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By email: exemptions@accc.gov.au

Re; **Honeysuckle Health and nib application for Authorisation AA1000542 — interested party consultation**

Dear Mr Pappa,
Thank you for the opportunity to provide comment as an interested party on the application from Honeysuckle Health Pty Ltd (HH) the equal joint venture formed between nib health funds ltd and Cigna Corporation (the applicants).

Introduction
The Australian Acupuncture and Chinese Medicine Association (AACMA), has been representing and advocating on behalf of its members and the Chinese medicine profession since 1973. Currently, the AACMA provides the largest representative voice for its members who make up the majority of registered Chinese medicine practitioners in Australia and the profession.
As at 30 September 2020, there are 4933 registered Chinese medicine practitioners in Australia according to the most current statistics from the Chinese Medicine Board of Australia (CMBA) https://www.chinesemedicineboard.gov.au/about/statistics.aspx

Background
In 2012, Chinese medicine was included under the National Registration and Accreditation Scheme (NRAS) for health professions as a registered allied health profession. Below from the NRAS website

"A further four allied health professions joined NRAS on 1 July 2012: Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners, medical radiation practitioners and occupational therapists. A description of the above disciplines included under NRAS is outlined in Chapter 2."
https://www1.health.gov.au/internet/publications/publishing.nsf/Content/work-review-australian-government-health-workforce-programs-toc~chapter-8-developing-dental-allied-health-workforce~chapter-8-allied-health-workforce

Private health funds categorise Chinese medicine practice as a natural therapy rather than allied health as recognised under the NRAS.

A natural therapy categorisation means the health funds pay a lower rebate to their fund members for a Chinese medicine consultation and treatment whether acupuncture treatment or Chinese herbal medicine.

This leaves the health consumer more out of pocket because their preferred option of a Chinese medicine treatment, which provides and benefits them with their best health outcome, receives a lower rebate.
Despite authorisation being granted on July 15 2020 by the ACCC for rebates for telehealth consultations especially during the COVD pandemic, the private health funds again discriminated by denying the patients of Chinese medicine practitioners rebates for such consultations while rebating other allied health professions for their teleheath service.

Comment
The background information provided is hugely relevant to our comment on the HH application
While the HH application declares negotiating with health care providers including hospitals, medical specialists, general practitioners and allied health professionals, their current recognition and categorisation of Chinese medicine suggests that our profession will not be included.
(https://www.nib.com.au/providers/extras?area=3BcXvzBPUs6Eya8sqQqGCW)

As AACMA sees it, there are three potential scenarios -

1 Fund members- the public who pay premiums to the health funds- who choose Chinese medicine treatments will be denied or may not benefit from the HH application if successful, because the natural therapy categorisation excludes Chinese medicine as an allied health modality
2 Chinese medicine will be included in this HH initiative though, if Chinese medicine practitioners are classed as natural therapists, the offers or payments to them will not have parity with the other allied health professions as is occurring currently. This is despite requiring the same mandated levels of education, insurance, and maintenance of professional development as the other registered allied health professions.
3 Negotiations with the Chinese medicine profession will be conducted without discrimination, equally as with any of the other registered allied health professions thus providing the public with a true and balanced benefit while still preserving their choice of preferred health care treatment with their preferred practitioner.

The projected collective buying power if authorised, will only provide accessibility to the health care providers with whom there is a contract potentially creating an inequitable market place and providing a similar health insurance system as seen in the United States of America.
Will the health consumer be impacted with higher health insurance premiums or decreased rebates for the privilege of gaining any benefit of the bulk buying; similar to paying a yearly fee to be eligible for bank rewards on credit cards?

