NOTICE OF LODGMENT

AUSTRALIAN COMPETITION TRIBUNAL

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

Lodgment and Details

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

REGISTRAR

Dated: 16/05/2022 10:13 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.

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	William James Pring
Address	363 Warrigal Rd, Burwood, Vic, 3125
Occupation	Consultant Psychiatrist
Date	12th May 2022

I, William James Pring], say as follows:

1. I am a psychiatrist witness and am authorised to make this statement on National Association of Practising Psychiatrists behalf.

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

3. I am a general psychiatrist who has worked predominantly in private practice for 41 years, but have also been involved in consultation–liaison (Psychosomatic) psychiatry in the public sector for 28 years, including twelve years as Director of Box Hill Hospital Consultation– Liaison Psychiatry Service.

4. I have served on the Victorian Branch of The Royal Australian and New Zealand College of Psychiatrists (RANZCP) including terms as Secretary, Chair, and as Branch General Councillor (Board director, for six years). Within the Australian Medical Association (AMA), I was firstly involved as a Committee Member, and then Secretary of the AMA Section of Psychiatry in Victoria. I have served as Psychiatry Craft Group Representative on the AMA Federal Council (Board member position, for four years) and was the Chair of the Federal AMA Public Health and

Aged Care Committee for two years. I was an AMA Observer on the Private Mental Health Alliance (PMHA) for 20 years, and Chaired the PMHA's Centralised Data Management Service (CDMS) Management Committee.

Background

5. In 1993, a committee chaired by Professor Fred Hilmer presented its National Competition Policy Review (**Hilmer Report**) to the Commonwealth government.

6. The Hilmer Report undertook an extensive review of, and reported on, national competition policy. The findings of the Hilmer Report strongly informed subsequent developments in Australian competition law.

7. At the time of the Hilmer Report, I was a member of a committee of the Australian Medical Association (**AMA**) that looked at the introduction of competition law in relation to health care. A key element of our examination was to determine the balance between public good and creating as free a health care market as was possible.

8. It was the opinion of the committee at the time, that large organisations could use contracts that were commercially in confidence to potentially split up the private profession by use of practices (such as insurance rebates) designed to incentivise doctors to treat patients in a manner that favoured the practitioner's commercial incentives over the ideal clinical treatment of the patient.

9. Ultimately, the committee – and I to this day – remain concerned about any commercial arrangement that presents an inherent conflict between ethics and remuneration for doctors.

Personal Experiences

10. Through my work within the AMA, I have been party to negotiations with Private Health Insurers (**PHIs**), private hospitals, the Commonwealth Government, consumers, carers, and the RANZCP (College of Psychiatrists). Separately, I have dealt – and continue to deal – with PHIs with respect to both my own in-patient practice, and patient experiences with PHIs.

11. After the Hillmer Report, PHIs sought – through lobbying the Commonwealth Government – to remove a number of specialties from eligibility for private hospital rebates. The three specialties

targeted by the health funds at the time were psychiatry, rehabilitation medicine and palliative care[1].

12. When it became clear that the Commonwealth Government was not prepared to remove those specialties from health insurance coverage, the health funds sought to obtain greater control over private psychiatric hospital services by requiring admission criteria, determined by them, to be adhered to by private psychiatrists.

13. Through negotiation between the RANZCP, AMA, Commonwealth Government, Health Funds and Private Hospitals, such admission criteria were not implemented. Instead, a negotiated decision was made to commence the collection of outcome measures in all Australian private hospitals, called the Centralised Data Management Service (CDMS).

14. Data was returned to each health fund for all their own members receiving a psychiatric hospitalisation. Public deidentified reports of the data were released by the CDMS annually. The Commonwealth Government also received the whole dataset, but this was done through what is called the Hospital Casemix Protocol (HCP).

15. In relation to my own patients who have been treated in private psychiatric hospitals, on a number of occasions PHIs have queried the type of care provided to my patients (through contacting the hospital concerned, which has a contract with the insurer).

16. Instead of approaching me directly, they have required private hospitals to allow them to audit my clinical notes, as written in the hospital record. I have pointed out that a contemporaneous consent to such access should be obtained by health funds at the time they wish to make such audits (as required under Privacy Law). They have claimed that the original consent provided by patients at the time of original fund entry, sometimes 20 or 30 years prior to the audit of the records, should suffice. I have pointed out that a contemporaneous consent is required under current privacy law. To me, this indicates a lack of respect for privacy by PHIs, which is relevant to their wish to collect data about providers, and about consumers.

17. In those instances, I have also offered to health funds that, with the explicit permission of the patient (and ideally in their presence), that I would be happy to negotiate with them the concerns that they have had about my care of their member. I have made this approach on the

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[1] Industry Commission Report 57, 28 Feb 1997, Commonwealth Government, ISBN 0 644 47628 1

basis that I believe that some administrative decisions are made by managers in Health Funds who have little knowledge of mental health care.

18. As long as my patient is agreeable, I am happy to be relatively open with the health insurers in those circumstances. I have also suggested that the health fund should have a medical practitioner who represents them, present in such discussions. That way, the health funds are likely to get an expert opinion about whether my own practice, as explained by me, is adequate or not.

19. In my opinion, the failure of PHIs to follow up their concerns and include their own medical expertise, indicates a lack of capacity of PHI managers to understand the complexity of medical practice; or otherwise, not have an interest in gaining such knowledge.

20. As an extension of such an approach, there have been times when I have been informed by hospital administrators that a particular PHI has been targeting a group of particular member experiences in the hospital (especially "high utilisers").

