Mr Stephen Ridgeway
Chair
Australian Competition and Consumer Commission
By email: exemptions@accc.gov.au

23 July 2021

RE: Application for authorisation AA1000542 Lodged by Honeysuckle Health and nib

Key Points:

- **If the Private Health Insurers (PHIs) are permitted to have collective bargaining power that will ultimately lead to a slippery slope of reduced healthcare choices for providers and consumers, the demise of Medicare, huge increases in out-of-pocket costs and poorer health outcomes.**
- **For-profit PHIs must prioritise the return to their shareholders, salaries of their company employees and their executives' bonuses over the healthcare received by their insured members. There are very few PHIs left that are mutual organisations that prioritise their members. Healthcare providers are seen by PHIs as standing in the way of their profits. Their primary goal is to reduce the amount of healthcare that takes place in order to maximise profits. So it in the interests of funders to try to disrupt independent healthcare processes.**
- **PHIs are increasingly trying to introduce contracts with private hospital health services that intrude on healthcare decisions that cause serious detriment to the community. I have numerous examples of contract clauses that they are currently trying to force on healthcare providers to disrupt standard quality healthcare processes and thereby reduce the amount of healthcare occurring. I also give examples of other methods that PHIs are using to attempt to adversely intrude on and interfere in the doctor-patient relationship and collaborative decision-making. They are becoming more brazen and appear to be conducting a multi-pronged campaign to dominate the healthcare environment.**
- **They require very tight regulation in order to protect the quality of healthcare occurring within the healthcare market. The universal Medicare system and the subsidisation of PHI funders, which subsidise most healthcare in Australia, allows healthcare providers and patients a relatively independent arena in which to conduct affordable healthcare interactions. It would be anticompetitive to permit the PHIs to have any more power than they already do to influence healthcare processes as they will use any power available to them to negatively disrupt healthcare processes. Any intrusion leads to negative health outcomes.**

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Biography

[1.] I am writing this submission following my participation at the recent predetermination meeting as a delegate of the Council of Procedural Specialists (COPS), to provide more specific detail on the points I made in my verbal submission.

I have been a medical practitioner for 30 years and a psychiatrist for 23 years. I've worked in both public and private sectors. I have been a Fellow of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) since 1999. Since 2008, I have served as Chair and Deputy Chair of the RANZCP Section of Private Practice Psychiatry, representing all private psychiatrists across both Australia and New Zealand.

I served as a general councillor on the RANZCP NSW Branch Committee between 2012 and 2019, and between 2014 and 2018 I was the Elected Chair of the RANZCP NSW Branch, representing psychiatrists and psychiatry trainees in NSW. I served on numerous committees, liaised with multiple stakeholders and advocated for mental health system reform.

I have also been a member of the Faculty of Psychotherapy Psychiatry since 2000, the Section of Perinatal Psychiatry since 2005, the Section of Youth Psychiatry since 2012 and the Section of Neurostimulation and ECT since 2013.

I have been a member of the Australian Medical Association Psychiatrists Group and Mental Health Committee since 2011.

I gained my Bachelor of Medicine and Surgery MB BS medical degree at the University of NSW in 1992 and in 2014 I was awarded an academic title by the UNSW Medical School – Conjoint Senior Clinical Lecturer – for my work teaching medical students, setting up medical student training at various hospitals, for helping to establish a Professorial Unit at a private hospital and multiple RANZCP-accredited psychiatry training positions. I have also had an active interest in teaching, lecturing, mentoring, coordination formal education programs and supervision of trainee psychiatrists, career medical officers, medical students and general practitioners.

Between 1998 and 2014, I served as counsellor and Deputy President of the Medical Benevolent Association of NSW, a not-for-profit charity run by doctors for doctors to provide psychosocial care for medical practitioners throughout NSW and the ACT. Since 2008, I have provided professional support to doctors struggling from medicolegal issues referred by a medical indemnity insurance company, MDA National. I have provided formal supervision to general practitioners pursuing extra training and certification in mental health.

I have admitted patients to multiple hospitals since 1999 including Rozelle Psychiatric Hospital, St John of God Hospital Burwood, Sydney Clinic and St Vincent's Private Hospital (SVPH) in Sydney. During this time, I pioneered the development of cutting-edge private services for borderline personality disorder, young adults,

substance addiction, psychotic disorders and the only mother-baby unit for perinatal disorders in NSW.

In 2021, I was elected Head of Department of Psychiatry at SVPH and medical director of its Young Adult Mental Health Unit admitting young people aged 16-25 suffering mental disorders. A service redevelopment process has commenced to develop enhanced clinical care pathways for the inpatient program, improved integration with the consulting suites, a significantly expanded day admission program, the establishment of a dedicated outpatient neurostimulation clinic (to provide youth-specific transmagnetic stimulation (rTMS) and direct-current stimulation (tDCS) treatment services) and specialist-grade digital mental health care.

Introduction

[2.] For the past 20 years, I've worked in the private sector. What called me to it was **choice**. The **choice** that our universal Medicare system gives us by subsidising healthcare – but giving those of us trusted and trained in healthcare to practice our knowledge, skills and arts for the community within fairly wide parameters – to ensure people are treated as *people* and not numbers. Flexibility is needed to do that.

[3.] Medicare has limits and boundaries, but it doesn't **force** us to practice within a funder-determined model of care, other than it being a **fee-for-service** method. It works surprisingly well.

[4.] Medicare could be made to work even better, and clinicians, advocates and medical colleges are working on that with the Government – the funder of what is considered by most people to be the best healthcare system in the world. The way to preserve the **choice** it gives healthcare professionals to practice good medicine is to <u>*not*</u> allow **Private Health Insurers (PHIs)** to have <u>*any*</u> collective bargaining power. This would prevent the PHIs from using that power to interfere, intrude and damage healthcare processes, which would be an inevitable consequence.

[5.] The ACCC is therefore making a 'life or death' **choice** here for Australians. If you give the PHIs *even part* of the exclusion they are seeking, they will ultimately use it to destroy Medicare. If you make an *exception* and give the PHIs this anticompetitive collective bargaining power, it will be known as the beginning of the end of our healthcare system…and the ultimate loser will be the consumers – because ***everyone will be robbed of their* healthcare choices.** You will have in effect enabled a big step towards the takeover of the healthcare system which the PHIs appear to be campaigning for.

You will have to explain to your children and grandchildren why you made a decision that led to many consumers being unable to afford essential healthcare for their families, if you open this door and grant them any degree of exclusion. In my opinion, you will have failed in your role as gatekeeper to keep the healthcare

market effective, fair and safe for consumers. *Please* ignore the promises, assurances and reassurances of the PHIs that they are interested in adding 'value' to improve health processes and outcomes – I strongly believe those promises are untrustworthy, manipulative and hollow.

[6.] In this submission, I provide you with real world examples of how the PHIs try to **rob choice** from the public and detrimentally impact on patient safety and the welfare of Australians – how they use **anti-competitive methods** to influence the healthcare of consumers, doctors and the doctor-patient relationship. As a psychiatrist, I can advise you that the best indicator of future behaviour is past behaviour.

I contend that you are obliged to consider what the PHIs will do with any additional market power, as they will use this power to influence future healthcare practices. Examples of their conduct, which I will provide you with, will show just how they are secretly trying to intrude on mental health care practices. These examples indicate what they have in mind to do with the increased market power they are seeking.

What *choices* did Medicare offer *me* to be able to perform my role as a healthcare provider?

