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AUSTRALIAN COMPETITION TRIBUNAL

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Lodgment and Details

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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

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Dated: 28/06/2022 3:38 PM

Important information

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Commonwealth of Australia

Competition and Consumer Act 2010 (Cth)

In the Australian Competition Tribunal

File Number:	ACT 4 of 2021
File Title:	APPLICATION FOR REVIEW OF AUTHORISATION A1000542 DETERMINATION MADE ON 21 SEPTEMBER 2021
Applicant:	National Association of Practising Psychiatrists

AND

File Number:	ACT 5 of 2021
File Title:	APPLICATION FOR REVIEW OF AUTHORISATION A1000542 DETERMINATION MADE ON 21 SEPTEMBER 2021
Applicant:	Rehabilitation Medicine Society of Australia and New Zealand Ltd

Statement

Statement of:	Dr Philip Morris
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Date:	28 June 2022

Filed on behalf of	National Association of Practising Psychiatrists, Applicant
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I, Philip Leo Patrick Morris, say as follows:

1 I am a psychiatrist and President of the National Association of Practicing Psychiatrists (**NAPP**).

2 I am authorised to make this statement on behalf of NAPP and, except where otherwise stated, make this statement from my own knowledge.

3 This statement is in addition to the statements I gave on 16 May 2022 (**Primary Statements**).

4 I make this statement for the purpose of direction 9 of the directions made by the Tribunal on 12 May 2022.

5 To the extent that I do not address a statement or allegation from the Authorisation Applicant's witnesses, this does not mean that I agree with it.

6 In preparing this responsive statement, I have reviewed my Primary Statements and the Affidavit of David Malcolm Du Plessis affirmed on 13 June 2022 and filed by the Authorisation Applicants on 14 June 2022 (**Du Plessis Affidavit**).

7 In this statement, I will not attempt to respond to or correct each and every point made in the Du Plessis Affidavit.

Statement of Dr Zoe Adey-Wakeling

8 I have had the opportunity to read, in draft form, the witness statement of Dr Zoe Adey-Wakeling (**Adey-Wakeling Statement**). Insofar as it is relevant to the practice of psychiatry, I agree with the Adey-Wakeling Statement, including the following matters:

8.1 the absence of properly established and broadly accepted value measures in Australia for sub-acute areas of medicine (Adey-Wakeling Statement paragraph [22]);

8.2 the inapplicability of public sector examples to the conduct proposed by the Authorisation Applicants through the expansion of the Broad Clinical Partners Program (**BCPP**) scheme (Adey-Wakeling Statement paragraph [23]);

8.3 the risk that value-based models of healthcare focus on cost reduction at the expense of patient outcomes (Adey-Wakeling Statement paragraph [24]);

8.4 the nature of clinical targets and guidelines as presently applied in the medical profession (Adey-Wakeling Statement paragraphs [40] and [50]); and

8.5 the likely impacts on clinical independence of the medical purchaser provider agreements (**MPPAs**) proposed by the Authorisation Applicants as part of the expanded BCPP (Adey-Wakeling Statement paragraphs [51] to [58]).

Affidavit of David Du Plessis

9 This Statement replies to the following matters contained in the Du Plessis Affidavit:

9.1 value based healthcare and contracting (Part C of the Du Plessis Affidavit);

9.2 the proposed inclusion of clinical targets in MPPAs (paragraphs [257] to [263] of the Du Plessis Affidavit); and

9.3 the proposed requirement for medical specialists to comply with clinical guidelines in MPPAs (paragraphs [264] to [272] of the Du Plessis Affidavit).

Value-based healthcare and contracting

10 NAPP is generally supportive of any initiative that is able to genuinely improve patient outcomes whilst lowering costs. This is the crux of value based care. However, the suggestion that the Authorisation Applicant's proposed conduct would generate such an outcome in respect of psychiatric care in Australia is false. This is because currently, there is an absence of properly established and broadly accepted value measures in Australia for any aspects of the practice of psychiatry, including acute psychiatry, sub-acute psychiatry, or extended care psychiatry, either in inpatient or outpatient settings, making the vital steps of evaluating patient outcomes impossible at this stage for any aspect of the healthcare system, let alone private health insurers (**PHI**s).

11 Other than a passing reference to negotiation with specialists and peak bodies representing new specialty areas (Du Plessis Affidavit [188]), the Du Plessis Affidavit is silent as to how patient outcomes are to be determined. A move towards value based healthcare would be a major change to the provision of health services in this country. Such a change would require systemic application to all jurisdictions (i.e. state and regional health care systems). As value based care is measured by dividing patient-centric outcomes by cost of delivery, it requires a complete dataset of patient outcomes. To move to value based care in psychiatry would involve identifying and defining the value of health outcomes that matter to patients and determining the cost of achieving those outcomes. Where health interventions are possible to precisely define, evidence-based guidelines and protocols can facilitate this process, as can encouraging innovation. However, health outcomes and costs need to be condition-specific and measured across the whole spectrum of care. Condition-specific approaches are further complicated in psychiatric practice by the heterogeneity and unreliability of psychiatric diagnostic constructs. The development of value based healthcare has to involve a collaboration between patients and their representatives, academic medical professionals,

specialists practising in the clinical areas of interest, economic analysis, and funding organisations. A consensus amongst these groups is necessary for any decisions about implementing value based healthcare to be successful. It is not possible to determine that the proposed conduct will lead to benefits for patients and the broader community without understanding the outcomes that will be used to evaluate success.

12 Furthermore, the care of psychiatric patients, both inpatients and outpatients, in both public and private sectors is governed by Mental Health Acts in all jurisdictions. These Acts are required because the unique nature of the illness characteristics of psychiatric patients demand that protections are needed to safeguard the health, safety and reputation of patients, and the safety of family members, treating physicians, nurses and other mental health staff, and the general public. These Acts mandate extended involuntary care in certain situations that would be incompatible with specific targets for hospital admission and patient length of stay. The presence and effect of Mental Health Acts on provision of patient care will severely complicate the assessment of patient-centric outcomes and the cost of delivery.

13 In his 2020 article in *BJPsych Advances*, Baggaley identifies the following challenges in implementing value based health care in the UK mental health care system:

13.1 Underdeveloped outcome measurement;

13.2 Poor understanding of cost;

13.3 Care is not organised by particular condition;

13.4 Care is not organised across the whole cycle of care; and

13.5 Most services cannot compete regionally or nationally.

A copy of this article is marked "**PM-1**" and attached to this statement.

14 Many of these concerns apply to Australia. In addition, in Australia, we have a larger private system (making data collection more challenging) and the public system differs from state to state.

15 Mr Du Plessis suggests that the Authorisation Applications would approach value based care by applying data analytics extrapolated from their health insurance database and then unilaterally require specialists to modify clinical behaviour to conform to certain quotas, targets and guidelines (Du Plessis Affidavit paragraphs [148] to [157]). This is not consistent with generally accepted value based healthcare models: see Baggaley (above).

16 The proposed conduct would also involve a significant conflict of interest. nib, as a PHI has an incentive in proposing their version of value based care, to reduce costs rather than improve patient

outcomes. Further, the Authorisation Applicants have not demonstrated that they appreciate the complexity of developing a value based healthcare program with respect to psychiatry. I do not accept that the version of value based care being proposed by the Authorisation Applicants would be of any benefit to the practice of psychiatric medicine, nor lead to any benefits for patients of psychiatric care – either acute care, sub-acute care, or extended care.