21. Once again, proper privacy protocols have not been put in place. However, I have suggested to the hospital administrators, that the psychiatrists associated with the particular targeted members of the health fund should be asked whether they would be willing to be present with health fund representatives, and including a doctor representing the health fund, in order to explain the treatments provided. At no stage have the health funds been willing to participate in such a cooperative process.

Treatment of mental health conditions in Australia

22. According to the Australian Institute of Health and Welfare report, 1st February 2022, (**AIHW**), private psychiatrists treat around 414,000 Australians per year, and the public sector treats 420,000 Australians each year,[2] around 10% of which are provided by private psychiatrists on an in-patient basis.[3]

23. Private psychiatrist care is remarkably cost efficient. The 414,000 Australians are treated privately each year, at a cost to the Federal Government of $389Million, and a cost to Private Health Insurance of $584Million per year. The 420,000 Australians entering the public mental

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[2] https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/expenditure-on-mental-health-related-services

[3]https://www1.health.gov.au/internet/main/publishing.nsf/Content/Medicare%20Statistics-1

health sector, are treated at a cost of round $11 Billion, to State and Federal Governments. It is unlikely that the changes suggested in the ACCC determination will improve the cost efficiency of private psychiatry. On the contrary, I would argue that the determination will produce a less competitive situation which is likely to cost PHIs more, and is likely to impair the adequate care available for consumers.

24. While most private psychiatry is a community-based outpatient service, the ability to be able to use private hospitals for the care of people in severe circumstances, for instance when they are feeling suicidal, or they require more serious treatment, is an important element of adequate psychiatric care.

25. Patients hospitalised for mental health conditions by private psychiatrists have some of the most severe conditions that can be managed, as revealed by 20 years of outcome measurement contained in the CDMS data set.

26. By the nature of their severe conditions, these patients are usually extremely vulnerable and it is my opinion, based on my experience, that if access to in-patient mental health services is reduced from the level presently available, then the outcome is likely to be much greater community morbidity.

27. Greater morbidity will be seen in terms of distressed patients who have been inadequately treated due to early discharge, inadequate time for evaluation in hospital, and because not all conditions can be adequately treated and controlled through outpatient care. Mortality through suicide is also likely to rise due to inadequate care.

28. At present, the majority of psychiatrists tend to enter no gap agreements with PHIs due to the common socio-economic vulnerability of their patients. Unlike procedural specialists, who usually do not obtain comprehensive psycho-social histories from their patients, psychiatrists spend extended time taking a comprehensive biopsychosocial history. We are thus aware of a patient's true socio-economic vulnerability, and rarely charge any gap amount.

The proposed conduct

29. In my opinion, the proposed conduct fails to recognise the complexity of the conditions that psychiatric patients suffer from, and fails to understand the clinical harm that can be done through seemingly simple competition law adjustments.

30. In my opinion, the Authorisation Applicants are seeking to rely upon available exceptions to competition law prohibitions in order to effect significant changes in national health policy. Such changes should only be implemented by Government, after broad community consultation and analysis. This would include analysis of the interaction between Medicare Commonwealth Medical Benefits (CMBS) funding and PHI funding. The presence of cost-shifting in healthcare between State Governments and the Commonwealth Government which distorts the healthcare market, should also be analysed.

31.

32. Under the proposed conduct, a small group of psychiatrists may be attracted to new agreements, if the remuneration from those agreements is much higher.

33. However, in my opinion, the vast majority of psychiatrists would not be attracted to such agreements, because of the knowledge that private health funds have not appropriately communicated with organisations representing psychiatrists, like the RANZCP and the Federal AMA.

34. I also consider that the agreements developed solely by health funds are likely to include inappropriate conditions on the work of psychiatrists (such as quotas on length of stay, times limits between admissions of the same patient, etc), and there is no limitation of the behaviour of the health funds with respect to the particular terms which may be inserted into their MPPAs (such as a prevention of clauses bearing on clinical practice).

35. Ultimately, I consider the most likely outcome for some psychiatrists will be they will decline any contracts with health funds that include such provisions, because the conditions are too limiting or uncertain. As a result, they will either reduce their inpatient work (switching to private outpatient consulting), or cause patients to have to pay a gap component for treatment (which is not currently paid under the no gap arrangements).

36. Private psychiatrists are therefore likely to return to simply contracting with their patients directly, and charging any necessary gap fees directly to the patients. The patients would then be in a worse position financially.

37. The difficulties dealing with health funds have increased significantly in recent years, and the proposed conduct would only exacerbate the problem.

38. I am not aware of any evidence to support the proposition that PHIs are in a good position to produce Medical Purchase Provider Agreements which are likely to enhance clinical care, especially in psychiatry.

Risks arising from early discharge of in-patients being treated for mental health conditions

39. Any reduction in the availability of requisite private in-patient services (and the consequent reduction in the ability of private psychiatrists to provide such care) would be likely to lead to a greater demand for public mental health hospital services. This is a severe skewing of the healthcare market, placing a burden on the public system which it is in no position to carry.

40. Public in-patient services are not well resourced, and would be unlikely to cope with an additional influx of patients requiring treatment which could flow from, for example, the inappropriately early discharge of in-patients from private hospitals.

41. The loss of a straightforward agreement with health funds (i.e. the current no gap agreements) due to the emphasis on forming new form MPPA contracts with specialists is likely to lead to a significant loss of public good for consumers.

Date: 13th May 2022

Dr William James Pring