[7.] Medicare gave me the **choice** to work in group practices, solo practices, a large 100-bed private psychiatric hospital (where I served as medical director for over 10 years) and for the past 10 years I've been part of a visionary team building a ground-breaking 20-bed young adult private psychiatric unit. We developed a safe therapeutic space for youth with emerging complex mental disorders. We established it because these youths were 'bouncing around' the emergency departments, public adult, paediatric units and private adult units, without their needs being met.

Without the Medicare and the PHI funding model, we clinicians could not have filled that gap in the NSW healthcare system with a private unit. Given it is a more expensive healthcare service than a typical general adult unit, I am certain that if the PHIs had the power to prevent its establishment, they would certainly have done so. That is despite early intervention obviously being a massive investment because ***early intervention*** of those youth may prevent many from developing chronic disabilities, which then will save the taxpayer a fortune in mental health care dollars in the long-run far outweighing the cost of the service.

[8.] Medicare gave me the **choice** to spend most of my time working as a ***clinician*** treating people with mood, anxiety, personality, psychotic, substance use and eating disorders. Throughout my professional career, I've treated the elderly, the middle aged, young adult, youth, parents and the mother-baby dyad. I ended up choosing to work in ***early intervention***, the provision of care to ***complex presentations***, inpatient ***multidisciplinary teamwork*** and ***collaborating with and supporting general practitioners***.

I've also chosen to get involved in ***healthcare advocacy*** through leadership roles

within the RANZCP. Here I have represented all private psychiatrists across Australia and New Zealand for 13 years. For four years, I was president of all NSW Psychiatrists – the largest group of private, public and academic psychiatrists in the country.

[9.] Medicare gave me the opportunity to discover how I could best utilise my knowledge, skill sets and interests. I wonder whether I would have been able to make these **choices** about how to best serve the community without Medicare. The thought of entering into rigid, one-sided, bureaucratic contracts written by PHI executives, actuaries and clerks – who believe *they* know how to make the best healthcare choices for me and my patients – fills me with dread.

How do private health insurers try to use contracts to disrupt healthcare decisions in a way that can cause serious detriment to the community?

[10.] The first occasion I saw PHIs **cause detriment** to my patients was when I was medical director of the only mother baby unit in NSW. This unit caters to families where postnatal depression strikes at the most vulnerable moment in their lives – when they have the responsibility to care for, what is for many, their first-born child.

One day in the mid-2000s, one of the largest PHIs in Australia decided – without warning or consultation – to *stop* paying the cost of board for the babies who needed to be cared for by their ill mothers, with the support of mental health nurses and mothercraft nurses. The PHI said their contract stipulated that they only had to pay for the person with the mental illness. The baby didn't count as how could a baby be mentally ill? They told us if it was the mother who was sick, they would only pay for the her healthcare, not the baby's.

[11.] The PHI forced many families who were in severe distress – at what was meant to be the best time of their lives but had become a health crisis for them, to be in an even bigger predicament. They found themselves needing to find out-of-pocket costs – even though many had taken out policies that were offered to them as gap free.

I have never forgotten this case because I felt so shocked, outraged and baffled at the depth of the insensitivity, lack of compassion and ignorance. The ignorance was a lack of understanding that the babies were suffering as badly as their mothers (not to mention the fathers) and deserved healthcare as much as the mothers. The PHI had used 'fine print' in the contract to get out of paying.

It is well established and non-controvertible that separating babies from their mothers has longstanding adverse impacts on them in every way – emotionally, physically and even cognitively downstream in their lives. Many of these babies were breastfed and the mental ill-health of their mothers meant these families needed mothercraft nurses to assist them to be able to continue breastfeeding, if possible. Where it was not possible, the babies required mothercraft expertise to wean them from breastfeeding. Many of these babies had physical ill-health like

reflux or birth trauma. There were also risk issues present. Some mothers needed supervision when interacting with the babies. Others required assessment of their capacity to care for the babies.

Payment for the babies' hospitalisation was eventually reinstated after some months of negotiation and pleading. Yes, it took months to convince that PHI that the babies were in fact unable to survive or thrive without their mothers' care. Why did it take so long? The PHI probably dragged it out so that some PHI executive could gain a financial bonus for noticing the loophole that made the PHI a greater profit.

[12.] I've seen Workers' Compensation Insurers, Life Insurers and Australian Defence funding agencies 'play games' like that *many* times – use fine print to try to get out of paying a cent more than they had to, irrespective of the pain and suffering of my patients / their members. It was so demoralising, humiliating and distressing for me to have to deal with Income Protection, Life Insurers and Defence Force funders, that I made a decision *not* to treat anyone whose funding was dependent on a managed care model, due to the intrusion into the doctor-patient relationship. Managed care made healthcare too difficult and complicated – clinicians always had to beg for more healthcare funding for admissions, medical treatments, even further consultations.

In contrast, the model of care facilitated by Medicare and the PHIs was more acceptable due to the relative lack of intrusion into healthcare practices. The managed care models of Workers' Compensation, Life insurance, and Defence schemes created too much "moral injury" to me and my patients for it to be acceptable. When clinicians leave a system that in turn reduces consumer choice. I have had to withdraw from treating patients and refused to take on new patients who were seeking care within a managed care model, as I find it unacceptably disruptive and detrimental. So detrimental an impact, in fact, that it is my opinion that those managed care systems actually perpetrate so much harm on the doctor-patient relationship and the patients directly, that it makes achieving good health outcomes almost impossible in the majority of cases.

[13.] In 2014, I was shocked to discover another situation where a PHI had used its contract to cause patient detriment by capping the number of ECT (electroconvulsive therapy) treatments that I could use in the management of a suicidally depressed inpatient under my care at a private psychiatric hospital. The patient receiving ECT required a course that went beyond the typical 12 treatments. But I discovered from the hospital management that the PHI had only entitled my patient to a maximum of 12 ECTs per calendar year in their contract. A course of 12 ECTs is considered a single course of treatment (3 ECT treatments per week for four weeks) but in some episodes of care more than 12 are required for an effective ECT course.

For the PHI executives and actuaries to unilaterally decide to cap the amount of treatment with ECT to one course of 12 per year for their members put me and my patient in an impossible situation. In this case the patient needed more than the usual 12 ECTs. And what if they relapsed and needed another course in that calendar

year? Was the PHI assuming that any ECTs beyond 12 would need have to be conducted in the public system or that the patient would be able to pay out-of-pocket for extra ECT?

Unfortunately, gaining access to ECT in the public sector is not usually at all straightforward and would likely be associated with considerable delays that could be very detrimental to the wellbeing and safety of the patient. It would be impossible for most Australians to pay for an inpatient admission of one month with three medical procedures per week over one month that involved a subspecialty proceduralist psychiatrist, anaesthetist and at least one ECT-trained nurse. It is quite possible that they would either starve to death or suicide if released home prematurely. The most common reasons ECT is given is for the treatment of severely ill melancholically or psychotically depressed patients, who have either lost the will to eat or live and have delusional guilt, persecutory delusions and auditory hallucinations commanding them to suicide.

In this case, I had to plead – on behalf of my patient – to the PHI to go beyond that cap for this life-saving treatment. Fortunately, the PHI in that instance accepted the rationale and agreed to pay for a few extra ECTs. I had seen Worker Compensation, the Department of Veteran's Affairs and Defence Force agencies put caps on treatment, admission and consultations. However, I had not seen a PHI use a managed care approach like that before. It was onerous and disturbing that I needed to beg a non-clinical third party for permission to utilise more of a treatment that my patient and I had collaboratively agreed was necessary. In fact, the hospital quality-control processes had been employed and there had been a second psychiatric opinion and collaborative-decision making with the patient and their family. Everyone agreed that this patient required a few more ECT treatments to complete their episode of care. Imposing that cap was a cruel, inhumane and degrading treatment of their member.

