Royal Australasian
College of Surgeons

14 June 2021

250–290 Spring Street
East Melbourne VIC 3002 Australia
Telephone +61 3 9249 1200
www.surgeons.org
ABN 29 004 167 766

Commissioner Stephen Ridgeway
Australian Competition & Consumers Commission
23 Marcus Clarke Street
Canberra ACT 2601

By email: exemptions@accc.gov.au

Dear Commissioner,

RE: AA1000542 – Honeysuckle Health and nib Determination– Submission

The Royal Australasian College of Surgeons (RACS) appreciates the opportunity to respond to the Draft Determination and to have met with yourself and your managerial and executive team.

Executive summary

RACS cannot support the Application made by Honeysuckle Healthcare Pty Ltd (HH) and other applicants for authorisation to form and operate a buying group despite the time being reduced to a period of five years and would urge the ACCC to reconsider its draft determination. RACS's concerns relate to the disruption this application and determination will impose upon our blended healthcare system.

- There does not appear to have been sufficient input from the Health Minister or Department as to whether this is within the public interest. It is not acceptable that the ACCC provide an exemption for what appears to be anti-competitive cartel behaviour. There is opposition from other key medical and hospital groups, also with significant concern that this is not in the public benefit from the health policy perspective.
- This application is inconsistent with current Government Policies, which allows practitioners to impose reasonable gaps to patients where appropriate. The committee, of which RACS is a member, is working on alternative models to reduce OOP expenses whilst maintaining practitioner independence regarding billing and maintaining patient choice regarding their treating hospital and practitioner. If this application is allowed to proceed it undermines current Department of Health policies and endeavours to protect the national interests of public healthcare.
- The application is counter to the notion of a blended healthcare system, clinical discretion and patient's billing choice. This represents contractual restrictions in an all or nothing bid for market supremacy influenced heavily upon the financial cost of a procedure
- It provides data and analytics in absence of any risk adjustments for geography, patients with existing medical conditions, complexity, and with no assurance regarding the governance of this data. There is also no discussion regarding the applicant's intention regarding public release of potentially damaging inaccurate data and no assurance that the data won't be used in a punitive manner against hospitals and practitioners rather than for quality improvement.
- Creates a cartel which could comprise up to 50% market share making it independently more powerful than any individual private insurer such as Medibank Private or BUPA that comprise collectively 50% of the market share, hence creating excessive power of a single entity regarding the setting of "value" based payments to hospitals and practitioners, which are not independently determined, nor reviewed or indexed. Whilst it is true that hospitals and practitioners can choose not to participate, there will be coercion to do so as the default payments offered in the absence of a contract may be so poor that financial viability of hospitals and individual practitioners would be uncertain, hence effectively forcing them to enter these contracts.
- As such the applicants appear to be using anti-competitive behaviour, to set its own "value" proposition and hence drive down payments to hospitals and practitioners. There is also clear evidence of this with NIB already reducing payments under contract to private hospitals, to

maximise their own profits. This will reduce choice, and more importantly reduce quality of care neither of which are in the public interest.

- Lastly, they plan to offer a total no gap experience for patients. Whilst superficially attractive, it is important to note that in the private system, practitioners are contractors of the facilities provided within a hospital but not employed by the hospital. As such the situation could arise that a hospital contracts to Honeysuckle, which would then force all practitioners that use the facilities of that hospital into contracts that they do not wish to engage in themselves. For medical staff who have built their careers at a particular hospital over a 20-to-30-year time frame it would not be possible to simply move to practice elsewhere, and as such this coerces them to sign contracts in order to continue practicing.
- Despite the assurances of no boycotts against non-contracted hospitals or doctors, this no gap program will be heavily marketed, forcing other major funds to follow suit, and effectively boycotting hospitals and practitioners who fail to participate in the contracts.

Detailed analysis

RACS is the leading institution for the training of surgical practice for more than 7,000 surgeons and 1,300 surgical trainees and Specialist International Medical Graduates in Australia and New Zealand.

