Medical Surgical Assistants Society of Australia

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Commissioner Stephen Ridgeway
Australian Competition and Consumer Commission

27th July 2021

Dear Commissioner Ridgeway,

I am the president of the Medical Surgical Assistants Society of Australia (MSASA), and in that capacity represent the several thousand doctors who assist regularly in private surgery. MSASA is a member organisation of COPS, the Council of Procedural Specialists.

Unfortunately I was unable to give my presentation on behalf of MSASA on 8th July, but I thank you for the opportunity to make a further written submission.

The MSASA executive has further considered the nib and HH proposals, the various submissions in response, and the replies by nib and HH. The meeting on 8th July was most informative.

MSASA believes there are 5 key public detriments that will flow from the proposed conduct should nib and HH be given approval to form this buying group, with or without conditions.

They are:

1. A loss of choice for surgeons, assistants, anaesthetists and patients.

2. A resultant loss of efficiency in the system - the more choice, the more flexible and adaptable the system is. If you reduce choice, the system is less able to cope with external shocks and efficiency suffers.

3. The erosion or total loss of the independence of the Medical Surgical Assistant role, which will increase perioperative risks for patients.

4. A large increase in the administrative cost of the health system due to extensive contracting requiring frequent renewal.

5. The introduction of US style “managed care”.

To explain these one must appreciate the sophistication of the current private surgical system which has evolved in a relatively “free market” since the introduction of Medicare in 1984. After 37 years, that system is mature and operates very efficiently.

When it comes to surgical assistants a wide variety of doctors perform the role, including specialist or full-time surgical assistants, GPs, Sports Medicine Physicians, surgeons (both active and retired), surgical trainees and others. Major surgery is all about teamwork and

surgeons tend to have regular teams of assistants and anaesthetists to help them. This leads to maximal efficiency in the long run. In daily practice things can and do go wrong - someone is delayed by an emergency; someone calls in sick; someone is double booked. In most cases these problems can be resolved very quickly, and surgery can proceed. Because of the free market (ie no contracts) a suitably qualified fill in assistant or anaesthetist can usually be found at short notice, and surgery can proceed with minimal delay, which is great for all parties, including the hospitals.

Now the detriments:

1. Under the proposed Clinical Partners Program (CPP) model there is an immediate loss of choice. The insured patient is "encouraged" to go to a CPP surgeon, and perhaps to a less convenient hospital, because there is a financial incentive to do so. But that surgeon may not be the preferred referral by that GP. The situation coerces the GP to refer differently. When it comes to choosing a surgical team, the surgeon has less choice - he or she must choose similarly contracted colleagues to provide both anaesthetic and surgical assistance services. This will likely restrict the pool of colleagues available making it more difficult to find replacements when staffing issues arise.

   Under a CPP model assistants will need to consider the viability of working with a CPP surgeon. If not so contracted themselves they will have to accept whatever fee the surgeon has "negotiated" or not, on their behalf. If this is unsatisfactory, MSA's will quickly decide to work with non-contracted surgeons, which will reduce the pool of assistants available to assist that surgeon. Ie loss of choice.

   This loss of choice will have flow on effects. The most significant will be the potential loss of experienced team structures that are important facilitators of high quality outcomes.

2. The loss of efficiency that flows from the aforementioned contracting restrictions is self-evident we believe.

3. Loss of independence of the Medical Surgical Assistant (MSA) role - under the CPP model the assistant will likely not have a direct financial contract with the patient. This is a big shift. One of the great advantages of the current system is the independence of the MSA. They have a separate financial contract with the patient and a separate **independent** duty of care to the patient. They must carry their own indemnity insurance. This relationship creates a patient advocacy role which is a tremendous risk management safeguard for the patient. If MSA's lose their independence, the risks to the patient will increase.

4. Australia's health system is highly regarded for its administrative efficiency. In contrast the US "Managed Care" system is notable for its bloated administrative costs. In Australia the administrative spend is approximately 10% of the overall spend. By world standards it is extremely efficient.

In contrast, the US administration spend is around 25% of the total cost.

Regardless of whether HH calls this managed care or not, when every doctor must sign contracts with multiple insurers just to go to work, and when these contracts will no doubt have to be renegotiated every year or two, that administrative workload will be immense, and that will represent a new ongoing cost to the system. If HH counters this by saying a large buying group would mean fewer contracts for doctors, this implies a far greater inequity in any negotiating process, which will be bad for doctors and ultimately bad for patients.

5. Finally, is the HH proposal going to lead to US style Managed Care? If you were to ask any of the medical groups opposing the buying group, the answer would be a resounding YES. If you were to ask nib and HH, the answer ought to be different, but in fact it is the same. It is also a YES.

   The applicants clearly laid this out in their submission of 30th June 2021.

   I refer to points 3.3-3.5 on page 3 of that document. Here the applicants explicitly state that the features in (c) and (d) below would constitute managed care and the Applicants strongly agree that they should **not** form part of Australia's healthcare system.

   (c) insurers controlling the healthcare provider that treats a consumer and/or
   (d) insurers controlling the nature of treatment that a consumer receives

   Now on page 10 at point 4.30 they go on to say:

   "The fundamental focus of HH is measuring the impact of treatment on patients and funding Providers according to the positive health outcomes of patients".

   That seems explicit to MSASA. HH intends to fund providers according to HH's (not the doctor's) assessment of treatments and the outcomes they produce.

   Controlling doctors by funding or NOT funding treatments is managed care by HH's own definition. **And here they state that this is the fundamental focus of HH.**

   Further at 3.4 the applicants state that:

   "3.3 (b) value based contracting or any funding model that is linked to performance"

   does not constitute managed care. How is a funding model linked to performance NOT an attempt to control a healthcare provider as in (c) above?

   Nib and HH are therefore intent on "Managed Care" by their own definition, while continually denying it.

In summary then:

1. All parties (including nib and HH) appear to agree that US Style "managed care" has no place in the Australian Healthcare system.

2. nib and HH health want to form a buying group whose "fundamental focus" is to fund providers according to HH's own assessment of patient health outcomes.

3. If funding is to be used as a tool to control treatment, by HH's own definition, this **IS** US style Managed Care.

By cloaking their vision in terms such as "value based contracts" HH are trying to deceive all of us, especially the ACCC. These VBC's are a wolf in sheep's clothing – they ARE "managed care".

Therefore the ACCC must NOT approve this buying group, even with conditions. Approval **WILL** set the Australian Healthcare System on the path to US Style Managed care, and there will be no turning back. This **will be** a **significant public detriment**, and it will far outweigh any of the claimed benefits of nib and HH.

Nib and HH already have their Clinical Partners Program and should not require the power of a massive buying group to prove its value. If nib and HH's vision is the best way forward for Australian private healthcare, then they should prove it with real Australian data (not US or overseas data) obtained with the permission of Australian consumers over the next several years. And they should demonstrate an eagerness by doctors to join such CPPs in normal market conditions, not during the course of a global pandemic when the private medical workforce is under extreme duress both clinical and financial.

The stakes are so high here that the burden of proof of public benefit must be set high. Nib and HH have little evidence to prove their claims and the ACCC must protect Australians from the high risk of severe public detriments.

Thanking you and your fellow commissioners for your consideration,

Yours sincerely

Dr Nigel Munday
President MSASA 2021

On behalf of the executive.