[14.] Sadly, I am less surprised these days when I discover increased instances of PHIs trying to intrude on healthcare practices. I have concluded that the insurance executive who made that decision about not paying for the healthcare and humanitarian needs of the baby – and refused to listen to the pleading of the healthcare practitioners – simply did not and could not afford to be caring, compassionate and caregiving. Because that's not their job. It's not what they are trained for. Apparently, it's not even legal for them to bring human values like 'compassion' into the equation – it's their priority to look after their shareholders, company employees and their bonuses.

The executive who withheld healthcare payments for babies suffering acute distress, grief and trauma that their mothers were so emotionally unresponsive and unable to care for them were doing what they were obliged to do. They are not healthcare practitioners. Their job is to maximise profits by minimising short-term costs. Their goal is diametrically opposite to mine – which is to prioritise the life, future health and wellbeing of my patients.

I must admit I am surprised that, over the past 16 months, most of the for-profit PHIs have chosen to block multiple attempts by the RANZCP to advocate to the Commonwealth Department of Health for Telehealth (video consultations) to become available in special circumstances – for the management of private psychiatric hospital inpatients whose care has become negatively impacted by the COVID19 pandemic.

The Department of Health have not approved Medicare funding for this because most for-profit PHIs have apparently refused to agree to provide their usual contribution for funding these specialist consultations. Even where an admitting psychiatrist needs to be in isolation for some weeks and telehealth could be used as a substitute during that time, this could mean that multiple inpatients could be able to continue their admissions rather than be prematurely discharged. There is simply no reason to prevent the treating specialist from being funded to conduct video consultations with their inpatients and the multidisciplinary team remotely during such rare circumstances. However, most for-profit PHIs have refused to pay for teleheath as a substitute for face-to-face care, even though it would have cost them no more than what would have occurred for normal face-to-face specialist inpatient care under usual circumstances.

It appears that the large for-profit PHIs have stooped to the level of exploiting a natural disaster to make extra profits. This shows that they would simply do anything to make an extra buck even if is to the detriment of their members and no matter the reputational damage that they might face. This is why they need to be firmly regulated. They need very clear legislative boundaries and limits to prevent them from causing public detriment. It is entirely responsible and appropriate for the PHIs to continue to be banned from collective bargaining.

Why is it in the interest of funders to try to disrupt independent healthcare processes?

[15.] To reduce *access* to healthcare reduces short-term costs. This can be done by:

- disrupting the doctor-patient relationship
- impinging on the independence of the doctor
- shifting the narrative from the doctor managing the patient's health problems to filling in reams of forms, waiting on the phone to speak to clerks, begging clerks to approve care – being distracted and wasting time engaged in a defensive legalistic process
- creating barriers to quality care and restricting choices – rather than spending healthcare dollars managing patients.

The only healthcare activity the PHIs clearly are *willing* to support is healthcare where they can control its price and costs in order to minimise their funding of episodes of care and maximise profits.

What if the PHIs undermine Medicare?

[16.] Well, that might be an advantage too for the PHIs because it means they have gained full control of healthcare. They know that it would suit the Government for the PHIs to provide healthcare funding rather than the Government. Therefore, it's a win-win for the PHIs and Government. Who loses? The community, who instead of quality care get a cheap and nasty system that forces us into a homogenous, one-size-fits-all product. We all **lose choice** when the PHIs have the power to minimise healthcare activity from taking place. The impact is a diminution over time of competition and detrimental flow-on effects such as reduced training, workforce skill sets and expertise to benefit the healthcare needs of the community.

[17.] I note that PHIs are using the rationale in their application that they are wanting to use value based contracts to improve healthcare outcomes. Quality care for healthcare practitioners means good care by those who have been trained, apprenticed, nurtured and regulated to provide a type of healthcare that consumers need and want, what the families of consumers want – their loved one to regain their health as much as possible. Everyone wants their care to be healing, supportive, symptom reducing, recovery-oriented, reducing suffering and distress and associated with improved functional outcomes. *That's* ***person-centred care***. *That's* care tailored to their ***individual needs***.

[18.] Have health insurance companies suddenly become expert healthcare providers themselves? Have insurance executives suddenly foregone their executive salaries and bonuses for 13+ years to obtain medical degrees? Have they been accultured in healthcare values and ethics? Of course not. So who would want them forcing their version of healthcare values down our throats, which we know inevitably means reduced **choice** and quality of care.

[19.] Do the PHIs really believe they know better than healthcare experts who have been using the scientific method, research and evidence-based practices for hundreds of years? Their argument that they will employ 'data analytics' to do a better job than clinicians to achieve healthcare outcomes just highlights their naivete, ignorance, nerve and narcissism to be willing to ***experiment*** on the Australian public and put their lives at risk. They simply want to **remove choice** from well-established, independent and market-driven healthcare decision-making practices and put at risk a health system that is envied across the world.

A huge improvement that *could* be achieved with regard to the healthcare data, statistics and information that PHIs hold would be to legislate that the healthcare information they hold be shared with independent healthcare researchers and healthcare providers so that we can make use of that data to improve health outcomes. It is in fact 'holding us hostage' by promising only to use that healthcare data for 'data analytics' *if* they are given permission to collectively bargain. They could all provide this information to clinicians and policymakers if they chose to.

[20.] Our healthcare system has unfortunately suffered increasing intrusions, fragmentation, inadequate funding and the introduction of more bureaucratic layers. But **Medicare** *has* survived and continues to maximise the power of the ***market*** by ***subsidising*** medical care to ensure that healthcare is widely accessible to the public.

[21.] The taxpayer also subsidies the PHI system to encourage those who wish to take up PHI to be able to do so. So eager has the Government been to make the private sector ***part*** of the universal healthcare landscape that they've increasingly made the private sector ***essential***. Whereas there used to be two overlapping systems, there are increasingly more services provided by the private sector that are otherwise largely inaccessible in the public sector. Nowhere more than in psychiatry has this become the case.

[22.] The private psychiatry sector (funded by Medicare) manages about 400,000 patients for about $800 Million per annum whereas the public sector manages 400,000 patients for 7.3 x that expense ($5,900 Million). "The public sector costs $10 billion to do its work, but the private psychiatrist sector costs $360 million to Government, and about $400 million to private health funds, for its effort". I am quoting the Submission to the Productivity Commission into Mental Health: 'Best Mental Health Investment – the Forgotten Half of Specialist Mental Health Care' by the Independent Private Psychiatrists Group (https://www.pc.gov.au/__data/assets/pdf_file/0014/241241/sub473-mental-health.pdf), which drew on data from the Australian Institute of Health and Welfare (2017). This shows how incredibly cost-effective the private Medicare sector is.

[23.] Cost effectiveness isn't the only difference. The model of care is quite different when it comes to mental health care. Whereas the public sector predominantly provides ***crisis care,*** the private Medicare sector provides ***longitudinal services***. About 7.7% of the private mental health sector involves inpatient admissions (AIHW, 2017) whereas most of the public sector mental healthcare dollars support healthcare taking place in the hospital setting.

