NOTICE OF LODGMENT

AUSTRALIAN COMPETITION TRIBUNAL

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Lodgment and Details

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

REGISTRAR

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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	Prof Philip Leo Patrick Morris AM
Address	Unit 201, Level 2, 50 Marine Parade, Southport QLD 4215
Occupation	Psychiatrist
Date	10 May 2022

I, Philip Leo Patrick Morris, say as follows:

1. I am a psychiatrist and President of the National Association of Practising Psychiatrists (**NAPP**) and am authorised to make this statement on NAPP's behalf.

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

3. I am a psychiatrist with 37 years of experience in public psychiatry, academic psychiatry and private practice. I have trained and practiced in psychiatry in Australia and in the USA. I have been responsible for patient care throughout my career and established the Australian National Centre for War-related Post Traumatic Stress Disorder and well as creating a national program of psychiatric rehabilitation for veterans and ex-defence force personnel before entering current private practice.

Curriculum Vitae

4. I hold a MBBS (Hons), BSc med (Hons), and PhD. I am qualified in psychiatry and addiction medicine in Australia and am a Fellow of the Royal Australian and New Zealand College of

Psychiatrists (FRANZCP) and a member of the Faculty of Forensic Psychiatry, the Faculty of Psychiatry of Old Age, and the Faculty of Adult Psychiatry of that College. I am also a Fellow of the Australasian Chapter of Addiction Medicine (FAChAM) of the Royal Australasian College of Physicians.

5. I am a Distinguished Fellow, Treasurer and Board Director of the Pacific Rim College of Psychiatrists, member of the Repatriation Pharmaceutical Reference Committee and a senior medical advisor to the Department of Veterans' Affairs.

6. I am a visiting professor of psychiatry at Bond University and have held professorial positions in psychiatry at the University of Melbourne and the University of Queensland, and am involved in teaching medical students and mentoring doctors training in psychiatry.

7. I am qualified in general adult psychiatry and geriatric psychiatry and addiction medicine in Australia, and Board Certified by the American Board of Psychiatry and Neurology in general psychiatry and geriatric psychiatry.

8. I currently have a private psychiatric practice on the Gold Coast, specializing in the psychiatry of older age, medico-legal assessments, and addiction medicine.

Private health insurers' role in funding specialist services

9. The Australian Health system is a hybrid system. It involves a public sector component and a private sector component. The public sector component is funded through the Commonwealth and the States and provides free hospital care for both inpatients and outpatients, and Medicare subsidised outpatient care for general practice and specialist care.

10. Private hospital inpatient care can be paid for directly by patients but this is expensive and most patients take out private health insurance in order to cover the majority of the costs for private hospital admission. Private health insurance covers the accommodation and other costs of private hospital admission and also contributes towards (or covers, depending on the type of policy) the fees of medical specialists seeing patients in private hospitals for consultations and for surgical and other interventions.

11. Under the Medicare Benefits Scheme, the commonwealth government establishes a base amount that the commonwealth government has determined should be reimbursed to each practitioner for each type of medical service provided by them. These amounts are recorded on the Schedule to the scheme (each, a **Schedule fee**).

12. In the case of patients with private health insurance treated as inpatients or, in some cases, day patients, the commonwealth reimburses the medical specialist an amount equal to 75% of the Schedule fee for each specialist service. Where a patient is insured with a private health insurer (**PHI**), the PHI is responsible for the remaining 25% of the applicable Service fee(s).

13. In most cases, a specialist will also have a contract with the patient's insurer under which the PHI and insurer agree on an amount to be reimbursed if the specialist agrees to either treat the patient on a "no gap" or "known gap" basis. In those instances, the reimbursement typically reflects a material premium to the applicable Schedule fee.

14. Under these contracts between specialists and PHIs, the PHI also provides the specialist with billing and administrative services which include the PHI pays the specialist the agreed amount and then obtains the applicable contributions from the patient and commonwealth. This service means that the specialist does not have to bill patients and health insurers individually and represents a considerable saving in administration and cost for the specialist.

15. In the practise of private psychiatry in private hospitals, the no gap arrangement with PHIs has been popular. Nearly all psychiatrists have such arrangements, and covered patients do not pay any additional out of pocket expenses for psychiatric specialist services while inpatients in private hospitals.

