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

REGISTRAR

Dated: 4/04/2022 2:03 PM

Important information

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

IN THE AUSTRALIAN COMPETITION TRIBUNAL **File No: ACT 4 of 2**

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

APPLICANT: **NATIONAL ASSOCIATION OF PRACTISING PSYCHIATRISTS**

APPLICANT'S STATEMENT OF FACTS, ISSUES AND CONTENTIONS

PART A: BACKGROUND FACTS

The Applicant

1. The National Association of Practising Psychiatrists (**NAPP**) represents the views of practising psychiatrists with respect to developments in health care which negatively impact on the effective treatment of patients suffering from mental health conditions.

2. Its membership base is national and includes practising psychiatrists in the public and private sectors who treat patients in both in-patient and out-patient environments.

3. NAPP advocates on behalf of patients and practitioners in order to ensure that quality psychiatric mental health care is accessible to all who need it.

The Application for Authorisation

4. 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**).

5. The Applicant participated in the ACCC's public consultation with respect to the Application, making submissions dated 27 May 2021, 23 July 2021, 6 September 2021 and 8 October 2021 (the last of which was not considered by the ACCC).

6. 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 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 participants in the collective buying groups, broadly involving:

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

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

III. collecting and disseminating data amongst the participants in each collective buying group with respect to the performance of contracting counterparties under their contracts (i.e. hospitals and specialists).

(**Proposed Conduct**)

7. In essence, the Specialist Conduct would be given effect to through the entry into individual contracts between each participating PHI and each medical specialist, known as a Medical Purchaser Provider Agreement (**MPPA**).[1]

8. 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.

9. The scheme known as BCPP relates to a whole episode of care which typically involves more than one specialist (in contrast to a circumstance involving an entire course of care typically provided by a single specialist).

10. 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.

11. 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 will govern all of the services provided by the specialist for that entire episode of care and will define each specialist's role in that episode of care (**BCPP MPPA**).

[1] 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.

12. 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

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

14. In principle, hospital cover provides cover for patients' in-patient and day-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**).[2]

15. Each PHI pays an amount in respect of a patient's in-patient or day-hospital costs (both hospital charges and those of the treating specialist(s)) up to an agreed amount, on a fee for service basis. These are typically paid directly to the service provider by the PHI.

16. 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.

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

17. 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.

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

19. 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

[2] 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.

as providing guidance on the clinical and administrative conditions under which benefits can be claimed.

20. 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.

21. In practice, the patient assigns their right to the Medicare component to the specialist and the PHI pays the balance to the specialist.

22. 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.

23. The extent of the 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.

24. 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 schemes 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 to 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.

25. 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.

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

27. 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[3], by reference to psychiatric services provided to in-patients or day-patients.

MBS Item	Service Description	Schedule fee	nib no gap fee[4]	AMA rec'd fee	BUPA no-gap fee[5]	AHSA no-gap fee[6]
297	New patient	$274.95	$322.80	$440	$329.85	$288.90 - $357.10
324	30 – 45 minute session	$140.55	$163.80	$295	$160.90	$148.90 – $181.00
289	Prepare a treatment and management plan, under 13 years with autism or other disorder, at least 45 mins	$278.75	$327.35	$615	$334.45	$286.60 – $347.60
866	DC Case conference > 45 minutes	$293.70	$341.15	$555	$352.40	$308.50 - $353.30

[3] 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)

[4] https://www.nib.com.au/docs/medigap-schedule-of-benefits-jan-2022

[5] https://www.bupa.com.au/-/media/Dotcom/Files/For-Provider/Bupa-Medical-Gap-Scheme-Schedules-1-December-2021_v2.xlsx?la=en&hash=FFA1AA715A7330AB36CD573696123071DA5D6F0B

[6] 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)

Table 1

PHI contracts with hospitals

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

The legislative landscape

29. 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).

30. 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.

31. 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.[7]

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

32. 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.

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

34. 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.*"[8]

35. 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.[9]

36. 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."

37. 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[10]"
>
> and

[8] 1996 Report, para 2.47
[9] 1996 Report, para 3.14
[10] 1996 Report, para 3.31

> "…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."[11]

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

38. 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.[12]

39. The failure of MPPAs led to the introduction of the GCSA which had a stated objective of controlling medical fees without contracted arrangements. Then Federal Health Minister, Dr Michael Woolridge 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."*[13]

40. 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.[14]

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

41. The PHIA replaced 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

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[11] 1996 Report, para 3.34

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

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

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

(Cth)), and introduced a comprehensive regulatory regime for the private health insurance sector.

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

43. Chapter 4 of the PHIA imposes various obligations 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."

44. 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.

45. 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."[15]

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

46. 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.

47. 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

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

(although, for reasons discussed below, there is a commercial disincentive for specialists to do so).