That means the private sector is the main arena managing people *beyond* their acute presentations – maintaining them and preventing further relapses. The longitudinal care provided means that psychiatrists, general practitioners and allied health clinicians know and understand these patients well as they are not 'one off' presentations, and are hence in a good position to make healthcare decisions collaboratively with their patients and their families, in particular to intervene early if a patient shows early signs of relapse.

[24.] Early intervention is considered essential and best practice to prevent a full-blown or florid relapse occurring. Sometimes that requires a private hospital admission. Successful early intervention prevents crisis presentations to the emergency department in the public sector. If the private sector were impeded from carrying out the healthcare done there, there would be overflow into the public sector and the healthcare costs would blow out explosively for the taxpayer. That's

one of the reasons it is in all our interests to support healthcare practices that have minimal intrusion into the model of care by the funders (Medicare and the PHIs). Otherwise, healthcare to our nation would cost more than double the GDP that it currently costs. You only need to look to the USA for an example of what the GDP would be if we followed their model of care.

[25.] The prior knowledge of the patient is just as important as their presenting symptoms because having previously managed a patient through an episode of care very ably helps the clinician predict the level of likely course, risks and most likely successful management plan to instigate at the onset of any further episode. There are quite a few factors for a clinician to put together to weigh the 'benefits versus costs' of a hospital admission and the rationale is different for each patient. That's person-centred care – the clinical and ethical quality standard.

[26.] Of course, the PHIs would like a simple method to determine rationale for an admission so that they can question its necessity, obstruct it if possible and minimise its duration in order to minimise costs. However, the PHIs know that the specific diagnosis of a mental disorder is in itself a very poor predictor of the need for an admission or the duration of an admission. That the healthcare clinician requires independence and collaboration with the patient to use their clinical skills to get the best patient outcomes is considered an impediment to PHIs focusing on minimising the amount they need to fund. However, blocking or hampering the doctor-patient from making critical healthcare decisions such as a hospital admission process would lead to higher suicide rates.

[27.] There is a lot at stake if the ambitions of the PHIs to gain control over healthcare decision-making is realised through their attempts to use contracts and other measures to impede healthcare providers – the doctors, nurses, allied health and medical administrators.

How will the PHIs maximise their oligopoly power to take over control of how healthcare occurs?

[28.] I have evidence that the PHIs already use every opportunity to ***detrimentally interfere*** in standard healthcare practices and processes and ***cause harm to the community even now***. They have no inhibition from using every dirty trick, to access every loophole and cleverly workaround any regulatory measure that they can get away with to try to inhibit healthcare from occurring.

What about the marketing campaigns that the PHIs are merely trying to improve effectiveness and efficiencies?

[29.] Remember – they are healthcare ***insurers*** – that means ***funders***. They are not ***healthcare providers*** – sworn to uphold healthcare values, ethics and quality practices. That's not their expertise, their calling, their primary role. They *don't* treat, care, nurture or relieve suffering. They pay for the doctor-patient to work together. If they want to be *both* funder and healthcare provider, *which* role will a

for-profit company be obliged to prioritise in the *long run*? They have an irreconcilable conflict of interest to try to be both a funder and healthcare provider.

[30.] Why do they advertise? For more business. For more income. For more profits. To pay their shareholders. To pay their staff. To pay executive bonuses. That is their 'day job' and we need them to do that. Whilst it is in our interests to have private health funders, it is a real shame that they aren't all mandated to be mutual societies whose purpose is to prioritise their ***members***. But most of them are for-profit. That's the reality.

Why am I taking my time to submit this statement?

[31.] Most PHIs want to obstruct me from doing my job of treating, caring, nurturing and relieving the suffering of my patients. That's why I'm taking my time away from my patients and family to write this application to appeal to the ACCC not to give them the power to obstruct me more than they already do from carrying out my role – trying my best to provide quality healthcare.

[32.] The PHIs will wreak havoc if we don't stand up to this dangerous application by Honeysuckle Pty Ltd (NIB and Cigna) to be granted an exemption permitting them to collectively bargain. It is perverse to give the PHIs the power to destroy our healthcare system. You must know they won't be able to help themselves. To give them the means to 'throw petrol' on the little fires already burning all around the health system. This will lead to the whole house burning down.

[33.] The PHIs are simply doing what predatory corporate powerpaths are meant to do – maximise short-term profits no matter what the long-term health costs. They don't care if they burn the house down to make their bonuses and dividends for their shareholders. They don't care how many patients they have to deny healthcare to. The more healthcare they prevent the more money left over from their members' contributions. Their marketing slogans to you that they want to prevent avoidable hospitalisations is exactly literally that. They want to reduce hospitalisations. No matter whether they are warranted, beneficial or lead to improved health outcomes in the long run.

[34.] They know my patients are costing them even larger profits. So they wish to reduce the amount of mental health care. They will do this no matter the suffering, the pain and the destruction it causes. They see doctors and other clinicians as in their way because we treat their members, admit them, investigate them, perform surgery on them, procedures on them and do what we can within reason to reduce their suffering, maximise their health, help them recover, save their lives, reduce relapse, maximise resilience, prevent disease, optimise quality of life. That all costs money. So we are the enemy of the PHIs' profits. We are in their way. In the way of their profits. Hence, it is unsurprising that they will do anything to control us. To slow us down. To minimise the healthcare delivered to their members. Less healthcare means more profits.

How do PHIs reduce healthcare?

[35.] By interfering, obstructing, wasting our time, wearing us down, putting bureaucratic impediments and barriers in the way of healthcare – anything that reduces the costs of healthcare.

[36.] PHIs have been using contracts to do this at an exponential rate over the past five years. I will show you some of the ways they have been trying to use contracts to interfere with inpatient psychiatric care. And they are becoming more effective at this, because over the past two years they have been increasingly 'policing' their contracts by conducting audits on healthcare facilities. These are fishing expeditions searching for *any* deviations or missing documentation or perceived gaps in the demands made in their contracts. They are finding any excuse to claw back funds that they have already paid to hospitals and to individual providers. They have been using this threat (demanding that already-paid funds be returned) as a method to exert control, influence and bully healthcare providers into minimising the amount of healthcare conducted. They have become more and more brazen. They have been recruiting health practitioners to indoctrinate and influence them. They have been trying to damage the viability of some hospitals as a means to then purchase the facility and downgrade the quality of care provided in them.

[37.] Surely, it's more than coincidence that the contracts between all the PHIs are looking more and more similar! Surely, they are colluding and making it harder and harder for hospital contract negotiators to defend the independence of the healthcare providers who admit patients to the hospitals. The PHIs in this way try to get the hospital administrators to do their dirty work. They put pressure on the administrators to put pressure on the individual healthcare providers who are employed staff or visiting doctors to the hospitals to conduct healthcare as the PHI sees fit. This, of course, is to minimise the amount of healthcare occurring and hence reduce healthcare costs.

[38.] Imagine how brazen the PHIs would become if they can legally collectively bargain with these intrusive managed care type contracts that they have been forcing on providers. These providers don't feel able to resist the individual PHIs as all the PHIs are introducing the same kinds of contracts. The providers don't want to risk having gaps in PHI cover.