Contracts with terms beyond 'no gap' and 'known gap' commercial arrangements

16. It is important to note that the typical no gap and known gap arrangements do not impose any obligations on the specialist that bear on clinical decision-making or provide patient-based data other than minimal information needed for billing purposes.

17. The arrangement is purely a financial and administrative one where, in committing to the no gap (or known gap) arrangement, the specialist is reimbursed by the PHI at a premium to the Schedule fee.

18. In the mid-1990s, the government at the time allowed PHIs to negotiate contracts with specialists that contained contract terms that extended beyond the financial arrangements reflected in today's 'known gap' and 'no gap' contracts.

19. Notwithstanding this, there has virtually been no adoption of such contracts, largely due to the fact that specialists rejected any form of contract that included terms that they perceived to impact on their clinical independence.

20. The medical profession generally has eschewed participating in contracts that interfere with specialist decision-making and patient-doctor relationships and which required the provision of private clinical data to the PHI.

21. While there have, from time to time, been attempts by individual insurers to try and introduce these types of contracts, specialists have been able to resist their introduction, as no one insurer has had the market share or scale to be able to require specialists to enter into such arrangements.

22. In my opinion, the combination of NIB and a significant number of other private health insurers (as well as the Department of Veterans' Affairs, motor vehicle accident insurers and WorkCover insurers) in the Honeysuckle Health collective buying group creates a significant market share that would effectively leave specialists with no option but to enter into these agreements.

23. If the provision of an attractive no gap or known gap arrangement – restricted to financial and administrative arrangements – was not continued, then over time specialists would be forced to enter into contract arrangements with the Honeysuckle Health collective buying group.

24. The template contract provided by the Honeysuckle Health group to the ACCC reflects that type of contract that specialists are likely to have to enter into.

25. While objectionable, the template does not even delve into much of the detail that would be likely to be contained in a final version or a version tailored for specific specialities, so it is difficult to comment on the template other than in generalities.

26. The loss of an attractive no gap policy for psychiatrists would mean the only practical option would be forced participation in Medical Purchaser Provider Agreements (MPPA) contracts that require specialists to comply with private health insurance expected specialist clinical decision-making behaviour and provide clinical and private information to private health insurers for their data analytic programs.

27. It would be impossible for psychiatrists to have no contract with a private health insurer as the administrative burden of collecting the Medicare rebate for each patient and the 25% component of the schedule fee from the private health insurer for each item of service for each patient during an episode of hospitalisation would be administratively onerous and costly to the point of impractical.

28. If the specialist with no PHI contract did not charge the patient a gap fee for each service, the specialist's remuneration would be uneconomic. As a result, the specialist would similarly be forced to enter into whatever form of MPPA contract was offered by the PHI.

29. The risk associated with contracts adopting the form of the template MPPA, is that that contracts, among other things, may impact specialist clinical decision-making with regard to the number of patients that can be admitted for overnight care, and by forcing specialists to use clinical guidelines as determined from time to time by the PHI to determine which patients are discharged and when.

The doctor-patient relationship in psychiatry

30. In the medicine generally, but in psychiatry in particular, the doctor-patient relationship is the key instrument through which therapeutic endeavours are implemented and managed.

31. In my experience it is critical for the patient to be reassured that the doctor has a genuine inquisitive and non-judgmental interest in their condition, and be open to the patient telling the full story of their presenting history and background. This can take both time and effort. The most important thing that I ask a patient when they come to see me in either an outpatient setting or in hospital is the question 'please tell me your story?' This has to be done in a way that encourages the patient to open up about their condition and all the factors that might have led to it and might sustain it.

32. For example, I have had experiences where with an older patient, after the patient was admitted to hospital for a suicide attempt, when asking the patient 'tell me your story' the patient has said that they have experienced three or four weeks of quite severe depressive symptoms, they have stopped eating and drinking fluids, they believe they are guilty of capital crimes, and they have tried numerous times recently to kill themselves, with the last attempt being recognised and leading to hospitalisation. This person had little in the way of previous psychiatric illness and had a supportive upbringing and developed a strong sense of identity and self-worth up until to the time they developed their depressive disorder. For that patient the treatment might be supportive psychological therapy for the patient and close family members, close observation for suicide risk, and electro-convulsive therapy. One might expect the patient to recover in two to three weeks and then should be ready for discharge to ongoing care as an outpatient.

