authorisation application (**Further Revised Application**) to limit the Specialist Conduct in respect of BCPPs to a maximum of 80% of the national private health insurance market (based on the number of hospital policies) (**Amended Proposed Conduct**).

80. On 21 May 2021, the ACCC published a Draft Determination, proposing to grant authorisation for the Amended Proposed Conduct, on condition that HH not supply services to any Major PHI as part of the BCPP if that supply would mean that HH was supplying services under the BCPP to PHIs in a State or Territory that collectively accounted for more than 40% of private health insurance policies issued in that State or Territory.

81. On 21 September 2021, the ACCC published its Determination in respect of the Application, granting conditional authorisation to:

[23] See Attachment A to Minter Ellison's letter of 8 April 2021, paragraphs 2.15 – 2.17 and 2.24. The Authorisation Applicants submitted to the ACCC that nib's current MPPAs were limited to pathologists and radiologists (on the one hand) and BCPP – being orthopaedic surgeons, assistant surgeons and anaesthetists (on the other hand).

- HH and nib;
- PHIs other than certain Excluded Entities (being the Major PHIs);
- International medical and travel insurance companies;
- governmental and semi-governmental payers of healthcare services; and
- any payer of health services of goods notified the ACCC, other than the Excluded Entities

  (together, **Authorised Entities**)

82. The authorisation applied in respect of the formation and operation of the collective buying group, including the provision of services to Authorised Entities, and the acquisition of contracting services by Authorised Entities from Honeysuckle Health in respect of the Hospital Conduct and the Specialist Conduct.

PART B: ISSUES

83. The principal issue before the Tribunal is whether the Amended Proposed Conduct, as contemplated by the Further Revised Application, satisfies the statutory criteria set out at s90(7)(b) of the CCA, in that it:

    a. would result, or be likely to result, in a benefit to the public; and

    b. the benefit would outweigh the detriment to the public that would result, or be likely to result, from the conduct.

PART C: CONTENTIONS

84. Pursuant to s101 of the CCA, the Application for a Review is a *de novo* rehearing of the Application.

85. The relevant application for the purposes of this hearing is the Further Revised Application, being the final form of application for authorisation submitted to the ACCC for its consideration.

86. The Applicant only takes issue with the Specialist Conduct and does not specifically seek a review in respect of the Hospital Conduct. However, the Applicant notes that it is for the Authorisation Applicants to satisfy the Tribunal that each of the Hospital Conduct and Specialist Conduct satisfy the criteria in s90(7)(b).

87. The Applicant contends that the relevant factual is the future in which nib and other participating PHIs collectively negotiate with private hospitals and independent specialists in accordance with the Amended Proposed Conduct.

88. The Applicant contends that the relevant counterfactual is the future in which the Amended Proposed Conduct does not occur – at least as far as the Specialist Conduct is concerned – and that and the status quo (at least in respect of the Specialist Conduct) is maintained.

89. The role of the Tribunal is to assess whether the Proposed Conduct satisfies the statutory test under s90(7) of the CCA.

Future with and without

90. The Applicant submits that in the future with the Amended Proposed Conduct:

    a. the members of the BCPP Buying Group (including the Major PHIs) would be likely to collectively negotiate BCPP MPPAs with applicable specialists (whether in the form of MPPA provided to the ACCC or in a different form, given that the scope of these contracts remains undefined);

    b. the members of the Specialist Buying Group would be likely to collectively negotiate MPPAs with individual specialists, with provisions consistent with those in the form of MPPA provided to the ACCC; and

    c. specialists would have no option but to enter into the arrangements proposed by members of the Specialist Buying Group and/or the BCPP Buying Group.[24]

[24] In the case of MPPAs proposed by the Specialist Buying Group, this is even more the case for rehabilitation specialists, given that they rely on referrals from other specialists and do not know the identity of the relevant PHI when accepting the referral.

91. The Applicant submits that in the future without the Amended Proposed Conduct:

    a. each of the Major PHIs would be required to separately negotiate MPPA terms with specialists;

    b. HH would not be able to jointly represent nib and each of the participants in the BCPP Buying Group and/or the Specialist Buying Group in collectively negotiating MPPAs with specialists; and

    c. rehabilitation specialists – and other specialists – would be unlikely to enter into any form of MPPA which imposed conditions that extended beyond those currently found in MPPAs – and, in particular, of the kind identified below in the form of MPPA provided by the Authorisation Applicants to the ACCC.