Clinical targets and guidelines

17 I have reviewed the template contract provided by the Authorisation Applicants ('Short Stay No Gap' Medical Purchaser Provider Agreement (**BCPP-MPPA**)). In this template agreement, nib sets targets on how many patients are to be admitted for overnight inpatient care, places an expectation on specialists to send all patients for home rehabilitation, asks specialists to provide nib confidential patient information, requires specialists to follow clinical guidelines as stipulated by nib from time to time, and requires specialists to keep hidden from patients the terms and conditions of their contracts.

18 At paragraph [188] of the Du Plessis Affidavit, it is proposed that the BCPP-MPPA type contract will be extended to areas of medicine beyond orthopaedic joint replacement surgery. However, Mr Du Plessis provides no information about what the nature of these new BCPP-MPPA agreements will be and provides no clarity on either their price or non-price terms.

19 If these contracts were applied to psychiatric specialists they would cause significant detriments to patient care and pose significant risks to the health and safety of patients and the safety of family members, psychiatrists and the general public.

20 In caring for patients with acute psychiatric problems requiring hospital admission the prescription of targets or quotas on inpatient admission or length of stay (as described in [157](b) of the Du Plessis Affidavit) would be dangerous for patients. Whilst medical practitioners are bound by ethical codes, it is naive to assume the entire profession would be immune to financial incentives. Whilst some patients may be suitable for community programs, other patients require extended admissions. Such incentives may, if improperly implemented, expose patients to relapse, suicide, and expose others (families and partners in particular) to potential harm. Any expectation to discharge all or a specified proportion of psychiatric patients to home or community rehabilitation would be incompatible with the varying nature of psychiatric patient conditions. Many require extended psychiatric hospitalization. Only some patients can be discharged immediately to home or community care and that home care is not available for private sector patients.

Academic work supporting NAPP's position

21 The position of NAPP in respect of the Authorisation Applicant's proposed value-based health care model is informed by a number of academic sources, some of which are briefly summarised below and also annexed to this statement.

22 Looi, Kisely et. al, in their 2021 article in *Australasian Psychiatry*, canvassed how value based contracting models (also known as 'managed care' models) often limit access to private hospital care and diminish the autonomy of patients and practitioners in choosing the most appropriate treatment. A copy of this article is marked "**PM-2**" and attached to this statement.

23 Looi, Allison et. al, in their 2022 article in the *Australian & New Zealand Journal of Psychiatry* considered the Authorisation Applicants' application before the ACCC. The article relevantly states that:

23.1 characteristics of value based contracting in psychiatry, as applied in Europe and the United States, include "gatekeeping of access to private psychiatry, requirements for prior authorisation (especially preapproval of psychiatric hospital care), review of care use concurrently and retrospectively, formation of PHI buyer-designed disease-management plans and care-networks";

23.2 "the restriction of choice of psychiatrist, as well as allied health providers, through selective contracting [by PHIs] may reduce access to psychiatric inpatient care and add to the difficulties already faced by those with mental health problems in obtaining treatment under their insurance cover";

23.3 "public perceptions of selective contracting and financial incentives or controls may also adversely affect the patient–doctor relationship'; and

23.4 "managed-care has been ineffective clinically and in controlling healthcare costs in the United States, but highly effective in adding to PHI profits".

A copy of this article is marked "**PM-3**" and attached to this statement.

24 Looi, Bastiampillai et. al, in their 2022 article in the *Australian & New Zealand Journal of Psychiatry* considered the same application before the ACCC. The article relevantly states that:

24.1 "although 'value based healthcare' is superficially attractive, much depends on how value based healthcare is defined. Of concern is the possibility that PHI-payors will use a narrow interpretation of value based healthcare as a way to reduce costs through inducements and financial penalties rather than one that encompasses healthcare outcomes that are important to patients and carers";

24.2 there is ‘limited data on outcome measures that are relevant to mental health patients’;

24.3 ‘a buying group representing PHIs will primarily be motivated by cost. As a result, psychiatrists could be subject to individual selective contracting, with non-disclosure agreements, which also include financial performance inducements and penalties’;

24.4 ‘the fiscally focused [Authorisation Applicant’s] version of value-based healthcare is predicated on managed care incentive models that are ineffective in either cutting costs or assessing and achieving patient-relevant outcomes’; and

24.5 ‘comprehensive value-based healthcare should therefore be firmly based on outcomes that are important to patients, as well as the accurate measurement of efficiency and effectiveness of care.’

A copy of this article is marked "**PM-4**" and attached to this statement.

Dated: 28 June 2022 Signed: ***Philip Morris***

Philip Leo Patrick Morris

Commonwealth of Australia

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Annexure Certificate

PM-1

This is the Annexure marked “PM-1” referred to in the statement of Philip Leo Patrick Morris dated 28 June 2022.

Philip Morris

ARTICLE

Value-based healthcare in mental health services

Martin Roger Baggaley

Martin Roger Baggaley, FRCPsych, is a consultant general adult psychiatrist and former Executive Medical Director of South London and Maudsley NHS Foundation Trust (SLaM). After serving as a military psychiatrist in the British Army from 1985 until 1997 he was appointed to the post of consultant psychiatrist for the Lewisham and Guy's Mental Health Trust and senior lecturer in psychiatry for the Guy's, King's College and St Thomas's Hospitals' Medical and Dental School, London. He is interested in quality improvement, patient flow and the importance of clinical engagement in medical management.
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SUMMARY

In value-based healthcare (VBHC) value is defined as outcomes that matter to patients divided by the cost of achieving these outcomes. Value is measured for discrete medical conditions across the whole cycle of care. Data on the value achieved by different providers is openly shared. Providers increase value using quality improvement (QI) techniques to improve outcomes, reduce costs or both. Patients or commissioners choose the provider achieving the greatest value. Units should compete regionally or nationally. There are challenges to implementing such ideas in the mental health services in the UK. However, measuring outcomes, understanding costs and using QI to drive up value may be possible without adopting the complete model that has developed in the context of a North American and acute hospital healthcare system.

LEARNING OBJECTIVES

After reading this article you will be able to:

- Define VBHC
- Explain the relevance to UK mental health services
- Understand the difference between QI and VBHC

DECLARATION OF INTEREST

None.

KEYWORDS

Value-based healthcare; mental health outcomes; service delivery; quality improvement.

Value-based healthcare (VBHC) is a theory based on the work of Professor Michael Porter and Professor Elizabeth Teisberg from Harvard Business School (Porter 2006). At its core, VBHC is a way of driving quality improvement. Unlike existing quality improvement projects, which tend to be stand-alone initiatives, VBHC aims to improve care across whole services or organisations.

The key principle can be summed up in just one equation:

$$\text{Value} = \frac{\text{Health outcomes}}{\text{Cost of delivering the outcomes}}$$

The value (to patients) of a healthcare intervention is measured by dividing the outcome (that matters to the patient) by the cost of delivering that outcome. An example might be the treatment of a patient with depression. The desired outcome might be to return to being happy and to go back to work. This may require an assessment, 12 sessions of cognitive–behavioural therapy (CBT) and 6 months of an antidepressant. The CBT might cost £1200 and the monitoring of the medication £1800, making a total of £3000. The outcome might be defined as remission of symptoms, perhaps a score of less than 7 on the PHQ-9, a resumption of a relationship and a return to work.