Billing vs. Clinical Discretion
Currently the no gap and known gap contracts are at the discretion of the clinician on a per patient basis. This proposal takes away that flexibility and autonomy so that every patient has to be billed as per the agreed contract with no clinician discretion, it is all or none, with similar coercion of hospitals to provide a no gap experience for patients.

1.16 Conduct voluntary, and no collective boycott
By creating an imbalance of power and effectively driving out 2 other buying groups, ACCC is allowing Honeysuckle Health exceptional anticompetitive powers and ultimately control of nearly 50% of the market share more than any individual health fund; heavily market these programs, and then passively coerce other non-participating funds and doctors into similar arrangements.

1.17 The Proposed Conduct will involve four categories of contracts
Hospital contracting – value-based care is managed care no matter how this is disguised. This application uses excessive market share to coerce hospitals and doctors to accept contracted rates at the determination of HH with the ability to continually reduce that amount year by year to maximise profits to HH and funds and reduce the viability of both individual doctors and hospitals. The only way reduced funding can be absorbed is by reducing add-on services, and quality of care which would not be in the public interest especially as there would be additional costs to both hospitals and practitioners in compliance with the requirements of HH.

1.28. For all types of contracts – data analytics
Data analytics are problematic with no details as to the governance of the data that is provided. Data may not be risk adjusted and hence the ability of Honeysuckle to determine quality, compliance, efficiency and value is flawed. Medibank Private recently engaged with RACS to analyse its outcome data and much of the data can be interpreted in different ways and can be used to "punish" medical hospitals and practitioners who do not provide what Honeysuckle considers value care. An example of this was the public release of urological surgical outcomes criticising urologists for a close to 100% readmission rate after bladder cancer resection within 6 months when this is in fact the standard of care.

This was reported in the lay media with major repercussions for all urologists in Australia with many patients criticising their surgeons for treating them in what was an entirely appropriate way. Without appropriate measures in place, raw data can be badly misinterpreted and damage reputations entirely unnecessarily. To reiterate, the pursuit of Quality Improvement (QI) via punitive means in absence of any risk adjustments makes this form of data analytics hugely problematic.

1.30, 1.36, 1.37 & 1.39 The Proposed Conduct involves 'value-based' contracting
RACS would argue that value care is simply a disguise for managed care. Honeysuckle will determine the "value" of a procedure, without any independent determination and monitoring of the true "value" of

an intervention, and then engage to ensure that hospitals and practitioners fall into line with this proposed determination of value. There is no independence regarding the true determination of the accuracy of the value of the procedure, and inevitably reduces a patient's autonomy to choose their treating clinician and hospital.

Based on this proposal, the contract would be for an entire gap free experience for patients, both clinicians and hospitals are unable to charge gaps to cover costs of care outside the "value" proposition. Under this model if a surgeon operates in a private hospital *and the hospital agrees to be contracted to a total no gap experience but a surgeon does not, this could then lead to damage to the surgeon's practice by being banned from operating on their patients at that hospital, reducing patient's choice and autonomy.* It may well impair a clinical decision to order an additional scan, or pathology test or engage the care of another specialist for an unexpected complication as it would fall outside the value proposition of Honeysuckle and the funds.

Hence the questions remain with this form of managed care, who sets the value, there appears to be no form of independence, and no monitoring nor indexing. Instead, a large market presence is created to reduce funding in future years on the basis of improved efficiencies. By controlling costs, clinical decisions that are made will be influenced by this value determination, potentially affecting patient care. It is introducing US style managed care despite their comments, whilst creating market power to pressure other insurers to match offerings.

3.8 Cigna
Cigna and its behaviour in the US is entirely relevant, driving profit for them and insurers, with improved costs not being passed onto consumers, and clearly highlights how this program overrides clinical independence in the name of self-determined value and best care, which is not in the public interest.

4.14 Public benefits
Transaction cost savings are debateable. Despite the applicant's comments, the heavily promoted no gap experience, will lead to the compound effect of subtle coercion of hospitals and practitioners despite reassurances not to boycott.