92. The role of the Tribunal is to assess whether the Proposed Conduct satisfies the statutory test under s90(7) of the CCA.

Public detriments

93. As stated above, for the purposes of this proceeding, the Applicant does not take issue with the Amended Proposed Conduct insofar as it relates to proposed collective negotiations with private hospitals.

94. Insofar as the application seeks authorisation for the Specialist Conduct, the Applicant contends that:

    a. allowing the Major PHIs to participate in BCPP Buying Group (to any extent, let alone up to 80% of a State or Territory market) would be likely to create significant public detriment (and that even excluding the Major PHIs from BCPP Buying Group is unlikely to adequately mitigate those public detriments); and

    b. allowing the Specialist Buying Group to undertake collective negotiations as contemplated by the Revised Proposed Conduct would be likely to create significant public detriment.

95. The principal public detriment identified and relied upon by the Applicant is that the Specialist Conduct, as reflected in the form of MPPA submitted by the Authorisation Parties to the ACCC (titled "nib health funds limited MPPA Short Stay No Gap, Feb 2021" (**nib BCPP MPPA**)), is likely to result in interference with each clinician's independent objective assessment of the course of treatment likely to be in the best interests of their patient.

96. In essence, the Applicant asserts that provisions in the nib BCPP MPPA either:

    a. contravene clause 172-5 of the PHIA, in that they limit the medical practitioner's professional freedom, within the scope of accepted clinical practice, to identify and provide appropriate treatments; or

    b. otherwise provide incentives or inducements for the medical practitioner to behave in a manner which could reasonably be considered to be contrary to the best clinical outcome for a patient.

97. The Applicant understands that the nib BCPP MPPA relates to the BCPP. However, in the absence of any indication from the Authorisation Applicants to the contrary, the Applicant contends that there is no reason to believe that the general terms of any MPPA negotiated by the Specialist Buying Group would be meaningfully different.

98. The nib BCPP MPPA contains an extensive list of undertakings which must be provided to nib (and, it is assumed, any PHI proposing to participate in the Buying Group).

99. Relevantly, these include:

    a. if clinically appropriate, work towards a percentage target for admission to overnight in-patient programs that reflects a percentage of that type of treatment being obtained by the fund's members;[25]

    b. the admission of clinically appropriate patients to home based rehabilitation;[26]

[25] nib BCPP MPPA, paragraph 7(e)
[26] nib BCPP MPPA, paragraph 7(g)

c. the specialist consenting to the disclosure and publication of Practitioner Information and Public Performance Data relating to each specialist's patients;[27] and

d. an obligation to collect and provide Confidential Performance Data to HH's nominee.

(together, **Undertakings**)

100. The nib BCPP MPPA states that:

a. nib is not a health professional or practice;[28]

b. nib will not interfere with, and acknowledges the independence of, the specialist;[29]

c. nothing in the MPPA limits the specialist's professional freedom, within the scope of accepted clinical practice, to identify and provide appropriate treatments;[30] and

d. without limiting the specialist's independence, the specialist will follow clinical guidelines as nib may reasonably require from time to time.[31]

101. The Applicant contends that:

a. while the terms of paragraph 10.2 of the nib BCPP MPPA (set out above) are reflective of the language of clause 172-5 of the PHIA, the reality is that the adoption of targets for clinical outcomes is fundamentally inconsistent with the notion of clinical independence; and

b. while the Undertakings are couched in terms of being subject to "clinical appropriateness", the fact that the nib BCPP MPPA reserves to nib – which accepts that it is not a health practice or health professional – the ability to require the specialist to adhere to clinical guidelines imposed by nib, raises real concerns that the specialist's clinical independence may ultimately be subject to the PHI's commercial imperatives, rather than the best interests of the patient.

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[27] nib BCPP MPPA, paragraph 7.3
[28] nib BCPP MPPA, paragraph 10.1
[29] nib BCPP MPPA, paragraph 10.2
[30] nib BCPP MPPA, paragraph 10.2
[31] nib BCPP MPPA, paragraph 10.3

Risk of behaviour inconsistent with patients' best interests

102. A key risk arising from the terms of the nib BCPP MPPA is that a PHI might cease to offer that agreement (which would be expected to provide higher reimbursement in return for the Undertakings) in the future to a specialist who fails to meet relevant performance targets, such as discharge rates or failing to meet nib clinical guidelines.

103. In those circumstances, it is entirely foreseeable that the specialist will take steps to ensure that they remain able to offer no gap coverage to patients insured by the relevant PHI, and this could involve the making of clinical decisions that are not necessarily in the best interests of the patient.