33. On the other hand, I have had the experiences where with a younger patient, after the patient was admitted to the hospital for a suicide attempt, when asking the patient 'tell me your story'

the patient has said they have been chronically depressed all their life, have never had a strong sense of self-esteem or self-worth, could not sustain personal relationships due to conflict and over-dependence, developed dependence on alcohol and illicit substances, and then told me (for the first time to anyone) they were sexually abused repeatedly by their father during late childhood and early adolescence until they ran away from home. It is clear that a patient in this situation requires a totally different form of psychiatric treatment than the case mentioned previously, and a prolonged hospitalisation might be necessary, with considerable intensive aftercare. Expectation of a full recovery is less likely and so discharge planning will be much more complex.

34. I raise these examples because in psychiatry the relationship between the treatment needed, the length of hospitalisation and the depth or intensity of services is not directly related to the condition on presentation to hospital or the diagnosis as it may be in some other areas of medicine where the conditions are more well defined (and aetiologies better known) and the treatments are more specific.

35. I am concerned that any homogenisation of treatment (via generic guidelines or otherwise) fails to reflect these clinical realities and may be dangerous for patients.

36. In my experience, the need to listen to the patient's story means that treatment decisions can never be pre-determined and the underlying issues revealed in the patient story will often lead to significant variations in treatment interventions even for patients admitted to hospital for seemingly similar problems, for example following a serious suicide attempt.

37. The relationship or bond developed in the process of the psychiatrist drawing out the patient's story over time enhances trust between patient and psychiatrist. In my experience, it is the forging of trust in the psychiatrist that is so important for patients accepting treatment and benefiting from treatment. Any intervention from third party PHIs that damage this trust will adversely affect patient care.

38. The issues I have discussed above in building the relationship between the patient and psychiatrist and the importance of trust in this relationship are well presented in an artistic way in a wonderful movie called Don Juan Demarco that was screened in 1995 and directed by Jeremy Levin and produced by Francis Ford Coppola.

39. The main actors were Marlon Brando (playing senior psychiatrist Dr Mickler, about to retire from a New York psychiatric hospital), Johnny Depp (playing a young man who dressed, behaved and believed he was Don Juan) and Fay Dunaway (who played Dr Mickler's wife).

40. The movie starts with Marlon Brando talking down the agitated young man from the roof of a ten-story building. The young man is admitted to a New York psychiatric hospital as an involuntary patient and Dr Mickler is assigned to look after him. The senior staff at the hospital believed the young man was psychotic and delusional.

41. The young man was not cooperative initially, but after Dr Mickler agreed to 'listen to his story' he became more compliant although he would not take any medication. As the days rolled on and Dr Mickler continued to inquisitively listen to his story in therapy sessions, the young man and Dr Mickler's relationship became more trusting.

42. Toward the end of this period of treatment Dr Mickler took the young man to the nurses' medication room. He asked Johnny Depp to take the antipsychotic tablets but he refused. After a prolonged pause Johnny Depp looks at the tablets in the palm of Dr Mickler, then looks at Dr Mickler, then looks back at the tablets. In the most poignant moment of this movie, after a pause the young man then looks into Dr Mickler's eyes and says, "for you doctor, I will take these tablets". The movie ends with both the young man and Dr Mickler leaving the hospital in good spirits.

43. Developing a therapeutic relationship with a patient requires time, patience and effort. It is essential that any psychiatrist treating patients has the ability to be able to modify the hospitalisation duration, the nature and intensity of the staff supervision and security for the patient, the type of medication, physical treatments (ECT for example), psychological interventions in the form of individual, group or couple/family therapy, and nursing and allied health support that the patient needs over a day-to-day period and be able to modify this treatment over time. This does not lead to easy application of insurer determined clinical practice guidelines or any requirements by health insurers to treat patients in certain ways.