[39.] I have identified five ways PHIs use contracts to try to control, obstruct and homogenise healthcare to ultimately reduce the amount of quality mental health care occurring:

- **(1) They intrude into decisions around referral and admission to try to reduce referrals and admissions from happening.**
- **(2) They try to influence the types and amounts of treatments occurring during an admission. They try to make treatments as 'cheap' and 'fast' as possible. They even try to have a say in which healthcare provider can provide what type of care. They try to introduce treatment schedules and demand that clinicians explain why they are deviating from the schedules in the contracts.**

- **(3) They try to override existing, established quality assurance processes by substituting their own treatment schedules and then conducting audits of their members' health records to find excuses to demand back funding. This makes health services less viable and vulnerable to their takeover.**
- **(4) They try to influence when and why a patient gets admitted to a hospital and then the duration of the admission.**
- **(5) They try to override trauma-informed, person-centred healthcare that is based on the biopsychosocial model where the weighting of management approach is collaboratively determined by the patient together with their doctors.**

[40.] I will now provide specific direct evidence of how the PHIs are trying to use contracts to intrude into mental health care, in direct contravention to the **'Guidelines for Determining Benefits for Private Health Insurance Purposes for Private Mental Health Care 2020 Edition', Australian Private Hospitals Association (APHA Guidelines)**, which states:

- "The Guidelines **cannot be prescriptive**…and are intended to provide **guidance**… in determining health insurance benefits" (Introduction, Page 3 of 25)

- "Health insurance benefits and funding models will support the provision of high quality, evidence-based care and **patient centric care**" (Principles, Page 4 of 25).

[41.] The PHIs had agreed to abide by these **APHA Guidelines**, but after the Commonwealth Government withdrew about ten years ago from the regular round table meetings that brought all the private hospital mental health stakeholders together, the PHIs have increasingly been flouting these Guidelines. They have been:

- Picking select content from the **APHA Guidelines** to use in their contracts – in effect exploiting what had been intended to be "guidelines" by pushing them into the psychiatric hospital clinical setting in contracts that they negotiate with hospital administrators as prescriptive treatment schedules
- Excluding mental health clinicians from the contract negotiation process
- Conducting audits of hospital medical records to check whether the healthcare provided to their members is consistent with these treatment algorithms
- Punishing the hospitals with financial penalties under the guise of demanding returns in funding that they claim the hospital have forfeited for not abiding by the rules, regulations and explicit details of the treatment schedules within the contractual clauses
- Making hospitals financially non-viable by demanding the return of up to 50% of the funding that they had already provided for inpatient care and then demanding that the healthcare processes of that service be modified by substituting a model of care of their choosing. For example, I am aware of a psychiatric hospital where a large PHI demanded that all admissions be capped at one week duration (instead of the typical 2-3 weeks duration) and they offered to fund out-of-hospital mental health care for those patients as an alternative to the lost inpatient care.

[42.] I will give evidence of de-identified excerpts from contracts that PHIs have tried to push during contract negotiations with private hospitals that flout the **APHA Guidelines**

in these ways. I have had to de-identify the information because the contracts are commercial-in-confidence, preventing me from revealing which PHIs tried to push these contractual obligations on which healthcare service providers. That is why the PHIs have been able to hide their practices from the public, who have been largely unaware that the PHIs have been trying to exert control over how they are managed in private hospitals.

[43.] **(1) Example of contract clauses being demanded by health insurer that are inconsistent with the APHA Guidelines regarding decisions around referral and admission processes and inpatient procedures:**

Overnight Mental Health Threshold Requirements means that the overnight mental health service includes:

(a) the decision by the Member's treating psychiatrist to Admit the Member, either prior to Admission or where the treating psychiatrist is unavailable prior to Admission, before 12:00pm on the day following Admission

(c) On any particular day, the therapeutic time requirement referred to in item XXX of this Part XXX will be deemed to have been met where:

(i) Mental Health Therapy is available on that day, for not less than the time specified in item XXX; and

(ii) the Member's treating psychiatrist, or other member of the treating multidisciplinary team in consultation with the treating psychiatrist, determines that it is clinically inappropriate for the Member to receive Mental Health Therapy (or the specific number of hours of Mental Health Therapy), or the Member refuses to participate in Mental Health Therapy, on that day, as documented in the Records of Treatment.

(d) a copy of the schedule of Mental Health Therapy included in the Records of Treatment and otherwise made available to **XXXX** at the time of audit, including documentation of the clinical rationale for any variations made to the schedule;

(f) multidisciplinary case conferences, as demonstrated by the following documented in the Records of Treatment… and where a Member's Episode of Care is seven days or more, occurring:

(iii) at a frequency of at least once every seven days, unless a multidisciplinary case conference is due to be held on a public holiday, in which case the frequency is extended such that the multidisciplinary case conference is held on the next day that is not a public holiday;

Overnight mental health services:

(d) Where a mental health service does not satisfy each of the Overnight Mental Health Threshold Requirements only because a date, the author's name or designation was not included in a document in the Records of Treatment on a particular day as required by the Overnight Mental Health Threshold Requirements, the daily Charge for a mental

health service referred to in item XXX or XXX is the overnight mental health service rate otherwise applicable under the relevant item reduced by 5%.*****

(a) (iv) for any day on which the Member does not attend at least four hours of Mental Health Therapy (commencing the first full day after the Member's Admission, unless the Member's Admission commences before 12pm, in which case commencing on that day), the Charge is 50% of the rate referred to in paragraph XXX or XXX, as applicable XXX

Comments:

[44.] The entire contract is a full-on legalise contract that tries to micromanage a patient's admission unabashedly using a plethora of requirements and conditions backed up by frank financial penalties for non-compliance as the lever – **is this not as prescriptive** as you can get?

[45.] In this first example here (a), this insurer appears to be demanding that admission needs to occur within less than 24 hours of the referral taking place. They appear to be trying to make the parameters narrower for the inpatient team to work within, creating a bureaucratic burden so high that a larger number of referrals will unable to be accommodated. This will cause more stress on referring general practitioners, external psychiatrists and consumers and their families who are usually in a state of crisis. So it will increase their mental health burden. Also, a significant number of referrals are people who are being accommodated in public hospital emergency departments, PECC units and acute admission units. Making the referral process more complicated, tedious and labour-intensive on both sides will likely lead to longer delays before patients can be transferred to the private unit. It is likely that more of these patients will be released from their public hospital environments sooner than is currently occurring putting them at increased risk, as many of them have just made suicide attempts and may be considered less than optimally recovered to be outside of a controlled specialist inpatient setting.

[46.] They also appear to be adopting a surgical or non-psychiatrist physician specialist practice where the specialist themselves often refers a patient for inpatient care who they have already consulted on as an outpatient. This is not necessarily the case for inpatient psychiatric care, where it is more typical practice for the consultant psychiatrist managing the inpatient to have either not met them previously or not necessarily providing outpatient care for that patient. So it appears that the insurer is trying to alter the typical specialist practice model in common current practice.

[47.] These strictly defined parameters will lead to private hospital mental health resources being channelled away from inpatient care of those with *severe* mental disorders, as this group requires more person-centred care and will be more likely to need exclusions from the homogenous product that the health insurers are wanting us to provide.

[48.] It will lead to specialists preferring outpatient private practice rather than being party to an overly bureaucratic frustrating inpatient system that they don't want to

participate in. This will undermine private mental health care and drive more patients into a public system that has poor capacity for the management of consumers who do not require crisis care.

[49.] In these times of increased Freedom of Information requests, how will patients feel about reading their non-attendance at a group therapy session being pedantically documented so as to be judged as due to their mental incapacity or their refusal. What if there were other valid reasons? In the young adult mental health unit where I admit, whilst they are recovering we selectively permit the youth attendance to participate in their school or university or Tafe studies – often as part of their treatment plan to assist them as a type of graduated exposure or to assess their distress tolerance or capacity to engage or simply so that they won't miss too much from some highly important developmental task. The PHIs appear to be trying to prevent us from utilising these types of person-centred care.