104. Further, nib BCPP MPPA requests orthopaedic surgeons to refer all clinically appropriate eligible patients to undertake post-surgery rehabilitation in an "at home" patient rehabilitation support program.

105. While the request is caveated by the reference to "clinically appropriate eligible patients", the very fact that targets are set for this request suggests that it interferes with clinical independence.

106. Significantly, the nib BCPP MPPA provides no indication as to who will have the responsibility for medical oversight of the patient while they receive in home rehabilitation. It makes no provision for how falls, post-operative complications, instability of pre-existing medical conditions and pain medication prescribing will be managed. This fact alone is indicative of the emphasis of the nib BCPP MPPA of the patient's discharge from hospital, rather than their welfare.

107. The nib BCPP MPPA requires the *orthopaedic surgeon* to refer all clinically appropriate eligible patients for rehabilitation the home following joint replacement. This assessment represents an out-of-scope practice by orthopaedic surgeons and is an assessment which should only be made by the rehabilitation physician.[32]

[32] NSW Health has published a scope of practice document which supports the view that rehabilitation in all settings is within scope of rehabilitation physicians and not within the scope of those practicing in surgical specialities. See https://www.health.nsw.gov.au/services/Pages/role-delineation-of-clinical-services.aspx

108. The appropriateness of an at-home rehabilitation program for a given patient should be determined by a rehabilitation medicine specialist who is specifically trained to make this assessment, taking into account a clinical assessment of the patient, their home setting and other psycho-social determinants of likely rehabilitation outcomes.[33]

109. While cl 7(h) of the nib BCPP MPPA obliges the specialist to make the patient aware that the doctor has signed an MPPA (and requests the specialist to notify the patient about the rehabilitation in home and support program), cl 19 provides that no aspect of the contents of the MPPA can be disclosed to any person. As such the patient would not be made aware of financial incentives offered to specialists to achieve targets in same day surgery and referral for in home rehabilitation. These financial incentives may affect clinical decision-making and consumer choice.

110. Currently, when a rehabilitation physician assesses a patient following a joint replacement operation and identifies them as clinically appropriate for rehabilitation at home, the patient has 3 choices. They can choose to be treated at home under medical supervision; they can choose to attend a day rehabilitation facility 2 -3 times a week for a set number of sessions, or they can choose to be admitted for overnight rehabilitation for a specific number of days (7 days on average). This allows patients to plan the timing of their surgery and ensure they have relevant resources or carers available in the home.

111. The nib BCPP MPPA requires the specialist to refer 100% of clinically appropriate patient to medically unsupervised rehabilitation in the home. The nib BCPP MPPA does not indicate that the consumer can play a role in decision-making. Indeed, it ties financial incentives to achieving targets for in home rehabilitation. As such, it dramatically reduce consumer choice.

Disclosure of confidential information

112. To the extent that such data might be used to benchmark clinicians, this will further contribute to the public detriment which arises as a result of providing incentives to

[33] In 2018, the RMSANZ produced an evidence based position paper, designed to indicate which patients are suitable for in-patient rehabilitation as opposed to ambulatory rehabilitation (being at home or outpatient rehabilitation) – see https://rmsanz.net/wp-content/uploads/2021/09/180503-FINAL-Positon-Statement-on-Rehabilitation-following-TKR-compressed.pdf)

clinicians to act in a manner that might benefit their rating, rather than their patient's best interests.

113. While access to de-identified data or identifiable data with patient consent may offer a benefit for the quality of patient care, the Authorisation Applicants have not indicated how they would use the data.

114. Deidentified data on all rehabilitation episodes from all rehabilitation hospitals in Australia has been maintained by the Australian Rehabilitation Outcomes Centre (**AROC**) since 2002.[34] The Authorisation Applicants have made no reference to the AROC data, or why that data is insufficient – if that is the case – for their needs.

115. The Authorisation Applicants have indicated that they will develop their own "quality targets" and "clinical guidelines", although they have not provided any indication as to how or whether the collected data will assist them in developing their targets or guidelines.

116. While the collection of data may be theoretically beneficial to the consumer if it is tied to a robust process for improving clinical outcomes, the Authorisation Applicants have not provided any evidence to support this being a proposed outcome.

