From: Mr Anthony Berger [redacted]
Sent: Saturday, 29 May 2021 8:22 AM
To: Exemptions
Subject: pplication for authorisation lodged byHoneysuckle Health PtyLtdandnib health funds limitedin respect ofthe Honeysuckle Health Buying GroupAuthorisation number: AA1000542

Der Sirs,
As a specialist surgeon in Victoria with nearly 40 years experience I wish to make the following comments about this plan.
In general terms I am concerned by the activities of any public listed company engaging in health care. NIB and the other listed companies must have a conflict of interest in what to return to patients from their premium payments. NIB returns the lowest proportion of their premiums as claims for medical services. The ACCC has stated that it is their belief that this merger will be to the benefit of the patient and yet already NIB insured patients are being treated differently due to the low provider payments. NIB/HH claim to reduce the out of pocket costs for patients by capping fees for surgical events but paying at a higher rate. How does NIB propose to cover these higher payments? Is it to be through higher premiums, reduction in shareholder dividends or some other practice to reduce their costs. No public listed company will do anything that adversely affects the bottom line. One must therefore question the motive behind this move. Many surgeons are suspicious about such proposals because of the lack of control.. Surgeons like all other professionals are allowed and in fact guaranteed by the Constitution to charge fees for their services as they determine. It is also stated in the MBS schedule that a surgeon is entitled to charge a reasonable fee for their services. This proposal removes this Constitutional right but I suspect with very little control.
On more specifics I wish to make the following comments:

1. Once a surgeon signs up to this program their fees will be fixed by NIB/HH. What is the process for indexation of that fee? As you know the differing methods of indexation of the Medicare rebates by the government and the AMA is what led to the gap problem in the first place. Will the indexation be negotiable or fixed by NIB, again with their absolute control. If there is no appropriate indexation then many experienced surgeons will not sign up to the detriment of the patients.
2. Once signed up will there be any control on the surgery proposed or the surgical implants chosen by the surgeon on clinical grounds? This may not be in the initial proposal however it must be on the agenda as a future method of cost control (increasing shareholder returns)
3. Will surgeons need to get approval for any procedure as happens with other workers compensation insurers and if so then who will make the decisions? Will this be a non medical claims officer or a specialist surgeon? Extra time taken to negotiate with insurance companies adds to the burden and will deter provider involvement.
4. This payment model apparently covers the entire service including the hospital, surgeon, anaesthetist and assistant. Anaesthetists are individual private contractors and there is no financial relationship between a surgeon and their anaesthetist. What happens if the surgeon has contracted to NIB but the anaesthetist has not? Dose this mean that the patient pays the anaesthetist separately or with the surgeon be forced to engage a NIB registered anaesthetist? What happens in the emergency situation where there is little choice or if a locum anaesthetist is required. There are specialist anaesthetists and specialist surgeons. Many surgeons work with particular anaesthetists due to their skills and understanding of the surgery being performed and the special requirements. They are not just technicians so cannot be moved around based on their registration with a certain insurance fund.
5. There are many levels of complexity in medicine and surgery. At present if a patient has for example a simple distal radius fracture then an appropriate fee is charged. If a more complex and severe fracture is to be treated then the surgeon may increase the out of pocket costs to reflect that difficulty. Just as a car repair may be simple or complex and the costs charged to the insurance company reflect the complexity. Will there be the ability for a surgeon to reflect that complexity or is this a one size fits all proposal. This will hence lead to surgeons treating complex problems not participating in this process and hence NIB insured patients will be treated perhaps by less experienced surgeons.

6. Is the rebate level for a surgeon individually negotiated or will there be a blanket rebate for all surgeons.
7. The most concerning aspect of this proposal is the concept that "value based contracting" will become involved. "The Proposed Conduct involves 'value-based' contracting1.30.The Proposed Conduct involves a value-based contracting model, which HH describes as comparing health outcomes with the costs of providing services to determine the value of the service from the healthcare payer's perspective" How does NIB/HH propose to assess the value and outcome of a particular surgeon? Will this be a google like patient satisfaction survey? Will this be a review of selected cases by an expert panel of peers? Is the complexity of a case or the type of surgical practice to be taken into account in determining value od a provider? As a specialist surgeon, had of a surgical unit, past president of national and international surgical bodies, my practice attracts complex problems that are beyond the skill of the referring surgeon or cases that have already been treated elsewhere and I am required to pick up the pieces. These cases obviously will have variable outcomes and perhaps outcomes not as good and a more simple surgical procedure or one that is done correctly first time rather that trying to salvage something after 3-4 previous failed procedures. Will my "value" be determined by comparison to a less experienced surgeon doing a simpler procedure or will my outcomes be judged by comparison to them. If this becomes the case then surgeons will start cherry picking cases with a guaranteed outcome and send the com[lex cases elsewhere or to the public system. Who is to be the judge?

   Experienced surgeons get to their current positions through many years of experience, training and are sought after by referring doctors and patients by reputation and skill. If this NIB/HH proposal does not reflect that skill and experience then NIB insured patients may well find that they cannot receive cover for surgery performed by the surgeon they want and to whom their GP has recommended. If the agreement does not reflect this and other concerns then many experienced surgeons will not participate with a disadvantage to the patient.

   I am sure there will be many replies to this review but it would be interesting to hear back,

   Sincerely,
   Anthony Berger
   Head of Hand Surgery St. Vincent's Hospital Melbourne
   Senior Surgeon Victorian Hand Surgery Associates
   Past President Australian Hand Surgery Society
   President elect Asian Pacific Federation of Societies for Surgery of the Hand