44. The idea that a single measure of health outcome required for value-based contracting would be able to encompass the complexity and variation in psychiatric treatment mentioned above is fanciful. It is inappropriate and likely to lead to poor individual patient care.

Broad Clinical Partners Program – Medical Purchaser Provider Agreements

45. Honeysuckle Health has provided a template contract, being its proposed Broad Clinical Partners Program - Medical Purchaser Provider Agreement (BCPP-MPPA). This BCPP-MPPA contract includes a number of terms involving expectations of specialist behaviour and information sharing that is well beyond the arrangements simply needed for administration and payment of the fees to the specialists for not charging a gap fee in these surgical cases.

46. The template may, or may not, be the actual model contract that is to be used by Honeysuckle Health and we are currently blind to the actual contract terms and conditions of the MPPA arrangements that likely to ultimately be imposed on specialists by the Honeysuckle Health buying group. There has been no clear description of the specifics of contracts that Honeysuckle Health plans to use.

47. I have examined the example MPPA template provided by Honeysuckle Health. Based on my experience in psychiatric practice over many years, I have identified a number of areas in these contracts that I believe will create problems for the psychiatrist-patient relationship. These areas include conduct under Item 7: Providers Undertakings, Item 10: Independence, and Item 19: Confidentiality and Protection of Personal Information.

Item 7: Providers Undertakings

48. In this section of the contract the NIB sets limitations on the number of patients that are treated by the provider who are allowed to have overnight inpatient treatment. This quota is 30% of the eligible 'customers' or patients undergoing joint replacement surgery provided by the provider.

49. An example given is less than 35% of eligible patients undergoing knee surgery and less than 25% of eligible patients undergoing hip surgery are expected to have an overnight admission. This is a clear example of the health insurer influencing clinical decision-making behaviour by the specialist.

50. It does not take into account the particular circumstances of the patient population that may be seen by a specialist (for example some specialists will have very elderly and frail patients dominating their patient population) and places a burden on the specialist to limit care to some patients in order to be able to meet the overall quota requirements.

51. If translated to the care of psychiatric patients, this condition would mean that there would be pressure on the psychiatrist to only admit to hospital a proportion of patients after presentation, for example, with a suicide attempt or a depressive illness, because the psychiatrist would be cognisant of the need to meet the health insurer's quota for overnight inpatient treatment.

52. This would place pressure on the psychiatrist to limit admissions for patients or risk being disciplined by the PHI, or having their contract terminated by the PHI. I have seen the damaging effect of unwell psychiatric patients being denied admission to hospital, with many turned away from hospital going home to complete suicide. I consider that the pressure from this type of term in the contract will adversely affect patient care.

53. For example, a 2007 report from Queensland Health (Patient Safety Report) identified 140 unexpected deaths of patients treated by Queensland Health in the previous year. More than half of these deaths (86) were of mentally ill patients who accessed Queensland Health facilities. Most of the deaths were by suicide; many within a week of a patient being assessed in Queensland Health emergency departments and not being admitted, or within a week of discharge from a psychiatric admission.[1]

54. In this section of the contract there is also an expectation that the specialist will admit all patients for at-home rehabilitation follow up. This again directs the specialist to modify patient care in a direction that may not be appropriate for the specific needs of the individual patient. If applied to psychiatry, this could mean sending a patient home after a specified period of time in hospital that was determined and recommended by the health insurer. A psychiatrist who felt pressured by a condition in the contract like this would risk treating the patient inappropriately, as early discharge may lead to relapse and suicide death of patients. I have seen the damaging effect of premature discharge on patient welfare in patients I have observed. The Queensland Health report mentioned above also noted the concerning numbers of patients who suicided in the week after psychiatric hospital discharge.

55. In this section, there is also a requirement for the specialist to provide the PHI with data and information, including confidential performance data, to allow the insurer to record and track the outcomes and performance of the specialist.

56. It is not specified as to what performance characteristics are valued and how they will be measured, and there is no provision for discussion and consensus between the specialist and the insurer to determine what aspects of care is valued by both.

57. In addition, the PHI expects the specialist to disclose private information on patients and the practitioner's performance to a clinical review consultant. There is no information about the identity of the consultant, or what qualifications or training they might have.