Inappropriateness of any requirement on a specialist to follow PHI guidelines

117. While evidence-based national guidelines *may* generate some benefits for patients, this can only occur when the guidelines:

a. are produced by, and under the control of, expert medical opinion;

b. follow guideline development protocols determined by recognised independent research entities such as the NHMRC; and

c. have the aim of maximising patient safety, clinical outcomes, efficacy and effectiveness, rather than minimising costs (the latter being potentially inconsistent with the best interests of the patient).

[34] https://www.uow.edu.au/ahsri/aroc/about/

118. Genuine individualised rehabilitation programs require the rehabilitation specialist to formulate a program that takes into account each patient's specific circumstances, including their at home needs, living environments and personal medical and psychiatric conditions and circumstances.

119. Any attempt by a PHI to develop and apply guidelines for decisions relating to the rehabilitation treatment of patients – including where, how and the timing of rehabilitation – seeks, by definition, to homogenise a diverse and variable group of patients and a set of unpredictable patient needs.

120. This detriment would be exacerbated in the event that a Major PHI was permitted to join in the Buyer Group.

Discretion to refuse to enter into an MPPA

121. While, strictly speaking, it is true that a specialist may elect whether or not to service a patient under gapcover arrangement or MPPAs (as opposed to the proposed nib BCPP MPPA, where no such option exists), it is disingenuous for the Authorisation Applicants to suggest that "*MPPAs are not critical to medical specialists, but are seen as an optional arrangement*", and that the statutory rights bestowed upon specialists by virtue of the MBS mean that insurers often do not have strong bargaining power when negotiating with medical specialists.[35]

122. In the Applicant's contention, these propositions are simply not supported by commercial reality.

123. As discussed above, there is typically a broad difference between the Schedule fee and the market rates for specialist services.

124. In reality, this means that if a rehabilitation physician (or, for that matter, any other specialist) failed to enter into an MPPA with a PHI, then treatment of members of that PHI would not be governed by any gap arrangement.

[35] Application for Authorisation, 23 December 2020, paragraph 5.13

125. As a result, a specialist would be confronted with the option of charging the patient the Schedule fee (which would be reimbursed by the PHI and Medicare on a 25:75 basis), or charging their standard fee, which would result in the patient facing a gap payment.

126. Given that patients are unlikely to want to pay a gap fee, and specialists are unlikely to be prepared to reduce their fees to the Schedule fee, the specialists would be commercially compelled to enter into the proffered MPPA where the negotiating counterparty represented more than a *de minimis* number of private health insurance policyholders.

127. This issue may be exacerbated in the case of the nib BCPP MPPA. That is, given the concerns expressed above with respect to the nib BCPP MPPA and that rehabilitation specialists are already able to enter into MPPAs with nib, it would appear that a rehabilitation specialist would only be likely to enter into the nib BCPP MPPA if:

a. the level of reimbursement offered under the nib BCPP MPPA was materially higher than currently offered under MPPAs (thereby reinforcing the commercial incentives); and/or

b. the standard MPPA was withdrawn, leaving affected specialists with no commercial option, but to enter into the nib BCPP MPPA.[36]

128. The Authorisation Applicants assert that an approximate market share of 20% (being within the forecast market share of each of the Buying Groups) would enable them to achieve their intended commercial outcomes.[37]

129. This conclusion is also shared by the Applicant, which considers that most specialists will have no commercial alternative, but to enter into the proposed MPPAs.

130. In addition to the factors set out above, a further relevant consideration for specialists is that where a patient is serviced under an MPPA, the PHI undertakes all of

[36] The Applicant accepts that this has not been suggested by the Authorisation Applicants, but the Applicant considers that this strategy would make logical sense, particularly given the extent of objections to the current form of the nib BCPP MPPA.
[37] Letter from Minter Ellison to ACCC, 8 April 2021, at paragraphs 4.2 – 4.3

the back-office administration associated with processing the no-gap contribution and obtaining the Schedule fee component from Medicare. In that sense, specialists have an additional disincentive to servicing a patient outside of the MPPA.

Public Benefits

131. Insofar as the Authorisation Applicants identify various public benefits arising by reason of the Proposed Conduct, the Applicant contends that the value of these benefits is speculative or overstated.

132. The principal benefits identified associated with the Specialist Conduct are described as:

a. transaction cost savings and efficiencies;

b. greater choice of buying group;

c. better health outcomes at a lower cost;

d. reduced healthcare costs and premiums for members;

e. no-gap experience; and

f. access to data and analytics.

Transaction costs and efficiencies

133. The Applicant accepts that collective bargaining is likely to generate some degree of cost saving and efficiency, particularly for smaller participating PHIs.