Unfortunately, 'value' can be confused with 'values', i.e. moral or ethical values. There are also clarifications required over what is meant by a health outcome and how to measure the cost. There is a requirement to measure outcomes that matter to patients, instead of outcomes that matter to clinicians: patients may have little intrinsic interest in their MADRS score. There is a further refinement to understand what the costs are over the whole cycle of a patient's care. Interestingly, Porter & Teisberg do not consider patient satisfaction as a health outcome for this purpose (Porter 2006).

The concept of VBHC tends to be closely linked with quality improvement. To improve value one needs to get either better outcomes for the same cost or similar outcomes for less cost. One way of improving value is to stop doing things that do not improve outcomes that matter for patients. There is a considerable amount of waste in healthcare. It is estimated that 30% of healthcare interventions in Australia are wasteful (Organisation for Economic Co-operation and Development 2017). Waste can be caused by making the wrong diagnosis, giving the wrong treatment or both.

Most case examples given by Porter & Teisberg (2006) are from acute hospital care, and VBHC has been most frequently implemented in acute hospital settings. There are relatively few examples of the use of VBHC techniques in mental healthcare. However, there is as much need to improve 'value' in mental as in physical healthcare.

VBHC suggests a more integrated and holistic approach to healthcare. This includes the integration of mental with physical healthcare. This may be where some of the greatest increase in value may be found.

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VBHC emphasises the importance of embracing and rewarding innovation. Mental healthcare may not be very equipment intensive but nevertheless innovation could be used to a far greater extent. For example, logistics management software used to manage retailers' home deliveries or minicab operations might be used to more effectively manage community nurses undertaking home visits; or there might be greater use of SMS texts, telephone calls and emails for patient contact rather than face-to-face contact (Williams 2017).

Competition as driver of improved value

Value-based competition

Porter & Teisberg (2006) explicitly assume that competition is one of the principal drivers to improve value. Although theoretically there is an element of competition in mental health service delivery in the UK, it is very limited. They suggest that there is a difference between value-based and zero-sum competition. In value-based competition, outcomes improve for patients, costs reduce and good providers expand and grow. In contrast, most healthcare systems in the UK are operated on the basis of zero-sum competition, in which the same pie is redistributed between providers. This is how most competition in the National Health Service (NHS) operates. Providers compete for the same business, often at reduced cost. This divides value rather than increases it (Rahman 2015).

In zero-sum competition, increased value is hoped to be achieved by either shifting costs or reducing costs by restricting services. So, in the NHS the clinical commissioning groups (CCGs) and NHS England try to shift costs onto providers rather than truly improve value. Providers and CCGs try to reduce costs by rationing or restricting access to services (Robertson 2016).

Economies of scale and bargaining power

Other strategies to increase value include increasing the size of the provider (i.e. hospital mergers or taking over larger geographical areas) to make efficiency because of size or to try to drive down price by using the size of the organisation as a bargaining tool.

Service delivery: integrated practice units

Porter & Teisberg (2006) suggest that competition should be for a particular medical condition across 'the full cycle of care'. They advocate organising delivery along service lines to treat, say, diabetes with all relevant clinicians brought together in a functional unit. Such units would specialise in a particular disorder or part of the pathway and become expert at delivering this type of care. Such care should be patient centred and integrated. They call these units condition-specific integrated practice units (IPUs).

It is not as easy to introduce condition-specific IPUs in mental healthcare, where individual diagnoses do not always correlate well with functional impairment or treatment need. This issue has been a cause of difficulty in designing reimbursement systems for mental healthcare (de Figueiredo 1985). For example, a patient with bipolar affective disorder experiencing a manic episode may need a similar treatment approach to a patient with schizophrenia. One could then have an IPU for 'psychosis'. However, there may be patients with bipolar affective disorder who have persistent depression who would be best treated by an IPU for 'depression'. Currently, most mental healthcare services are organised by age (i.e. child and adolescent, working age, and old age). One could envisage an IPU for eating disorder or borderline personality disorder offering services across the lifespan. An early onset team is a form of IPU although perhaps not strictly condition specific.

Outcome data as a driver of value-based competition

Porter & Teisberg (2006) emphasise the central importance of information to drive competition. This information must include transparent data on the outcomes of treatment (outcomes that matter to patients). They point out that clinicians cannot compare their performance against others without the right outcome data. Furthermore, patients cannot choose the best provider without knowing the results achieved by different units. The evidence across acute care shows that publishing and disseminating outcomes from competing providers drives up quality (Shekelle 2008).

Value-based competition means focusing not just on lowering costs but also on providing value for patients. The actual competition should be on results and on medical conditions over the full cycle of care. Porter & Teisberg argue that, in the long run, high-quality care would reduce costs. In my view, many NHS clinicians do not truly accept this point and consider it some form of management 'double-speak'. This may be because NHS clinicians are intrinsically cynical and dismissive of management initiative. They also may have experienced real cuts to services disguised as 'improvement'. However, there is considerable evidence to support the contention that there is only a weak association between cost and quality (Hussey 2013). If a patient is diagnosed accurately and treated with the most effective evidence-based intervention,

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improves as quickly as possible and is then kept well away from costly in-patient beds, it is far cheaper than a poorer quality pathway (Newman-Toker 2013).

Porter & Teisberg suggests that 'value' must be driven by provider experience, scale and learning at the level of the medical condition concerned. This is very much an argument for specialisation and hard to achieve in typical NHS mental health trusts when most mental health professionals are generalists. Indeed, in the past few years, in response to reducing resources community mental health teams have become less not more specialised.

Competition should be regional and national and not just local. Results information to support value-based competition must be widely available. Innovations that increase value must be strongly rewarded. There may not be many dramatic innovations in treating acute psychosis. However, simply ensuring that the most appropriate protocols are used, for example the early use of clozapine, may result in significant cost savings (Lawrie 1998). Cutting costs may lead to long-term expenditure. For example, if assessments are largely performed by less experienced and less qualified mental health professionals, there may be errors in diagnosis and delays in instigating effective treatment.

In the NHS in general, and perhaps mental health in particular, we are a long way from achieving this. The majority of initiatives focus on cost savings. There is little real competition among mental health providers and most competition, if it exists, is local.

A practical example: first-episode psychosis across the care cycle

An example of treating a medical condition across the whole cycle of care might be a first episode of psychosis. The outcome measure most commonly used by the NHS in first-episode psychosis is the Health of the Nation Outcome Scales (HoNOS) but collection of data-sets, especially paired outcome measures, is patchy (Macdonald 2015). There is a clear requirement to agree a more comprehensive and useful set of outcome measures for the illness. Then there is the need for such measures to be collected and disseminated. The Royal College of Psychiatrists has a working group establishing a common set of outcome measures for this purpose and the International Consortium for Health Outcomes Measurement (ICHOM) has also established outcome measure sets for particular mental health conditions.