58. It would be unreasonable for a specialist to reveal confidential and private patient information to someone who is not properly trained and experienced in the dealing and analysis of this type of information.

Item 10:Independence

59. In this section, the PHI requires the specialist to agree to follow clinical guidelines as required from time to time. These clinical guidelines are not specified and it is unclear where they are drawn from.

60. Clinical guidelines in medicine are generally substantial documents that are developed by professional colleges and learned bodies, and government treatment advisory boards, with the input of the treating specialists, academic evidence, clinical trial data, consensus expert opinion, and the involvement of patients and consumer organisations.

61. There is nothing in this section of the template MPPA to indicate how clinical guidelines are to be developed and how they are to be implemented.

62. Clinical guidelines always have a caveat that they should only be applied in the context of the circumstances of the patient and within a trusting doctor-patient relationship. Yet in this section of the BCPP-MPPA, the specialist is asked to agree to follow the PHI's guidelines that have no specificity about any of these issues. It is simply impossible to assess this obligation one-way or the other.

Item 19: Confidentiality and Protection of Personal Information

63. In this section of the contract, the specialist is prohibited from revealing confidential information about the BCPP-MPPA.

64. As mentioned above, patients admitted to psychiatric care are often anxious, suspicious, suffering from paranoid thinking, hyper vigilant and very sensitive to the attitude of the psychiatrist treating the patient and particularly sensitive to whether there are any third parties who might be influencing the psychiatrist's treatment of the patient.

65. The demand that these BCPP-MPPA type contracts are to be kept confidential or secret from other parties, including patients, will feed into the fear of patients suffering from psychiatric illnesses (especially those with psychotic conditions, severe personality disorders, posttraumatic stress conditions, substance use disorders, and those whose conditions arise from compensable

injuries) that others are manipulating their care. This can destroy the psychiatrist-patient relationship and lead to serious adverse outcomes.

66. Any MPPA that involves conditions other than the purely administrative provisions about payments for no gap arrangements should always be made public so that psychiatric patients can be aware of the nature of the potential interference in psychiatrist decision-making and any conflict of interest that might arise due to the imposition of a PHI into the psychiatrist-patient relationship.

Benefits asserted by the authorisation applicants

67. The authorisation applicants suggest that substantial cost savings and better value care would result from them pursuing the proposed conduct.

68. In the area of psychiatric practice, it would be unlikely for there to be significant savings from collective contracting with psychiatrists, because currently most no gap and known gap contracts have essentially the same terms and conditions and are easily set up with psychiatrists. No negotiation of individual terms and conditions occurs.

69. Furthermore, because almost all psychiatrists participate in no gap arrangements with PHIs, there is unlikely to be any cost savings for patients, as they are not exposed to out of pocket expenses.

70. The authorisation applicants also assert that the introduction of BCPP-MPPA contracts will usher in value-based contracting and improved clinical care.

71. In my opinion, the claim of improved patient care cannot be substantiated, due to the inherent subjectivity associated with the use of the term 'value' and lack of clear criteria for measuring such outcomes.

72. For example, a PHI's view of 'value' may mean a lower cost per item of specialist service, or fewer specialist services per episode of care, or reduced hospital admission days. This is very different to the concept of 'value' for psychiatric patients and psychiatrists – for these two groups 'value' is more likely to be recovery from illness and the attainment of the highest functional capacity.

73. Even if ‘value’ is determined by reference to lower costs per item of specialist service, fewer specialist services per episode of care or reduced hospital admission days, and this is achieved, the value may obscure the true cost.

74. That is, over time, the interference with appropriate patient care may result in patient relapses and more frequent hospitalisations, leading to higher overall costs for insurers over time (or, in the case of public hospital admissions, for the government and the Medicare system).

75. In my opinion, in the context of psychiatric treatment, the proposal to introduce value-based contracts with the use of a standardised health outcome measurement that has not been established as useful in psychiatric treatment settings is a flawed concept. I do not consider that it will bring any benefits to patient care; on the contrary, I consider that it will bring significant detriments to patients and psychiatrists.

Date: 16 May 2022

Philip Morris

Prof Philip Leo Patrick Morris AM