[50.] With such stringent requirements for group attendance many of these other activities have been deemed inconsistent with those requirements. Already, these requirements have led to patients being excluded from other activities and set up tensions within teams where:

- Administrators or team leaders pressure staff to pressure patients
- Specialists conducting ward rounds are discouraged from seeing their patients during group therapy activities and there have been instances of patients missing their psychiatric consults to their clinical detriment
- Specialists conducting ward rounds have experienced frustrated and anxious nursing and allied health staff resistant to give access to patients in group or just before groups.

[51.] The adverse distortions to clinical care are multiple and difficult to predict and likely to be patchy and to affect some health services more than others. Psychiatric care will become perversely devalued and diminished as a result of these ridiculous pedantic punitive contractual agreements. Small hospitals or those with less beds have less bargaining power and are more likely to feel forced to agree to such 'managed care' type of contracts. It is likely that psychiatrists will become more likely to want to practice at larger hospitals with less punitive contracts. The smaller hospitals and services may 'select' for psychiatrists who themselves are prone to having more bureaucratic, subservient and financially motivated mindsets. It may well attract more junior psychiatrists who are more vulnerable to being acculturated in non-healthcare values.

[52.] It will likely diminish the amount of genuine holistic biopsychosocial care patients will receive. It will likely reduce the number of subspecialty units or units that cater to patients suffering more severe disorders. It will make therapeutic environments less therapeutic in general by setting up clinical staff to need to act like prison wardens enforcing general rules, regulations and requirements. This has the potential not only to turn therapeutic environments less therapeutic but to potentially damage the therapeutic milieu such that it is no longer able to function to provide genuine and needed psychological therapy. What can be a facilitating environment becomes instead a site for bureaucratically-endorsed abuse/non-containment and re-enactment of past

abuses due to power imbalances. It will also likely lead to many more premature discharges as patients are asked to leave for non-compliance with the insurance-led requirements of patients to comply to homogenous programs.

[53.] The second type of attempted intrusion by PHIs is into the type and duration of treatments and who can provide them, which I have divided into:

- **(2A) Types and specific amounts of treatments that must be used**
- **(2B) Decisions around who can be employed on the multi-disciplinary team**
- **(2C) Details of explanations provided for any deviations from the expected inpatient care**

(2A) Let's look at what the APHA Guidelines says about the types and specific amounts of treatments to be used:

"Consideration must be given to the **most appropriate... recovery oriented treatment options**" (Page 4)

"**Choice** and access to a **range of treatment options in consultation with the patient** and where nominated and clinically appropriate their family or carers" (Page 7)

"Comprehensive **individualised care**, access to treatment and support services able to **meet specific needs during the various stages of the individual's illness**" (Page 7)

"There will be situations where evidence does not exist for the level of complexity of some mental health problems and the nature of some forms of psychotherapeutic treatment" (Page 8)

"**At all times, in the selection of treatment options, the focus needs to be on individual needs and restoration or stabilisation of function, taking into account environmental factors for the patient, patient preferences and the patient's support systems**" (Treatment and care options, Page 10)

"It is expected that program modules designed to develop/increase skill levels or to prevent relapse will be conducted...**where possible and clinically appropriate**" (Page 10)

[54.] **Example of contract clauses being demanded by health insurer that are inconsistent with the APHA Guidelines regarding this issue**

Overnight mental health services

(a) If a rate for a mental health service provided to a Member who is Admitted for one or more Admitted Days at:

(iii) subject to item XXX of this XXX, for each day on which the Member attends at least 4 hours of Mental Health Therapy, the Charge:

(i) for any day on which the Member does not attend at least four hours of Mental Health Therapy (commencing the first full day after the Member's Admission, unless the Member's Admission commences before 12pm, in which case commencing on that day), the Charge is 50% of the rate referred to in paragraph XXX or XXX, as applicable XXX,

provided that the maximum Charge reduction under this item XXX will not exceed 50% of the total amount for all Admitted Days in the Member's Episode of Care calculated in accordance with the applicable rate referred to in paragraph XXX, or XXX,

(b) On any particular day, in determining whether the Member attended at least four hours of Mental Health Therapy for the purpose of items XXX and XXX, the following will be taken into account:

(i) consultation time with the Member's treating psychiatrist (as indicated by the MBS item number);

(ii) participation in specialised group therapy programs and one-to-one counselling/therapy sessions, as set out in the Member's documented schedule of planned Mental Health Therapy, where evidence in the Records of Treatment (or otherwise made available for review at the time of the relevant Onsite Audit) demonstrates that the Member attended the programs/sessions;

(iii) where there is documentation in the Records of Treatment of Mental Health Therapy provided by a career medical officer, medical registrar, medical fellow or equivalent, this will be considered to amount to 30 minutes of Mental Health Therapy on any particular day;

(iv) where there is documentation in the Records of Treatment of Mental Health Therapy provided by a Mental Health Nurse, 20 minutes will be allocated per interaction between the Member and a Mental Health Nurse, up to a maximum of 60 minutes per day, but this does not include bedside nursing care (for example, provision of medication and taking observations).

[55.] Just in case there is any question as to how pedantically and seriously the insurer intends to utilise these clauses in their audits, down to the fine detail, they provide this "Worked example":

A Member is Admitted for overnight mental health treatment at a XXX Hospital with a length of stay of 10 days Each of the Overnight Mental Health Threshold Requirements IS satisfied but on days 2 3 and 4 no Mental Health Therapy is provided There is also no document in the Records of Treatment that it was clinically inappropriate for the Member to receive Mental Health Therapy on those days or that the Member refused to participate in Mental Health Therapy In accordance with item XXX the Charge for days 2 3 and 4 IS 50% of the rate referred to in item XXX

Comments:

[56.] The insurer appears to be trying to determine the ingredients of our inpatient program by weighting them based on their preferences and threatening penalties, as shown. This will distort the types of interventions that our service will be able to provide. Their weightings fly in the face of evidence-based interventions, individualised care, patient preference and medical interventions.

[57.] It is most concerning that the health insurers are becoming **"prescriptive"** by unilaterally developing their own definitions, strictly defined parameters and thresholds as to what they consider "mental health therapy". Is it reasonable for the insurer to determine these thresholds? Is it not up to clinicians (i.e. who are overseen by regulatory bodies such as Medical Colleges, the national AHPRA, state-based Medical Boards and Health Care Complaints bodies, the AMA, the federal and State Courts etc), hospital-based clinical leaders and healthcare hospital accreditation systems (which have their own federal and state based regulatory bodies overseeing them) to determine the parameters and thresholds around quality medical care? This is very dangerous territory for healthcare practitioners, providers and the other regulatory bodies to give up to health insurers.

[58.] Due to the heavy contract penalties – with even small penalties likely to accumulate and rob the healthcare service of its funds, providers will be forced to provide a more homogenous product – that means less person-centred or less "patient centric care".

[59.] The level of required documentary evidence purely for the purpose of protecting hospital income in the event of a PHI-instigated audit associated with financial penalties for minor absences of information that they have stipulated as necessary has crossed the line into being unreasonable, intrusive and distracting from clinical priorities. Furthermore, it will risk reducing clinical resources being prioritized for patient care. Requiring this level of paperwork by clinicians undermines time spent on direct clinical care of the patients. It is classic managed care methodology to turn clinical care into a bureaucratic exercise that undermines independent best practice mental health care. It is an attempt to substitute existing quality control processes with processes that reflect PHI priorities.