It is often hard for clinicians to accept that high-quality care is cheaper. However, if excellent diagnostic services quickly diagnose first-episode psychosis and begin treatment to achieve early remission, large sums of money may be saved by avoiding subsequent hospital admissions. A major problem is the absence of national and regional competition. This is due to the fact that much mental healthcare is linked with local authority social care. Also, there are relatively few elective admissions and a greater proportion of emergency admissions, many presenting via the emergency department or a place of safety (Crisp 2017). It is much easier to send a patient from London to Newcastle for a hip replacement if the unit in the north-east produces much better outcome results than it is to send a patient with first-episode psychosis.

Results need to be 'real' outcomes that are important for patients. In the NHS excellence is usually judged not on results but on compliance with particular nationally imposed external pathways and protocols.

Defining conditions and care cycles

The question of what constitutes a 'medical condition' in terms of mental health services is difficult (Jablensky 2016). It can, however, be defined, especially for specialised services. So, autism or eating disorder could be good examples of services that could be compared on results across the whole cycle of care. Treatment-resistant severe affective disorder also could be looked at in this way. Some trusts have tried to organise services along disease lines; for example, the South London and Maudsley NHS Foundation Trust created clinical academic groups for psychosis, mood anxiety, personality disorders and so on. This can work well in some situations but it can complicate service delivery in particular local services that work better when integrated.

It can be difficult to decide when a care cycle begins or ends. Many of the patients in secondary mental healthcare have long term conditions and are cared for in the service for many years. In such cases a care cycle might be defined by a particular time duration, for example a year of care.

Value is said to be improved by treating one thing well rather than treating everything. Many mental health clinicians in the UK treat everything that comes their way. There would be advantages in having clinicians who just treat one particular condition. This is possible in some national and tertiary clinics but the problem is again the difficulties of treating people on a regional or national basis.

Requirements for delivering VBHC in UK mental health services

A criticism of Porter & Teisberg's theories on VBHC (Box 1) would be that they are both USA and acute-medicine centric. It is therefore not certain that they

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BOX 1 Key requirements for value-based healthcare (VBHC)

- Measuring outcomes that matter for patients
- Measuring the costs of achieving these outcomes
- Focus on a particular medical condition
- Focus on the whole cycle of care

can be easily applied to the NHS in the UK in general and to mental healthcare in particular. However, There have been some encouraging initiatives, for example from St Andrew's Healthcare, a charity providing specialist mental healthcare for young people and adults (Wallang 2018). There is considerable evidence that organisations that pursue systematic quality improvement and the concepts of value-based medicine provide better and safer care. Both the East London (Shah 2018) and the South London and Maudsley NHS Foundation Trusts have embarked on such an approach (both in partnership with the Institute of Healthcare Improvement) and have demonstrated early benefits. The experience of organisations in the USA such as the Cleveland Clinic and Intermountain Healthcare (Porter 2006) shows that this is a long-term endeavour and the real benefits are achieved several years into the programme.

There are several obvious challenges to implementation in the NHS, the first of which is that routine outcome measures (whether they equate to outcomes that matter to patients or not) are not in use across many mental health settings in the UK. Second, few pathways or interventions have been properly costed. Third, there is a lack of patient choice and practical difficulties in receiving care from another provider in a different locality.

Determining outcomes that matter to patients

A typical method is to hold workshops with patients, carers and clinicians to explore what are the outcomes that matter to patients and determine ways of measuring them. It is important to use outcome measures that are agreed by the majority of providers and that are robust and validated. It is also important to use measures that are easy to collect and score. Such outcome measures must be transparent and fed back to – and owned by – the clinical teams, who must take responsibility for understanding how they compare to other teams and strive to improve their outcomes. There are a number of organisations and teams working to support the development of standard frameworks for outcomes, such as ICHOM (mentioned above), the Consensus-Based Standards for the Selection of Health Measurements Instruments (COSMIN) team and the Core Outcome Measures in Effectiveness Trials (COMET) initiative.

Outcome measurement is generally underdeveloped in mental health services. There are some exceptions; for example, the Improving Access to Psychological Therapies (IAPT) programme has a very thorough and systematic system (Clark 2018). Many trusts have made progress in collecting HoNOS data. However, it is unclear whether such measures capture outcomes that matter to patients. Even if they do, there are not adequate systems to compare outcomes both within a trust and then across trusts. There are often concerns raised that there would be incentives to 'game' outcomes. In practice, there is little evidence that this is widespread. It would be relatively easy to introduce audits and external reviews to police the system. There have been some useful developments in collecting quality of life measures in NHS trusts, for example the use of DIALOG (a computer-mediated procedure structuring routine patient–clinician communication) at East London NHS Foundation Trust (Priebe 2007) or Recovering Quality of Life (ReQOL, a generic self-reported outcome measure) at Berkshire NHS Foundation Trust (Keetharuth 2018).

Measuring the cost of interventions and payment systems

The understanding and measuring of the costs of interventions at an individual patient level are just as problematic as the measurement of outcomes.

In some teams, it might be possible to roughly estimate by dividing the cost of running the team by the case-load. However, to really move to VBHC it is necessary to be able to measure cost at a patient level. Of course, there needs to be clear description of what the intervention is. Some psychological interventions are manualised but many are not. What actually goes on in a follow-up session with a consultant psychiatrist (Killaspy 2006)? What sort of therapy is happening in a psychology session? What is the care coordinator actually doing? There is a need for common description of interventions, their cost and the grade of staff required to deliver them. Kaplan & Anderson developed a methodology to define the cost of individual elements in an intervention (Kaplan 2004). A cost-effectiveness analysis in a clinic in Stockholm, Sweden, combined time-driven activity-based costing (TDABC) with clinical outcome to measure value in the CBT treatment of depression (El Alaoui 2016).

The type of payment system is crucial. The intention of moving to an outcome-based commissioning

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approach would support and be consistent with a value-based healthcare approach. This would involve issuing long-term contracts with payment for outcomes rather than activity. There would still be a requirement to measure outcomes that matter to patients. There might not necessarily be direct competition with other organisations but the performance of competitor organisations would influence the reimbursement of the providers.

There would need to be a set of nationally agreed outcome measures and standard units of cost. The commissioning arrangements would need to align to these outcome measures such that providers were rewarded for achieving good outcomes. The providers would need to capture the outcome measures achieved and there would need to be systems to make the results (and costs to achieve them) open and transparent internally to the organisation and externally to other providers in potential competition, as well as to commissioners and patients.

Facilitating patient choice and movement to better providers

For VBHC as Porter & Teisberg envisage to truly work in the NHS, patients (and/or commissioners) would need to be able compare value (outcomes that matter to patients/cost to achieve those outcomes) for a specific condition across the whole cycle of care. Having compared value, they would need to be able to access the services that offered the best value.

This is clearly not practicable in many cases owing to geographical constraints. So, if a crisis resolution/home treatment team in Newcastle were to offer outstanding value, it would not be possible for patients in London to access that team. However, it might work for some services in some areas.

Specialised regional or national services could operate on VBHC principles. For example, mother and baby, forensic, low secure and intensive care in-patient facilities that demonstrated outstanding value could develop and attract patients.

It is conceivable that modern technology such as telemedicine could allow organisations to operate over wider geographical areas and allow some type of franchise model such that patients could choose services, say, from Northumbria operated by an affiliate in London (Williams 2017).