Another issue that could have an impact relates to the preferred provider schemes private health funds have for their members.
For example, practitioners of nib's First Choice Network have their maximum fee rate set by nib-

"The First Choice Network is a community of trusted healthcare professionals who provide health services at a set reduced cost or agreed discount to nib members to help lower out of pocket costs. The agreed reduced cost can vary between First Choice providers; however, you agree not to exceed the set reduced cost."

https://www.nib.com.au/providers/first-choice-network

While AACMA recognises that it is the individual practitioner's choice to be part of such a program **just** for promotion on the nib website or which ever other health fund preferred practitioner they are, it doesn't seem equitable or right that an entity that makes money from annually increasing health fund premiums paid by the public, can set and limit the fee that a registered practitioner can charge for their service. This longstanding economic agreement program has an illegal aspect as nib states that it has gathered together a group of "trusted" professionals and therefore endorses, which breeches National Law by providing a testimonial that certain practitioners are superior to others. This history provides little faith in the organisation's future intentions.

As stated in 5.14, *"In relation to the medical gap scheme and general treatment network, the HH Buying Group would not be negotiating agreements with Providers. Due to the large number of individual health providers in the industry (circa 50,000), the HH Buying Group will be managing schemes based on a standard schedule of rates and terms and conditions. nib's current scheme is determined on a state basis for dental and physiotherapy networks and a national basis for other types of general treatment networks and its medical gap scheme".*

Who has set this standard schedule of rates and terms and conditions?
On what are these standard rates based? Is it the Medicare standard or the eight State or Territory Work Cover schemes or some other standard?

Will inclusion of a practitioner mean further fee limits on the treatment or services they provide?

As Comcare recognises and accepts Chinese medicine practitioners to deliver acupuncture treatments, the Department of Veterans Affairs will only accept a general practitioner providing the acupuncture treatment. This makes it more difficult to speculate on any impact Government payers will have on the bargaining process.

Summary
Chinese medicine is a registered allied health profession under the NRAS but is categorised as a natural therapy by private health funds thus potentially excluding the profession from the negotiations proposed in this application. Considering the three scenarios postulated

- Scenario one potentially disadvantages the health consumer if no contract is negotiated because Chinese medicine is not recognised as allied health
- Scenario two potentially disadvantages the Chinese medicine practitioner if fees are limited as for a natural therapy and not allied health
- Scenario three would need Chinese medicine to be recognised and reclassified by the health funds as a registered allied health profession

The First Choice and other preferred provider programs have shown that fee limits are set by the private health insurers and to be included, while still a personal and professional choice by the practitioner, is not as advantageous to the practitioner as promoted. The supposed benefit to practitioners is promotion on the health fund website implying

endorsement and testimonial, though now made almost redundant by the consuming public's increased use of Google and other search engines for information.
Will this new initiative if authorised, further impact on the earning ability of contracted practitioners if set fee limits are a requirement for their participation?
Fee limits set and imposed by agents external to the profession or industry is a threat to true competition because it benefits the external agents and their needs and not the profession or industry. These fees are set without any consultation with the representative professional bodies thus completely disadvantaging their members' ability to fair and equitable earnings.

Conclusion

Due to the necessity to preserve confidentiality as requested by the lawyer representing HH there is insufficient information provided to allow for the full evaluation of the scope of this initiative and the attendant negotiations are only imaginable.

While the intent seems to be that the projected collective buying power will provide benefits to the consumer, any net benefit will only be available to the health consumer whose health insurer is a participant or whose health practitioner has a negotiated contract with the collective.

This could potentiate a restriction of choice for the public. The precedent for this form of practitioner exclusivity and insurance cover is seen in the broken USA healthcare model, where those that can least afford healthcare are significantly disadvantaged, and the subsequent burden of chronic disease management and healthcare will be further thrust upon and potentially overwhelm Medicare

There is no clarity on what type of contract would be offered to participating practitioners so it is difficult to approve such an initiative and certainly not for a ten year period especially in the volatile market of private health insurance.
Would the initial contract for participating health providers stand for the whole ten years authorised or be renegotiated every year?

Travel insurance companies have been listed as possible participants, is there not some conflict of interest as nib, one of the applicants, has acquired QBE travel insurance and now operates in that space?

As a professional association representing a registered profession with relatively few registered practitioners compared with medical specialists, general practitioners or the other registered allied health professions and thus less clout, AACMA believes that Chinese medicine practitioners would not be perceived equitably and our members and potentially their patients would be disadvantaged by the approval of such an authorisation.

Thank you for considering our comment.

Yours sincerely,
Waveny Holland
AACMA President