[60.] More resources will flow towards providing a defensive clinical care approach – it will force upon the clinical scenario more closer scrutiny by hospital administration to ensure intensive effort is made to comply with the detail in the contracts. More energy will go into 'looking good' – the shop front – rather than actually 'providing' high quality care.

[61.] **(2B) What the APHA Guidelines says about who can be employed on the multi-disciplinary team:**

Nursing staff "may include", in addition to ACMHNs:
"registered and enrolled nurses and nurse practitioners registered with AHPRA".
Appropriately trained mental health professionals will make up the majority (minimum 60%) of the staffing numbers [p 14]

[62.] **Example of contract clauses being demanded by health insurer that are inconsistent with the Guidelines regarding this issue**

Definitions

Mental Health Nurse means a Health Professional with postgraduate study in mental health nursing at Graduate Certificate, Diploma or Masters level or solely qualified in the area of mental health nursing.

Comments:

[63.] In trying to restrict the types of clinicians a mental healthcare service can employ based on their narrow definitions of some clinicians based on their own preference of credentials, this is very dangerous territory as it will take away any individual health service from determining its own staffing formula to meet the clinical needs of the subpopulation it is trying to serve.

[64.] **(2C) What the 'Guidelines for Determining Benefits for Private Health Insurance Purposes for Private Mental Health Care 2020 Edition'** (**Australian Private Hospitals Association) says about any details of the specific biopsychosocial ingredients of inpatient care:**

"Hours per patient day will be an average of 4 hours, with the aim of achieving 4.2 hours, per patient day over 7 days" [p 14]

[65.] **Example of contract clauses being demanded by health insurer that are inconsistent with the APHA Guidelines regarding this issue**

Overnight mental health services

(a) If a rate for a mental health service provided to a Member who is Admitted for one or more Admitted Days at:

(iii) subject to item XXX of this XXX, for each day on which the Member attends at least 4 hours of Mental Health Therapy, the Charge:

(A) where during the Episode of Care the mental health service satisfies each of the Overnight Mental Health Threshold Requirements, the rate referred to in paragraph XXX or XXX, as applicable; or

(B) where during the Episode of Care the mental health service does not satisfy each of the Overnight Mental Health Threshold Requirements, 50% of the rate referred to in paragraph XXX or XXX, as applicable; and

(i) for any day on which the Member does not attend at least four hours of Mental Health Therapy (commencing the first full day after the Member's Admission, unless the Member's Admission commences before 12pm, in which case commencing on that day), the Charge is 50% of the rate referred to in paragraph XXX or XXX, as applicable,

provided that the maximum Charge reduction under this item XXX will not exceed 50% of the total amount for all Admitted Days in the Member's Episode of Care calculated in accordance with the applicable rate referred to in paragraph or

(b) On any particular day, in determining whether the Member attended at least four hours of Mental Health Therapy for the purpose of items XXX and XXX, the following will be taken into account:

(i) consultation time with the Member's treating psychiatrist (as indicated by the MBS item number);

(ii) participation in specialised group therapy programs and one-to-one counselling/therapy sessions, as set out in the Member's documented schedule of planned Mental Health Therapy, where evidence in the Records of Treatment (or otherwise made available for review at the time of the relevant Onsite Audit) demonstrates that the Member attended the programs/sessions;

(iii) where there is documentation in the Records of Treatment of Mental Health Therapy provided by a career medical officer, medical registrar, medical fellow or equivalent, this will be considered to amount to 30 minutes of Mental Health Therapy on any particular day;

Comment:

[66.] The **APHA Guidelines** encourages thinking in terms of averages over 7 days rather than an unreasonable expectation that every patient is going to be mentally fit to be able to attend 4 hours *minimum* per day. It is more helpful to think about averaging over each week of admission but again this is a guideline and it would be more appropriate to provide an average amount of therapeutic interventions and the proportion of that that is actually utilised by any patient is reflected in their needs, capacity and impact on other inpatients.

[67.] **(3) What the APHA Guidelines says about** quality assurance processes**:**

"engage in recognized quality assurance processes, including review of services against the National Safety and Quality Health Service Standards 2nd Ed, by an **independent accreditation agency**" (Page 5)

[68.] Example of contract clauses being demanded by health insurer that are inconsistent with the APHA Guidelines regarding this issue

Overnight mental health services:

(e) Where a mental health service does not satisfy each of the Overnight Mental Health Threshold Requirements only because a multidisciplinary case conference does not occur at the frequency required by the Overnight Mental Health Threshold Requirements (**Due Date**), the daily Charge for a mental health service referred to in item XXX or XXX is 50% of the overnight mental health service rate otherwise applicable under the relevant item, only for those days after the Due Date.

[69.] Just in case there is any question as to how pedantically and seriously the insurer intends to utilise these clauses in their audits, down to the fine detail, they provide this "Worked example":

A Member is Admitted for overnight mental health treatment at a XXX Hospital, with a length of stay of 10 days. There is no multidisciplinary case conference during the Member's Admission documented in the Records of Treatment, but all other Overnight Mental Health Threshold Requirements are satisfied, and the Member attended more than four hours of Mental Health Therapy on each day. In accordance with item XXX, the daily Charge for days 8, 9 and 10 is 50% of the rate referred to in item XXX

Comment:

[70.] Any audits unilaterally conducted by an insurer are an inappropriate measure to use to gauge whether a service is 'complying' with their terms of any contract as it is examining clinical processes and measures and there is a conflict of interest as it pays for the insurer to find fault as that means they can argue for return of funds and it gives them an excessive degree of control over an individual's clinical care.

[71.] If the health insurer wishes to undertake an audit they should pay for a mutually-agreed, appropriately qualified and independent (3rd party) agency to conduct any audits.

[72.] Any individual admission should not be funded piecemeal such that financial penalties are applied for minor incursions. If it is too late to change this as there are existing contracts with these clauses, at least there should be an independent auditor and independent arbiter about financial penalties. It is a complete farse for an insurer to be able to send their clerk to examine confidential sensitive psychiatric files for the purposes of conducting a fishing expedition to find excuses to claw back funds already paid. This is undermining viability of these clinical practices and healthcare services.

[73.] Outcome data has been collected for many years and those results should be adequate to show whether a hospital is providing quality care, along with accreditation of services and accreditation of clinicians.

[74.] **(4) What the APHA Guidelines says about decision-making about referral for inpatient care:**

"Treatment in the most facilitative environment **appropriate for the individual patient**" (Page 7)

"The following factors need to be considered when selecting the most appropriate setting for care delivery: patient acuity, level of distress and disability; level of social supports in the home; geographical considerations" (Choice of setting, Page 8)

[75.] **Example of contract clauses being demanded by health insurer that are inconsistent with the APHA Guidelines regarding this issue**

I am aware of examples of insurers demanding evidence of the high acuity in their contracts. The closest I can find states:

"Criteria 1

A psychiatric service is provided to a member who meets the relevant admission criteria set out in the Mental Health Guidelines:

1. High risk of harm to self and others
2. Incapacitating symptoms of distress
3. The needs to establish the nature of a disorder, initiate or stabilise complex treatment modalities
4. Significant problems in initiating treatment, or continuing treatment in another setting."

[76.] The response at the hospital negotiating this clause was to educate nursing staff about HONOS scoring to ensure patients are adequately scored so that the PHI isn't going to argue that the patient wasn't sick enough to warrant admission. Here is a quote from a sensitive internal memo:

"All records are checked by the NUM on discharge and issues with underscoring are discussed with the individual nurse and/or the team".