Locally provided services and specialised mental health trusts

Should trusts specialise in particular things they are good at? Local services are expected to provide care for all and this is likely to remain so for general community mental health teams. However, in specialised care it could be possible for some trusts to offer, for example, eating disorder, forensic or perinatal services regionally or nationally. There is an issue, however, about interfaces and the interoperability of information systems to contend with this specialisation. The experience of providing some services separate from local community services (e.g. tier 4 child and adolescent mental health services) has not been positive.

The opposite problem is that the services offered may be too narrow and not be sufficiently integrated with, for example, primary or social care. So, a very specific service line might only treat, say, an eating disorder but not comorbid mood disorders. There are examples of VBHC in mental health services being based on an integrated primary care model.

The role of quality improvements

Determining outcomes (that matter to patients) and the costs of achieving such outcomes is only part of the challenge. There is some evidence that simply measuring outcome and cost can drive up value (Campanella 2016). However, major transformation requires that systems and methods improve value, either by improving outcomes, reducing cost or both. There may be a number of steps in the patient pathway that do not add value, i.e. improve outcomes that matter to patients. These need to be identified and stopped. Then the time saved needs to be used either to do things that do add value, i.e. improve outcomes in individual patients, or to see more patients (thus increasing productivity).

There are a number of well-researched quality improvement (QI) methods, such as lean, the Toyota Production System, the Model for Improvement and the ‘plan–do–study–act’ (PDSA) cycle (Healthcare Quality Improvement Partnership 2015). It probably does not matter which is selected provided that the clinical teams have the necessary knowledge and resources to engage in QI.

The challenge is that becoming a VBHC organisation requires a massive cultural change throughout, from the frontline staff to the board of directors. This requires persistence and determination of leadership, resources and many years or effort. The history of many such initiatives in the NHS is an attempted top-down implementation by an enthusiastic few which is abandoned in a few years to be replaced by the next big idea.

Summary

What is VBHC?

Value-based healthcare (VBHC) is an ideology that offers a potential solution to the universal healthcare conundrum of an inexorable increase in demand due to demographic change in a world of constrained

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resources and ever-increasing expectations. At its heart is a simple relationship of defining value as outcomes that matter to patients divided by the cost of achieving these outcomes. Having defined value, providers then resolutely and persistently pursue increasing value by improving outcomes and reducing the costs of producing such outcomes. This can be achieved by using protocols, cutting out wasteful practice, providing evidence-based interventions and exploiting innovation. The outcomes and costs must be condition specific and measured across the whole cycle of care. These outcomes and costs must be openly published and shared with other providers and patients. The system should allow super-specialisation and make care available regionally and nationally. Patients and commissioners should be allowed to choose those providers who demonstrate excellent value. In a free market economy, such providers would expand and grow while mediocre providers would shrink and eventually close.

Is it transferable to UK mental healthcare?

There are objections that VBHC is a USA- and acute-centric approach incompatible with the culture and ethos of the NHS in the UK (Box 2). There are clearly major challenges in measuring and collecting outcomes that matter to patients and in measuring patient-level costs. There is a lack of well-embedded QI methods and processes. Most UK mental healthcare is provided by local services that have an effective monopoly and do not treat individual medical conditions across the cycle of care.

There are some NHS services in which it would be relatively easy to adopt the Porter & Teisberg model in its entirety and it would be beneficial to do so. Most obviously, relatively stand-alone specialised services such as eating disorders could become condition-specific IPUs. It would require consensus on outcomes (that matter to patients) and agreement on packages of intervention, which would be costed to allow different IPUs to compare their achievement in terms of value. It would require the ability of successful IPUs to increase their capacity and a willingness for commissioners to respond to improved values.

BOX 2 Challenges in implanting value-based healthcare (VBHC) in UK mental health services

- Underdeveloped outcome measurement
- Poor understanding of cost
- Care is not organised by particular condition
- Care is not organised across the whole cycle of care
- Most services cannot compete regionally or nationally

There are other units/teams that could be considered condition specific, such as challenging behaviour, mother and baby, and early-onset psychosis. These might be compared on value, even if geography makes it is difficult to move patients to teams that are producing increased value.

Would it benefit the NHS?

Porter & Teisberg (2006) argue that it is irrefutable that measuring and publishing healthcare outcomes improves quality. The added benefit of a VBHC approach is that it links cost to outcome and emphasises the importance of competition. It is indeed likely that, if NHS mental health providers could manage to measure and compare outcomes that matter to patients, measure and compare costs, and implement a robust and systematic QI programme, the standard of care would improve considerably and costs would reduce. VBHC as envisaged by Porter & Teisberg might need adaptation to suit the NHS and mental healthcare, but even in a modified form it has much to commend it.

MCQ answers
1 c 2 a 3 b 4 a 5 b

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MCQs

Select the single best option for each question stem

1 As regards VBHC:

a it was first proposed by Michael Porter and Elizabeth Teisberg from Harvard Medical School
b patient satisfaction scores are an important component of outcomes that matter to patients
c value-based competition is a key principle in VBHC
d competition is best if local
e successful providers should not grow in size.

2 As regards value (to patients) of healthcare interventions:

a value is increased by stopping wasteful practices
b value is decreased by reducing costs
c value is increased by improved patient satisfaction scores
d it has been estimated that up to 50% of medical interventions in Australia are wasteful
e value is decreased by innovation.

3 As regards VBHC:

a VBHC refers to ethical and moral values in healthcare
b VBHC initiatives have begun in several UK mental health trusts
c lean methodology is the only QI methodology in VBHC
d VBHC is best implemented in small chunks of the clinical pathway
e value is reduced by increased outcomes.

4 The following applies to VBHC:

a innovation is an important concept in VBHC
b IPU is a term for independent or private providers
c outcomes should be determined by clinicians
d outcomes need to be kept confidential for commercial reasons
e different providers can use any outcome measure they choose.

5 According to the principles of VBHC:

a providers must provide all possible clinical pathways
b providers should only provide pathways at which they excel
c providers should not be allowed to fail
d the only acceptable outcome measures are those of importance to researchers
e zero-sum competition is best.

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File Number: ACT 5 of 2021

File Title: APPLICATION FOR REVIEW OF AUTHORISATION A1000542 DETERMINATION MADE ON 21 SEPTEMBER 2021

Applicant: Rehabilitation Medicine Society of Australia and New Zealand Ltd

Annexure Certificate

PM-2

This is the Annexure marked “PM-2” referred to in the statement of Philip Leo Patrick Morris dated 28 June 2022.

Philip Morris

Psychiatric services

AUSTRALASIAN PSYCHIATRY

A clinical update on managed care implications for Australian psychiatric practice

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Abstract

Objective: To provide a clinical update on private health insurance in Australia and outline developments in US-style managed care that are likely to affect psychiatric and other specialist healthcare. We explain aspects of the US health system, which has resulted in a powerful and profitable private health insurance sector, and one of the most expensive and inefficient health systems in the world, with limited patient choice in psychiatric treatment.
Conclusions: Australian psychiatrists should be aware of changes to private health insurance that emphasise aspects of managed care such as selective contracting, cost-cutting or capitation of services. These approaches may limit access to private hospital care and diminish the autonomy of patients and practitioners in choosing the most appropriate treatment. Australian patients, carers and practitioners need to be informed about the potential impact of private managed care on patient-centred evidence-based treatment.