48. Under standard gapcover arrangements, a specialist agrees to the terms of the MPPA for all patients, and relinquishes the right to charge amounts to patients that fall outside the fees agreed under the MPPA, although critically, clinical independence is not affected – the restriction is purely financial.

49. In contrast to the gapcover agreements and MPPAs discussed above, the BCPP MPPA requires 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.

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

Psychiatric care

51. Patients attending hospital as a result of a mental health episode often present with a diverse range of – usually complex – presentations (including emotional and psychological distress), requiring a careful diagnosis by the attending psychiatrist.

52. The diagnosis and treatment will vary from patient to patient, with no two patients being identical.

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

53. There are currently 36 PHIs in Australia, with the three largest insurers – the Major PHIs – accounting for approximately 62% of the private health insurance market nationally and nib accounting for approximately 10% nationally.

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

55. 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.

56. Presently, AHSA represents 23 of the 35 PHIs operating in Australia,[16] together accounting for approximately 19% of the national PHI market.[17]

The ACCC Determination

57. 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.

58. 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 BCPP MPPAs[18].

59. 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.

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

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

62. 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

[16] https://www.ahsa.com.au/web/fundlist
[17] fhttps://www.ahsa.com.au/web/doctors/forms/registration__direct_credit_authority
[18] 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).

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.

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

    - 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**)

64. 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

65. 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

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

67. 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.

68. 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).

69. 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.

70. 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 the status quo (at least in respect of the Specialist Conduct) is maintained.

71. 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

72. 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 the 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 BCPP Buying Group and/or the Specialist Buying Group.

73. 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. regardless of whether any other unrelated collective bargaining arrangements were attempted in the marketplace, it would be unlikely that psychiatrists, in particular, and other specialists, in general, would enter into any form of MPPA which did any more than determine the rates of contribution under "no gap" or "known gap" policies (in contrast to the form of MPPA provided by the Authorisation Applicants to the ACCC).

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

Public detriments

75. 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.

76. 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.

77. 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 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.

78. In essence, the Applicant asserts that provisions in the nib 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.

79. The Applicant understands that the nib 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 to negotiated by the Specialist Buying Group would be meaningfully different.

80. The nib 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).

81. 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;[19]

    b. the admission of clinically appropriate patients to home based rehabilitation;[20] and

    c. the specialist consenting to the disclosure and publication of Practitioner Information and Public Performance Data relating to each specialist's patients.[21]

    (together, **Undertakings**)

82. The nib MPPA states that:

    a. nib is not a health professional or practice;[22]

    b. nib will not interfere with, and acknowledges the independence of, the specialist;[23]

    c. nothing in the MPPA limits the specialist's professional freedom, within the scope of accepted clinical practice, to identify and provide appropriate treatments;[24] and

    d. without limiting the specialist's independence, the specialist will follow clinical guidelines as nib may reasonably require from time to time.[25]

83. As noted above, while the nib MPPA is stated to be for BCPP and in respect of joint replacement surgery, there is no suggestion by the Authorisation Applicants that a similar form of MPPA could – or would – not be utilised in dealings with other specialists, such as psychiatrists.

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[19] *nib MPPA*, paragraph 7(e)
[20] *nib MPPA*, paragraph 7(g)
[21] *nib MPPA*, paragraph 7.3
[22] *nib MPPA*, paragraph 10.1
[23] *nib MPPA*, paragraph 10.2
[24] *nib MPPA*, paragraph 10.2
[25] *nib MPPA*, paragraph 10.3

84. In fact, the Authorisation Applicants have explicitly indicated their intent to expand the application of the nib MPPA to other specialties.[26]

85. The Applicant contends that:

    a. while the terms of paragraph 10.2 of the nib 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 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.

Risk of behaviour inconsistent with patients' best interests

86. The application for authorisation of conduct (being the Specialist Conduct other than BCPP) in the absence of a clear form of proposed MPPA that is to be negotiated with psychiatrists – and non-BCPP specialists more generally – is, without any confirmation as to the boundaries of that agreement, in and of itself concerning.

87. A key risk arising from the terms of the nib MPPA is that a PHI might cease to offer an MPPA to a specialist who fails to meet relevant performance targets, such as discharge rates or failing to meet nib clinical guidelines.

88. In those circumstances, it is entirely foreseeable that the specialist will take steps to ensure that they remain endorsed by the relevant PHI, and this could involve the making of clinical decisions that are not necessarily in the best interests of the patient.

[26] Letter from Minter Ellison to the ACCC, 27 August 2021, Section 1 (specifically, paragraph 1.4)

Disclosure of confidential information

89. An essential aspect of the psychiatrist/patient relationship is the patient's confidence in the confidentiality of their treatment and that their health and well-being are the primary focus of the psychiatrist.