[77.] In Item 1 above the insurer is attempting to disqualify patients from admission if the hospital they have been referred to is unable to accommodate them within 24 hours.

[78.] I am aware of an insurance contract that refuses to pay for admissions where eating disorders or substance use disorders are the predominant mental disorder arguing that the unit doesn't have subspecialty expertise. The consequence is that the hospital's administration discourages psychiatrists from including these diagnoses and downgrading them to state "disordered eating" or "eating disorder in remission" or 'substance abuse" rather than "dependency".

Comment:

[79.] It won't be long before they demand thresholds being met, second opinions (subjecting patients to assessments and recommendations by other PHI-hand picked clinicians or 'hired guns') and other measures to delay and disrupt the care of the clinicians chosen by the patient and their general practitioners.

[80.] This a dangerous precedent for insurers to define which mental disorders are coverable by their policy and the level of acuity that they are willing to fund.

[81.] The example I have provided here shows the consequences of restrictive clauses that narrow the reasons a PHI will fund an admission – it leads to clinical staff being put in the outrageous situation of needing to ensure their documentation about the patient reflects the PHI requirements rather than what is required to communicate and meet the patient's needs. This will cause a massive detrimental impact on the quality of patient care.

[82.] **(5) What APHA Guidelines says about biopsychosocial care specifically with regard to physical healthcare of patients with mental disorders:**

"The treatment plan will address the **physical health** of the patient" (Page 11)

[83.] **Example of contract clauses being demanded by health insurer that are inconsistent with the Guidelines regarding this issue**

> **Overnight mental health services**
>
> (b) On any particular day, in determining whether the Member attended at least four hours of Mental Health Therapy for the purpose of items XXX and XXX, the following will be taken into account:
>
> (iv) where there is documentation in the Records of Treatment of Mental Health Therapy provided by a Mental Health Nurse, 20 minutes will be allocated per interaction between the Member and a Mental Health Nurse, up to a maximum of 60 minutes per day, but this does not include bedside nursing care (for example, provision of medication and taking observations).

Comment:

[84.] The PHI contract here is defining therapeutic hours in ways that exclude physical health interventions and monitoring. This in effect penalises nurses engaging in physical health interventions and monitoring.

[85.] The gap in recognition of the importance of addressing physical health conditions and risks (whether associated directly or indirectly with the mental health problems) is stark.

[86.] PHI contracts like this one pushing for a focus on the group psychological therapy component of a psychiatric admission to the exclusion of their medical care, expecting patients to pay for anything beyond treatment of their mental disorder supposedly because they are in a mental health setting, shows a concerning disregard that the patient is under the clinical care of a psychiatrist who is a medical specialist who is ultimately medicolegally responsible for the healthcare of the patient.

[87.] I am aware that the **Australian Private Hospitals Association** has been trying without success to reverse this obscene refusal by PHIs to fund management of comorbid physical conditions in their **Draft APHA position statement: Private Health Insurance coverage for medical and surgical treatment of patients with a psychiatric diagnosis**.

Conclusion

[88.] I have shown you evidence of the unscrupulous methods that the PHIs have been increasingly trying to use to influence healthcare practices and processes, including:

- Denying their members quality medical care by influencing referral and admission processes

- Capping the amount of care and interventions permissible in a year
- Influencing the duration of admissions by imposing financial penalties for complex patients and complications
- Introducing prescriptive treatment schedules, audits of their members' health records and imposing financial penalties for lack of compliance with the treatment algorithms in their contracts, thereby overriding existing quality assurance processes, standard medical practices (trauma-informed, person-centred care and collaborative decision-making) and influence the type of care that a patient receives (preferring cheaper, simpler and faster types of care)
- Trying to influence specialist opinion leaders and high-profile clinicians
- Tactics to undermine the viability of health services in order to then gain an advantage in purchasing or controlling targeted health services

[89.] On 24th December 2020, the same date that the NIB/Cigna alliance applied for this exemption that would give them greater power to push clauses as highlighted above into private hospital contracts, the Commonwealth Department of Health opened a public consultation in response to the ***PHIs lobbying for another exemption***.

[90.] They want permission to be able to make ***contracts with individual clinicians*** to thereby enable them to fund ***outpatient care*** in the specialty fields of ***palliative care, rehabilitation medicine and mental health***.

[91.] If they win that exemption from the Commonwealth Government *and* the exemption to collectively bargain, that will allow the entire oligopoly of PHIs to have a massive anticompetitive power in the healthcare industry. It would open the floodgates to PHIs pushing contracts with any content they wanted onto private hospitals providing inpatient care *and* individual clinicians providing outpatient care.

[92.] **Which patients would be affected?** Dying patients, those so disabled from massive injuries and severe conditions that they require rehabilitation care, and those with mental disorders. It is noteworthy that they have targeted the most vulnerable patients first. Because that's what predators do.

[93.] Where will it lead? Well, the CEO of a large PHI was quoted in a newspaper article a few years ago stating that his PHI did not wish to pay healthcare providers for any adverse outcomes. He implied that in the event of an adverse health outcome it would be assumed that the healthcare providers involved must have been negligent. It was chilling to learn that he was even quoted as saying that if a suicide occurred, why should the PHI have to pay the healthcare providers involved? The insensitivity of that perspective goes to the core of why you cannot trust PHIs with more power than they already have. They will misuse that power if you give it to them. Their promises are absolutely worthless.

[94.] If that is what PHIs mean by poor "value" then they are saying they only consider value to occur where there are positive outcomes. They will devalue any healthcare that they consider to be of low value. Anyone who has a chronic condition, complex needs, disability or is terminally ill might be dubbed to be too low in value to fund. This is very

very dangerous territory to potentially give them to decide who is valuable enough to fund.

[95.] My colleague, Dr Melinda Hill, who is a psychiatrist with psychoanalytic training has provided a verbal submission and written submissions (one signed by 53 psychiatrists and trainees and one on behalf of the National Association of Practicing Psychiatrists), in which she explains the adverse psychological effects on patients and healthcare clinicians of PHIs being able to impose secret contracts containing secret clauses that enables managed care to creep into medical practices (as I have shown evidence of above) with healthcare services or clinicians. She also explains how this is incompatible with effective, quality and ethical healthcare practices. I fully endorse that view.

Secret contracts either directly with clinicians or indirectly through Trojan Horse strategies such as pushing contracts with hospitals that effectively recruit hospital administrators and managers to impose managed care practices on the healthcare employees and visiting medical officers is not only unethical – as it undermines trust and is abusive behaviour – it also distorts collaborative healthcare decisions and thereby undermines healthcare processes and health outcomes.

[96.] This multipronged ***campaign to introduce US-style managed care*** into Australia must be absolutely, completely and firmly stamped out right now.

[97.] It is important to send a strong message to the entire PHI industry that there is no chance of their being able to be exempted from an anticompetitive regulation that is in place for good reason.

Do not give NIB/Cigna permission to collectively bargain in 40% of cases. Even 4% permission would be the equivalent of letting their 'toe' enter the back door.

Please 'say no' to managed care being brought to our shores by *completely* closing the door to them. Don't given them *an* exemption. Otherwise, our house will end up being burnt to the ground.

Yours sincerely

Dr Gary Galambos, Conjoint Senior Lecturer, UNSW
Consultant Psychiatrist

Delegate, Council of Procedural Specialists (COPS)
Section of Private Practice Psychiatry, RANZCP
AMA Mental Health Committee