134. However, it is far from clear the extent to which the saved transaction costs are largely attributable to negotiations with hospitals (which understandably require significant resources, separate complex negotiations and specific contracts[38]), as opposed to the negotiations with specialists.

[38] See Application for Authorisation, 23 December 2020, paragraph 4.4

135. In the Applicant's experience, any savings in respect of individual specialist are unlikely to be meaningful, as the MPPAs are offered on a pro-forma basis to specialists.

136. The Authorisation Applicants' submissions to the ACCC do not provide any meaningful insight as to any transaction cost benefits arising from collective negotiations with specialists.

137. To the extent that these are in the form of consolidated back-office functions, the Authorisation Applicants accept that such benefits will be more limited for those PHIs who are members of existing buying groups.[39]

138. Relevantly, in this respect, is the fact that many of the smaller PHIs forecast to join the nib/HH buying group are already members of the AHSA who benefit from scale efficiencies. The Authorisation Applicants have not provided any evidence to suggest that the incremental efficiency for these PHIs is material, or otherwise relevant as a form of public benefit.

Greater choice of buying group

139. The Applicant does not accept that the introduction of a further buying group generates any meaningful public benefit, over and above the competitive tension that already exists in the market.

Better health outcomes at a lower cost

Lower cost

140. The Authorisation Applicants assert that "*the key public benefit*" of the general gap scheme and treatment networks is in the provision of access to efficient prices at low transaction costs, thereby reducing healthcare costs and premiums for consumers.[40]

141. The Applicant rejects this proposition and contends that while the collective bargaining may well have the result of reducing transaction costs and the cost of providing healthcare services *by the PHI,* there is no basis for suggesting – let alone

[39] See Application for Authorisation, 23 December 2020, paragraph 4.9
[40] Letter from Minter Ellison to ACCC, 8 April 2021, at paragraphs 4.4

concluding – that any such savings would be likely to be passed on to consumers in the form of lower premiums.

142. Further, such savings – to the extent that they exist – would be likely to be short term savings and fail to account for longer term costs arising from possible relapse, medical complication, corrective surgical procedures (such as manipulation under anaesthesia) or extended outpatient care. In many instances, such savings are illusory, as they are simply shifted from the PHI on to the patient (for out-patient treatment) or the Government (for services provided through the public health system).

143. In fact, as a for-profit organisation, the primary goal of nib – and each other for-profit PHI - is to generate profits for its shareholders. The Applicant does not challenge the appropriateness of the for-profit healthcare model; only that it is entirely inconsistent with any suggestion that savings would be passed on to consumers. There is simply no evidence to support this critical element of the public benefit relied upon by the Authorisation Applicants.

144. The Applicant also rejects the relevance of HH's parent's experience in the United States, as the private health environment in the United States is fundamentally different to that in Australia.

145. The Applicant accepts that a reduction in costs *per se* – even if not passed on to consumers – can be a form of efficiency capable of constituting a public benefit. However, the extent of any such benefit in the present case is unquantified, remains speculative and is outweighed by the public detriments identified above. Further, the Applicant contends that the economic benefit of any such savings is diluted – or possibly even extinguished – if those costs are simply shifted to another party.

Better health outcomes

146. The Applicant does not accept that the Specialist Conduct is likely to result in better health outcomes. For the reasons discussed above, the Applicant contends that the structure of the nib BCPP MPPA is likely to result in decisions being made by clinicians as a result of non-clinical considerations, such as performance targets or meeting nib's

clinical guidelines. This will also be true in the event that similar provisions to those objected to in the nib BCPP MPPA are included in standard MPPAs.

147. The Authorisation Applicants have stated that HH will collect and aggregate claims data, following which it will establish performance benchmarks against which a specialist will be assessed.[41]

148. The Applicant contends that while these benchmarks may reflect an average or median outcome, they cannot adequately reflect the specific nuances of each particular patient or their clinical circumstances. As such, the financial incentives to which they are tied, seek to influence – or are likely to have the effect of influencing – specialist treatment on specific cases where the patient's specific circumstances may not be adequately considered. In this sense, the use of this data may not be in the best clinical interests of the patient.

149. The Applicant further contends that the Specialist Conduct may well result in increased costs for patients if, for example, the patients are discharged earlier than a clinician might otherwise discharge them, and the patient requires ongoing out-patient care at home or in private practice, in the place of in-patient care. Unlike the in-patient care, such out-patient care would not be covered under the PHIA at all and patients would be liable for any charges in excess of any applicable Medicare rebate for general practitioner or specialist services.