90. The fact that patient outcomes are to be collected and reported by nib (see the definition of Performance Data in the nib MPPA) is likely to undermine these key clinical principles.

91. Patient outcomes should not be reported, even on an aggregated basis, as this may have the effect of influencing the course of treatment or a decision to treat a patient.

Inappropriateness of any requirement on a specialist to follow PHI guidelines

92. Similarly, psychiatrists need to be able to respond to the patient's needs acutely without any requirement to consult third-party guidelines, particularly where the guidelines are not prepared by a recognised specialist body.

93. There is no simple standard measure currently available that is used within clinical psychiatric practice. This reflects the clinical reality of the diversity of patients' presentations, their age and social milieu (amongst other factors).

94. Further, different psychiatric treatments have different clinical foci, both short and longer term, that contribute to the determination of the appropriate treatment.

95. While uniform guidelines *may* generate some benefits for patients, this will only be of limited assistance and only where the guidelines are produced by, and under the control of, expert medical opinion and where those guidelines have the aim of maximising clinical efficacy and effectiveness, rather than minimising costs (the latter being potentially inconsistent with the best interests of the patient).

96. Genuine individualised psychiatric care requires the psychiatrist to define, together with each individual patient, that patient's desired and realistic clinical outcomes, at that point in time and for that individual's circumstances. This is an ongoing process within the therapeutic relationship.

97. Any attempt by a PHI to develop and apply guidelines for the treatment of patients – including as to how and when they might be discharged from hospital – seeks – by definition – to homogenise a diverse group of patients and patient needs.

98. 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

99. While, strictly speaking, it is true that a specialist may elect whether or not to service a patient under a gapcover arrangement or MPPAs (as opposed to the proposed BCPP MPPA), 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.[27]

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

101. As discussed above, there is typically a broad difference between the Schedule fee and the market rates for specialist services. While this varies across specialties (and specific services provided by specialists), it is the Applicant's contention that very few specialists charge an amount equal to the Schedule fee.

102. In reality, this means that if a psychiatrist (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.

103. 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.

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

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

105. 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 it to achieve its intended commercial outcomes.[28]

106. This conclusion is also shared by the Applicant, which considers that psychiatrists – as well as other specialists – will have no commercial alternative, but to enter into the proposed MPPAs.

107. 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 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

108. 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.

109. 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;

[28] Letter from Minter Ellison to the ACCC, 8 April 2021, at paragraphs 4.2 – 4.3

d. reduced healthcare costs and premiums for members;

e. no-gap experience; and

f. access to data and analytics.

Transaction costs and efficiencies

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

111. 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[29]), as opposed to the negotiations with specialists, which typically involve limited – if any – negotiation and the use of standard form contracts.

112. In the Applicant's experience, any savings in respect of individual specialist are unlikely to be meaningful, as the MPPAs typically are offered on a pro-forma basis to specialists – at least in the case of psychiatrists.

113. 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 generally, let alone psychiatrists.

114. To the extent that these benefits 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.[30]

Greater choice of buying group

115. 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.

[29] See Application for Authorisation, 23 December 2020, paragraph 4.4
[30] See Application for Authorisation, 23 December 2020, paragraph 4.9

Better health outcomes at a lower cost

Lower cost

116. 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.[31]

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

118. 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, attempted suicide 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).

119. In fact, as for-profit organisations, the primary goal of each of the PHIs is to generate profits for their 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.

120. 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.

121. 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

[31] Letter from Minter Ellison to the ACCC, 8 April 2021, at paragraphs 4.4

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

122. 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 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.

123. 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.[32]

124. 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. As such, they 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.

125. 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.

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

Reduced healthcare costs and premiums for members

126. 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.

No-gap experience

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

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

129. As noted above, it is the Applicant's understanding that most – if not all – psychiatrists 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 psychiatric care.

130. More generally, the Applicant does not object to the collective negotiation of commercial terms for no-gap services; 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

131. 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 Specialist Conduct, as opposed to the Hospital Conduct.

132. That said, the Applicant remains concerned that the sharing of data may have the effect of ultimately impacting upon independent clinical decision making if it is used for the purpose of establishing clinical targets.

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

Net public benefit

134. 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.

135. 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 the contractual arrangement between the PHI and the treating specialist is likely to result in the independence of the specialist being compromised.

Orders sought from the Tribunal

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

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

III. require any specialist to have regard to any clinical or treatment guidelines formulated by any organisation other than a recognised specialist body representing that area of medical specialisation; or

IV. 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.

138. In the alternative to (b) above, the Applicant seeks an order in similar terms, but limited to negotiations with respect to contractual arrangements with practising psychiatrists.

4 April 2022

D Preston

Owen Dixon Chambers West

National Association of Practising Psychiatrists