4.26 Increased no gap experience for customers
The Broad Clinical Partners program – completely disrupts the patient-doctor relationship and impacts on the duty of the doctor to be putting interests of patients first. It is a stated aim to put downward pressure on out-of-pocket expenses for patients by non-participating doctors – if hospital agrees to a contract with HH, and the patient is promised a no gap experience as a result, then this places pressure on any surgeon, anaesthetist or assistant who chooses not to participate to be forced to enter into a contract as otherwise they could not provide their services in that hospital. Hence the applicants are effectively creating a situation where practitioners have no choice and will be forced into that position.

RACS supports a respectful doctor – patient relationship which leads to a mutually pleasing professional relationship with improved patient outcomes as the goals of a surgeon treating patients. The relationship begins with the patient selecting the surgeon they wish and being treated on the terms they wish. No relationship is improved by a dictatorial approach – in this case by a company directing treatment options and care of a patient to a surgeon of the company's choice. There may be a variety of reasons why this may be the case. This is alluded to in item 4.26 but it didn't strike RACS as strongly presented.

4.106 suggests practitioners who do not join may do fewer procedures but charge more OOP. This is not possible if contractually a no gap experience for the entire episode of care (medical + Hospital) is promised to the patient. It is clearly of no benefit to the public to be encouraging surgeons (in particular) to perform fewer procedures (as there is clear data confirming the volume – outcome relationship, the more one does a procedure the better the patient outcomes), and certainly no public benefit creating an incentive to increase out of pocket expenses due to reduction in workload. It also does not take into account high risk procedures, with specialist surgeons reluctant to take on these complex cases due to the risk of complications being publicly reported in the HH data analytics and not being reimbursed appropriately which, again, is not in the public interest.

4.82 Competition between private health insurers
If the other major insurers are excluded from the Buying group, why are they included in the Broad Clinical Partners program? Even at 40%, this creates significant power within the market, and provides

a platform to drive down fees paid to practitioners for their services, reducing patient choice, reducing quality of care, and perversely likely to worsen the problem all medical associations are dealing with, namely the inappropriate “booking or administration” fees.

4.98 Medical specialist contracting

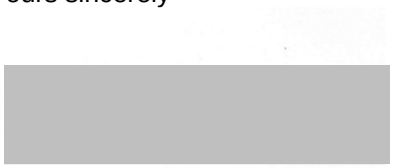
RACS proposes that Honeysuckle will engage as many funds as possible, drive down benefits paid to hospitals and by collective anti-competitive behaviour drive down benefits to clinicians as most clinicians will be "forced" to participate. This is particularly obvious by the fact that there is no limitation of which funds use their services to contract doctors. Those that choose that they do not want to participate may well be forced into it by their hospitals due to Honeysuckle's insistence of a total no gap experience. It is also inevitable that they would use substantial marketing to promote this program, hence effectively creating a boycott against non-participating surgeons and hospitals.

Conclusion

What this application and **subsequent determination creates is a vertically integrated managed care environment to the benefit of payers and** to the detriment of hospitals, practitioners and ultimately patients. At 40-50% penetration HH would become the largest force in the marketplace and would use this power to drive down payments under contract to hospitals and doctors. There will be substantial pressure of the non-participating funds to replicate what Honeysuckle is proposing, and equally significant pressure on hospitals and practitioners to be coerced into contracts that are based on a funding model that is not independently determined, is not reviewed nor indexed appropriately, and where performance is based on flawed analytics. This carries significant risk of reduction of choice of hospital and doctor for patients, of reduced quality of care, and significant risk of unintended consequences. RACS strongly feels that this application is not in the public’s interests nor consistent with current Government policies.

RACs strongly urges the ACCC to reconsider its draft determination and wishes to voice its opposition to this proposal and our disagreement with the draft determination recommendations. We are always open to continual discussions where needed with yourself and the ACCC.

Yours sincerely



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