Keywords: managed care, private health insurance, Australia, mental healthcare, policy

Managed care originated in the United States of America (US) and has spread to European countries that rely heavily on private health insurance (PHI). It has the following three major elements: selective contracting, cost-cutting in the name of efficiency, and caps on the choice or quantity of services that are provided.[1] There is evidence of a similar trend in Australia with the recent emergence of a health-contracting company, aligned with the private health insurer NIB,[2] that will allow the insurer to selectively contract hospital, medical and allied health services through a separate business entity, thereby potentially allowing the development of managed care models which PHIs may consider offer business advantages. Accordingly, it is important for psychiatrists to be informed of the history and implications of managed care, especially in relation to private psychiatric practice. We also discuss potential responses to the challenges raised by managed psychiatric care, which are also relevant to other domains of specialist healthcare in Australia.

Australia's private healthcare system

The relatively unique structure of Australian healthcare is based on two elements. One is publicly funded univer-

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sal and comprehensive insurance providing free hospital treatment, subsidised out-of-hospital medical services and subsidised pharmaceuticals (Medicare).[3] The other is a PHI sector that provides private hospital, other dental and allied health services (e.g. psychology, optometry, dietetics, etc.)[3] as well as wellness programmes (e.g. exercise programmes, gym memberships).

Australian governments, state and federal, fund the bulk of healthcare, largely through revenue from federal taxation that is disbursed to the states that are responsible for health service delivery.[3] This includes grants for hospitals, as well as a direct federal subsidy, through Medicare for primary (GP and related) and secondary care medical consultations, including psychiatric care. Non-government finance contributes 33% of the overall spending on healthcare, of which 18.8% is for patient out-of-pocket expenses, the PHI sector providing 8.4%, with the remainder largely from injury compensation schemes.[3]

There has been a recent small decline in the percentage of Australians with private hospital treatment coverage from a relative high of 47.4% in June 2015 to 43.9% in December 2020.[4,5] The resulting stagnation in PHI income may therefore partially explain the interest in new modes of PHI, such as managed care.[5] However, PHI continue to bank high profits – for example, AUD 1.03 billion in the second quarter of June 2020 for the whole of Australia, even after bringing forward AUD 1.4 billion in distant future claims and a 15.8% rise in administrative costs, including management bonuses.[6]

Managed care history and developments

Prototypical managed care arose from community cooperative health insurance in the US, underpinned by a virtual monopoly on health pricing in collaboration with the American Hospitals Association. Examples included Blue Cross and Blue Shield in 1939.[7] The growing involvement of the US government in health care in the 1960s through Medicare and Medicaid followed a similar pattern.[7] US Medicare (federal, for those over 65 or under 65 and with a disability) and Medicaid (state and federal, for those with very low income) are governmental versions of private health insurance schemes, in contrast to Australian Medicare, which directly reimburses eligible citizens/permanent residents for private health consultations. The final step in the path to managed care was the advent of Health Management Organisations (HMOs), such as the prepayment capitated Kaiser Permanente healthcare plan.[7]

The essential elements of managed care – selective contracting, incentives to improve efficiency and utilisation management[1] – were contained in an integrated organisational structure that combined financing and delivery of care under managerial and fiscal discipline.[7] HMOs, as well as Medicare and Medicaid, came to dominate the provision of PHI in the US.[7] These organisations selectively contracted with providers who retained some autonomy but also accepted utilisation management – that is, capitation of services.[7] Managed care was ultimately found to be less effective in controlling costs than expected.[7] Despite this, PHI managed care organisations then moved to take over Medicare and Medicaid.[7] The US PHI, through a managed care model gives service-purchasers and insurers considerable freedom to decide who is covered, for what, and at their determined price, at least before the Affordable Care Act.[7] According to the OECD in 2019, in the US, only 35.9% had public health cover, while 54.9% had private health cover (including managed care).[8] The US spent 16.9% of its GDP on health, compared to Australia's spend of 9.3%, and the OECD average of 8.8% of GDP.[9] Despite high expenditure, large sections of the US population have poor access to care with a 65% need-adjusted probability of visiting a doctor, compared to the OECD average of 78.6%, and 7.4% of households (i.e. the poorest) with catastrophic health spending in the US compared to 3.2% in Australia.[8] Partly through PHI managed care, the US also has very low provision of psychiatric beds by comparison with other OECD high-income countries.[9]

Germany, the Netherlands, Switzerland and Israel have adopted managed care for PHI in a tighter governance form than the US, in that while healthcare insurance is provided by independent PHIs, the market is closely regulated by the national government.[1, 10] This managed competition is similar to the Australian situation, where the federal government regulates and monitors PHI companies through the Australian Prudential Regulation Authority (APRA). Managed care, in such government-regulated markets has the following features and dynamics, which are, as adapted from Shumeli et al.[10]:

1. A bilateral monopoly between purchaser and provider as opposed to a provider monopoly, purchaser (PHI) monopoly, or monopolistic competition.[10]
2. Power relationships between PHI and providers that vary according to the relative size and number of PHIs and providers including their political influence and organisational strength.[10]
3. The tension between managed care versus traditional PHI. For instance, patients may prefer possible cost containment from capitation with managed care rather than a profusion of plans and deductibles from traditional indemnity-based PHI.[3, 10]
4. The sociocultural acceptability of managed care such as restrictions on patient choice of provider and the range of services provided.[10]
5. Competition regulation and anti-trust laws where, depending on the legal framework, selective contracting of providers could be regarded as anti-

competitive and discriminatory, such that it is prohibited by anti-trust regulation.[10]

Managed care implications for private psychiatry in Australia

The potential perils for private psychiatry in Australia arise from the basic characteristics of the managed care model, namely, selective contracting and utilisation management, especially as the results of financial incentives for improved efficiency or quality have been disappointing.[11,12]

The relative size and number of the PHIs (36 in 2016)[3] concentrates power with the PHIs to manage care. From this exercise of market power, PHIs may shift away from traditional health indemnity insurance so as to contain costs in a superficially attractive manner for patients, even though it may restrict their autonomy in selecting a provider and ultimately constrain psychiatric care.

Managed care is not a solution to the affordability of psychiatric services for patients in the private sector. In terms of office-based psychiatry, a major contribution to patient costs is the failure to raise fees under the Medicare Benefits Schedule, while in the case of hospital care funded by private health insurance, there have been above inflation premium increases in spite of continuing corporate profits.[6]

As seen in the US, the costs of administration and a plethora of managed care plans have ultimately created their own inefficiencies,[7] not least of which is non-medical administrative gatekeeping of access to providers, hospitals, services and formulary access of pharmaceuticals.[1,13] Psychiatry has not flourished in the US under managed care, and there has been a shift to very large managed-behavioural-health-organisations (MBHOs) which are sub-contracted by more than one US PHI to provide mental healthcare.[14]

Actions for consideration

One of the greatest challenges to managed care is the Australian sociocultural environment. The continuing prominence of the private health sector indicates its ongoing relevance to patients and the community, with 59% of admissions to hospital being publicly funded, and 41% of admissions being privately funded in 2016.[3] Managed care, through selective contracting, markedly constrains patient choice of provider, which is particularly important in psychiatric practice, where due to the personal nature of mental illness, the development of rapport and trust is essential to the therapeutic relationship. Similarly, the added administrative burden and devolvement of clinical decision-making as a result of managed care guidelines and gatekeeping of treatment by non-clinical staff may hinder the collaborative planning of care between patients and psychiatrists. In addition, the formalisation of a gatekeeping bureaucracy in managed care will likely increase administrative burdens over time, as well as alienating patients from direct interaction with their psychiatrist.