Reduced healthcare costs and premiums for members

150. As discussed above, the Applicant contends that there is no basis for attributing any weight to the contention that savings achieved by for-profit PHIs will be passed on to policyholders, in part or in full, either by way of lower premiums of deferred increases in premiums.

151. Further, as noted above, PHIs do not cover costs associated with consulting room based outpatient episodes of care, and MPPAs cannot regulate – nor cover – fees

[41] See further Application for Authorisation, 6 May 2021, paragraphs 4.18 - 4.19

charged by specialists for those services, including planned procedures or courses of treatment.

152. In the case of patients referred to rehabilitation in the home, any consultations with specialists or general practitioners in the community cannot be covered through no gap arrangements and patients are likely to be required to pay any out of pocket expenses for medical services while receiving rehabilitation and support programs in the home.

153. To the extent that those services are provided in the home, rather than in hospital, the requirement to discharge patients to at home care simply shifts the burden from the PHI to the patient in a non-transparent manner. As such, the proposed conduct is unlikely to reduce costs for patients.

No-gap experience

154. The Applicant accepts that the introduction of a no gap experience for policyholders is a public benefit.

155. However, the weight of that benefit must be assessed having regard to the future with and without the Specialist Conduct.

156. It is the Applicant's understanding that almost all rehabilitation specialists already provide in-patient services on a no gap basis. That being the case, the Specialist Conduct is unlikely to introduce any benefit not already being enjoyed by policyholders with respect to rehabilitation care.

157. More generally, the Applicant does not object to the collective negotiation of commercial terms for no-gap services (or known gap services, in the event that nib chooses to offer them in the future); rather, its objection remains targeted to those non-price elements of an MPPA which otherwise generate the public detriments discussed above, and in respect of which it objects.

Access to data and analytics

158. The Applicant accepts that access to some data and analytics might generate some public benefit although, again, it is unclear what value this data might have in the context of the Specialists Conduct, as opposed to the Hospital Conduct.

159. That said, the Applicant remains concerned that the sharing of data – beyond that ordinarily acquired by PHIs in processing claims – may have the effect of ultimately impacting upon independent clinical decision making if it is used for the purpose of establishing clinical targets.

Net public benefit

160. In the circumstances, it is the Applicant's contention that the public benefits of the Amended Proposed Conduct (many of which are asserted, but which are not capable of being verified) are significantly outweighed by the associated likely public detriments and that the Amended Proposed Conduct does not satisfy the net public benefit test set out at s90(7)(b) of the CCA.

161. While the Applicant accepts that some forms of co-ordination may result in improved outcomes for patients, it contends that the tipping point towards public detriment occurs when – as is the case here – the contractual arrangements between the PHI and the treating specialist are likely to result in the independence of the specialist being compromised.

Orders sought from the Tribunal

162. As indicated above the Applicant does not object to the Amended Proposed Conduct insofar as it relates to hospitals.

163. Insofar as the Amended Proposed Conduct relates to Specialist Conduct, the Applicant seeks the following orders from the Tribunal:

a. that none of Medibank Private Ltd, BUPA Hi Pty ltd, Hospital Contribution Fund of Australia Ltd and HBF Ltd (in respect of Western Australia) may participate in

any collective bargaining conduct with respect to the commercial arrangements to be entered into between them and individual medical specialists; and

b. insofar as HH is permitted to represent PHIs with respect to the negotiation of the commercial terms on which individual specialists will be compensated for providing specialist services to holders of private health insurance policies, the Applicant seeks an order that no contract negotiated with, or offered to, individual specialists (whether as part of BCPP or otherwise):

I. include any target percentages for admissions or treatment outcomes;

II. permit any assessment of the appropriateness of rehabilitation care in the home to be undertaken by any specialist other than a rehabilitation medicine physician;

III. require patients to be discharged to rehabilitation in home treatments where the clinician's reasonable independent assessment is that in-patient treatment is in the patient's best interests;

IV. require any specialist to agree to a contract term which requires the specialist to have regard to any clinical or treatment guideline formulated by any organisation other than a recognised and independent academic specialist body representing or including representatives of that area of medical specialisation and informed by evidence based research; or

V. otherwise, in the clinician's reasonable opinion, have the likely effect of interfering with the clinician's reasonable independent assessment of the ideal treatment of each patient.

4 April 2022

D Preston

Owen Dixon Chambers West

Rehabilitation Medicine Society of Australia and New Zealand Ltd