Suggested actions:

1. Patients need to be fully informed of the perils of managed care by PHIs, which fundamentally will significantly constrain patient choice of provider, facility and mode of treatment. There is an important role for medico-political professional organisations representing psychiatrists, such as the RANZCP and AMA, to inform the public.
2. Psychiatrists must advocate for evidence-based psychiatric care that is collaboratively co-designed by doctors and patients, without managed care interference from non-clinical PHI administrators. This can be achieved through the joint advocacy of medico-political professional and mental health consumer-carer organisations.
3. Psychiatrists need to advocate for ongoing transparency for evidence-based PHI decision-making regarding purchasing of medical services, hospital and allied health care, based on the relevant research into health systems, especially for non-pharmacological therapies.
4. Independent university-based research into PHI psychiatric service delivery, efficiency and outcomes is necessary to inform and guide governmental and healthcare policy.
5. At the governmental and healthcare policy level, medico-political professional organisations representing psychiatrists, should advocate against managed care models for the substantive reasons outlined above, including the fiscal and healthcare failure of the model in the US, as well as the legal anti-competitive elements of PHI service-purchasing asymmetry.

Conclusion

Managed care is not a solution to the affordability of private psychiatric, or indeed any specialised medical services. It is essential that psychiatrists, and other doctors, advocate for person-centred, evidence-based healthcare, as opposed to ceding to a fiscally constrained managed care model.

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Applicant:	Rehabilitation Medicine Society of Australia and New Zealand Ltd

Annexure Certificate

PM-3

This is the Annexure marked “PM-3” referred to in the statement of Philip Leo Patrick Morris dated 28 June 20

Philip Morris

Check for updates

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Cui bono? Is Australia taking a step to managed healthcare as in the United States?

Jeffrey CL Looi[1,2,3], Stephen Allison[3,4], William Pring[3,5], Stephen R Kisely[3,6,7] and Tarun Bastiampillai[3,4,8]

> *Lucius Cassius, whom the Roman people used to regard as a most honest and most wise judge, was in the habit of asking time and again in lawsuits: 'to whom might it be for a benefit?'*
>
> —Cicero: Pro Roscio Amerino

Proposal for a healthcare buying group

The Australian Competition and Consumer Commission (ACCC, 2021) is an independent statutory body that oversees competition and fair trading. It is currently reviewing an application by Honeysuckle Health (HH) and NIB to form and operate a buying-group to negotiate and manage contracts with healthcare providers on behalf of private health insurers (PHIs). HH is a joint venture of Australian health insurer NIB and Cigna Corporation, a global health services company based in the United States. Individual practitioners and healthcare providers have registered their concerns with the ACCC about the possible effects on choice and autonomy for patients and healthcare providers. The ACCC has released a draft determination that is broadly supportive of the proposal based on the balance of risks and benefits. We discuss the policy implications for patients and private psychiatrists in Australia.

Of concern is that the ACCC's terms of reference are restricted to regulatory harms and benefits rather than broader effects on healthcare. We ask *cui bono*, who benefits from the approval of such a buying-group – patients, doctors or just health insurance companies? Accordingly, we discuss whether HH could be a vanguard for managed-care through selective contracting of healthcare providers, financial controls and increased administrative burdens for patients or providers (Looi et al., 2021)?

In terms of benefits, the ACCC considered that there will be

> *… a greater choice of buying-group for healthcare payers and more competition between buying-groups. The ACCC considers … [it] is likely to result in some public benefits in the form of better input into contracts, better information for participants in the HH Buying-groups and some transaction cost savings, mainly for healthcare payers other than private health insurers.* (ACCC, 2021)

The concentration of financial bargaining power through the buying-group will facilitate benefits to consortia of PHIs and healthcare payers, without necessarily benefitting the public, especially if the savings are not passed on, but are added to company profits and executive salaries.

In terms of risks, the ACCC acknowledged that

> *…it is likely that some private health insurers, including major insurers, will join HH's … Program. The ACCC considers, if all private health insurers are able to join the … Program, this potentially uncapped aggregation is likely to result in public detriment by reducing competition between acquirers of medical specialist services.* (ACCC, 2021)

Given this possibility, the ACCC proposed that HH not provide buying-group services to more than 40% of the PHI market in any Australian jurisdiction. However, in their response, HH proposed a 60% share of the PHI market, effectively dominating the Australian market (ACCC, 2021). If accepted, this outcome would greatly reduce competition and be further against the public interest.

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Buying-group mediated managed-care

The formation of the HH buying-group could be the first step to managed healthcare in Australia, with all the attendant disadvantages of similar models in Europe and the United States (Brown and Glied, 2020; Duijmelinck and van de Ven, 2016). Such a buying-group would allow for the selective contracting of healthcare providers. Although this may seem initially attractive through guaranteed patient flow, providers are then dependent on the buying-group for continued referrals and so potentially vulnerable to demands for large discounts (Duijmelinck and van de Ven, 2016). The concentration of care-purchasing through a buying-group, especially if it represented up to 60% of PHIs, would create an enormous differential of bargaining power between the buying-group and an individual psychiatrist.

Managed-care is presented as a way to improve efficiency through the use of financial incentives. However, a systematic review of financial incentives for improved performance in value-based healthcare (which has been a term used in the ACCC hearings by HH) found that schemes that reward doctors for performance have a lower chance of improving care than those that do not, and that incentives as a proportion of revenue were not associated with effectiveness of patient care (Scott et al., 2018).

Another characteristic of managed-care is aggressive utilisation management, as used in the United States, comprising techniques to manage healthcare costs through buying-group intercession into individual patient care decision-making, ostensibly to assess the appropriateness of care (Duijmelinck and van de Ven, 2016). Utilisation management would thus involve gatekeeping of access to private psychiatry, requirements for prior authorisation (especially pre-approval of psychiatric hospital care), review of care use concurrently and retrospectively, formation of PHI-buyer-designed disease-management-plans and care-networks – all greatly increasing the administrative burdens and reducing patient access to treatment (Duijmelinck and van de Ven, 2016).

The restriction of choice of psychiatrist, as well as allied health providers, through selective contracting may reduce access to psychiatric inpatient care and add to the difficulties already faced by those with mental health problems in obtaining treatment under their insurance cover. Public perceptions of selective contracting and financial incentives or controls may also adversely affect the patient–doctor relationship. For instance, such arrangements in the United States have included non-disclosure agreements between healthcare providers and managed-care companies about referral and financial arrangements, while patients have reported a lack of transparency about fees charged by healthcare providers (who may be further contractually constrained from discussion). The worst aspect of utilisation management for patients has been the administrative burdens and uncertainty of prior authorisation, gatekeeping and review of care, which has restricted access to providers, hospital treatment and even pharmaceuticals (Looi et al., 2021).

Managed-care has been ineffective clinically and in controlling healthcare costs in the United States, but highly effective in adding to PHI profits. The consequent weaknesses in PHI coverage, especially for psychiatric care, led to the Affordable Care Act, aimed at forcing PHIs to provide community-rating resembling the current situation in Australia (Brown and Glied, 2020). Managed-care has evolved to a further level of subcontracting in the United States, with buying-groups purchasing services from conglomerated managed-behavioural-care-organisations (Looi et al., 2021). The negative impacts of managed-care and restriction of access to private psychiatric hospital and allied health services in Australia would necessarily fall upon beleaguered public mental health services.

Conclusion

Buying-groups greatly increase the bargaining power of PHIs in comparison to private practitioners and hospitals. Licensing a buying-group to purchase healthcare on behalf of up to the proposed 60% of PHIs will facilitate managed-care selective contracting, financial controls and utilisation management, and thus reduce patient choice of psychiatrist, hospital venue and modality of care, as well as eroding the doctor–patient relationship. On this basis, the ACCC should reject the application.

Author's note

William Pring is now affiliated to Private Psychiatry, Melbourne, VIC, Australia.

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Commonwealth of Australia

Competition and Consumer Act 2010 (Cth)

In the Australian Competition Tribunal

File Number: ACT 4 of 2021

File Title: APPLICATION FOR REVIEW OF AUTHORISATION A1000542 DETERMINATION MADE ON 21 SEPTEMBER 2021

Applicant: National Association of Practising Psychiatrists

AND

File Number: ACT 5 of 2021

File Title: APPLICATION FOR REVIEW OF AUTHORISATION A1000542 DETERMINATION MADE ON 21 SEPTEMBER 2021

Applicant: Rehabilitation Medicine Society of Australia and New Zealand Ltd

Annexure Certificate

PM-4

This is the Annexure marked "PM-4" referred to in the statement of Philip Leo Patrick Morris dated 28 June 2022

Philip Morris

Check for updates

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Whose values are represented in value-based healthcare?

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'Don't you see that the whole aim of Newspeak is to narrow the range of thought? In the end we shall make thoughtcrime literally impossible, because there will be no words in which to express it'.

– George Orwell

Value-based healthcare is a model where providers, such as hospitals and physicians, are paid based on health outcomes against the cost of their delivery (Porter, 2010). This is in contrast to fee-for-service, capitated approaches, and activity-based funding where payment is dependent on the volume, factoring in case complexity, of healthcare services provided to people. For instance, public mental health services in Australia are largely funded through block grants.

Value-based healthcare features in the submission of Honeysuckle Health (HH) to the Australian Competition and Consumer Commission (ACCC) for the formation of a buying group that would act on behalf of a significant proportion of private health insurers (PHIs) and other third-party payors, such as worker's compensation providers. HH is a joint venture of Australian health insurer NIB and Cigna Corporation, a global health services company based in the United States. Although superficially attractive, much depends on how value-based healthcare is defined. Of concern is the possibility that PHI-payors will use a narrow interpretation of value-based healthcare as a way to reduce costs through inducements and financial penalties rather than one that encompasses healthcare outcomes that are important to patients and carers (Zanotto et al., 2021). We discuss the implications of a narrow PHI-payor-driven implementation of value-based healthcare, based primarily on cost reduction, for private psychiatric practice in Australia.

There is a danger that PHI-driven value-based healthcare could replace existing practitioner and patient-driven assessments of the quality and safety of healthcare, including outcomes and cost-effectiveness. For instance, private and public hospitals and community services have already adopted outcome measurement as a routine. In mental healthcare, casemix and outcome data are collected by the Australian Private Hospitals Association Private Psychiatric Hospitals Data Reporting and Analysis Service, the Australian Institute of Health and Welfare, and the Australian Mental Health Outcomes and Classification Network. To date, the focus has been largely on patient outcomes rather than solely on costs. However, the HH interpretation of value-based healthcare may change the status quo primarily towards cost containment.

The evidence to date is not encouraging, with limited data on outcome measures that are relevant to mental health patients. More broadly, a systematic qualitative review of the outcome research on value-based healthcare in general found that of 47 included studies, only 16 used patient-reported outcome measures, and only 3 reported comprehensive outcomes (Zanotto et al., 2021). This was less than those specifically reporting cost-saving outcomes. Importantly, these data are derived entirely from studies of primary care, medical and surgical specialities, and not mental health services. Zanotto et al. (2021) concluded that a more comprehensive approach to assessment and implementation of value-based healthcare was needed, specifically focussing on the gap in outcome measures that are relevant to patients. Given that, formally defined value-based healthcare initiatives have not demonstrated effective outcome measurement – how then can the 'value' of healthcare be assessed?

The concentration of bargaining power within a PHI buying group may allow the imposition of their definition of value-based healthcare (Looi et al., 2021a). As business entities,

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PHIs and payors are primarily responsible for their owners/shareholders and thus are profit-focused (Looi et al., 2021a). This likely explains the focus on financial cost-saving, thereby maximising profit for shareholder benefit, as highlighted in a previous systematic review of value-based healthcare (Zanotto et al., 2021). Accordingly, a buying group representing PHIs will primarily be motivated by cost. As a result, psychiatrists could be subject to individual selective contracting, with non-disclosure agreements, which also include financial performance inducements and penalties (Looi et al., 2021a). In addition, this arrangement could cut costs through managed care by prospective and retrospective gatekeeping of access to hospital and allied healthcare, as well as algorithmic management protocols that limit patient and psychiatrist choice (Looi et al., 2021a). This fiscally focused value-based healthcare model would have minimal regard to the values of patients or their doctors.

The United States is where this process is most advanced, including adoption by public sector health insurance programmes, Medicare and Medicaid (Looi et al., 2021b). The formation of the huge HH buying group will certainly affect private practice, and its influence might also spread to the Australian Medicare system with the adoption of a narrow fiscally driven model of value-based healthcare. Despite their widespread use, there is little evidence that value-based healthcare incentives for providers are effective in improving patient outcomes (Scott et al., 2018). Indeed, the more rigorous the study design, the less evidence there was of positive outcomes. There were few differences by country, primary versus acute care, pay-for-performance with incentives to reduce costs, or pay for performance alone (Scott et al., 2018). Pay-for-performance was less effective than paying for specific quality improvements, and there was no association between positive outcomes and the amount of financial incentives (Scott et al., 2018).

In conclusion, the fiscally focused HH version of value-based healthcare is predicated on managed care incentive models that are ineffective in either cutting costs (Scott et al., 2018), or assessing and achieving patient-relevant outcomes (Zanotto et al., 2021). As Orwell observed, the meaning of a word, such as value-based healthcare, can be forcibly defined by the user of the term, and, for PHIs this could mean profit. In turn, the resulting healthcare system would be constrained to target profit. Comprehensive value-based healthcare should therefore be firmly based on outcomes that are important to patients, as well as the accurate measurement of efficiency and effectiveness of care. These factors must be considered together to assess the true value of healthcare. Psychiatrists and patients must advocate for comprehensive evaluation of mental healthcare in the private and public sectors, arguing against the fiscally focused PHIr version of value-based healthcare that will reduce choice and access to care. Otherwise, as Porter (2010) warned, *'Cost reduction without regard to the outcomes achieved is dangerous and self-defeating, leading to false savings and potentially limiting effective care*'.

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