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The Honourable Justice O'Bryan
Deputy President
Australian Competition Tribunal

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Re: Application by Honeysuckle Healthcare Pty Ltd and other applicants (nib) 'buying group' and the up-and-coming Australian Medical Association hearing in the Australian Competition Tribunal

Dear Justice O'Bryan,

We greatly appreciate your time in reading our letter.

1. Summary

Royal Australasian College of Surgeons (RACS) is the subject matter expert and peak body for surgeons in both Australia and New Zealand. We have been lobbied by our fellowship and surgical specialities to write to the Australian Competition Tribunal (ACT) expressing our concerns as to the new turn of events with respect to the Honeysuckle Healthcare Pty Ltd and other applicants (nib) 'buying group' Application for authorisation under section 88(1) *Competition and Consumer Act 2010* (the Act).

In short RACS supports the Australian Medical Association (AMA) in their letter submitted to you on the 6 May 2022 (20/124) *Re: Application by National Association of Practising Psychiatrists (NAPP) and Rehabilitation Medicine Society of Australia and New Zealand Ltd (RMSANZ) (ACT 4 and 5 of 2021)*. On 13 May 2022, Norton Rose Fulbright Australia reached out to RACS via email to inform us of Honeysuckle Health and nib buying group's next steps-

> *"… the Authorisation Applicants will contend that the Tribunal should affirm the ACCC decision to grant authorisation but vary the Authorisation such that: (i) the period of Authorisation is extended from 5 to 10 years; and (ii) the condition preventing Major PHIs from joining the HH Buying Group is removed in respect of medical specialist contracting"*

This takes us back to 2020, and to the original Application made by Honeysuckle Health and nib buying group which RACS, the AMA, and many others had rejected. When the Australian Competition & Consumer Commission (ACCC) made its final Determination on the 21 May 2021 to authorise Honeysuckle Health and nib buying group to operate a program that would only account for up to "40 per cent of private health insurance policies in any state or territory", and limited to "five years", RACS had resolved itself to accept the ACCC's Determination.

> *"… to grant authorisation with a condition for 5 years... until 13 October 2026 with a condition that the Applicants must not supply services to Medibank, Bupa, HCF and HBF in Western Australia."*[i]

It is both bewildering and disconcerting that the Honeysuckle Health and nib buying group have now decided to take such an unsettling hard-line approach against the intended wishes of the ACCC. By doing so, it has forced RACS's hand to write you a letter expressing our grave concerns that the Honeysuckle Health and nib buying group is attempting to plunge the Australian healthcare system into an incompatible U.S styled managed care structure which will do more harm than good in the long run. We will apply the 'no net public benefit test' and 'future with or without test' within the parameters of a policy perspective while the AMA will take a more legal approach in their up-and-coming August 2022 hearing, and your *do novo* review.

2. Background

In 2020 RACS's and other specialities' primary concern was with the December 2020 ACCC Application by Honeysuckle Healthcare Pty Ltd and other applicants (nib) for authorisation to form and operate a buying group for a period of 10 years. Over the course of a year entering into 2021 RACS alongside over 100 other concerned healthcare groups had provided written submissions disagreeing with the original Application. RACS supplied submissions on 11 March and 14 June 2021.[ii] RACS's reasoning behind our rejection of the original Application by Honeysuckle Healthcare Pty Ltd and other applicants (nib) remains unchanged with respect to the new Honeysuckle Health and nib buying group retro-variant on the ACCC Authorisation.

Our arguments that the Honeysuckle Health and nib buying group's Application in 2020 and subsequent variant on the ACCC Authorisation in 2022 are uncompetitive, and detrimental to our patients, and go against our blended healthcare system. RACS argues that there is no 'net public benefit'. While RACS appreciates the legal competition element and restrictive trade practices under Pt IV of the Act, there is also the equally important clinical element which RACS has complete authority to speak on as subject matter experts.

ACCC initially indicated that there was insufficient evidence that value-based contracting was the same as managed care as practitioners had the right not to sign a contract, and that the PHI Act (2007) prohibits a PHI or buying group directly influencing the medical care of the patient. RACS would argue that managed care is exactly what will occur if this Application is successful. The bargaining power of a buying group that includes all major PHIs would be such it would create significant difficulties for any hospital or specialist not to enter contracts. The Buying group would then create preferred provider lists of hospitals and specialists and using flawed data analytics a "league ladder" of hospitals and specialists, and effectively boycotting non-participating specialists.

Whilst the group may claim not to interfere with clinical autonomy of specialists, they indeed do this indirectly via the funding contracts for hospitals. By reducing the value of contracts to hospitals, hospitals are forced to reduce services available to specialists to treat their patients in an effective manner, which will reduce quality of care. We are already seeing this in Australia today with difficulties reaching a contract agreement between BUPA and Ramsay Healthcare. If BUPA were represented by a Buying group that included all major PHIs it would be impossible for Ramsay healthcare not to enter an agreement at whatever rate was offered as their bargaining power would be sufficiently eroded. As such, what is proposed is indeed managed care as it reduces choice of specialists to their preferred providers, and does indirectly affect quality of care by coercive contract negotiations with hospitals.

Our three resounding issues with this current state of affairs are as follows.

- **Managed agreements:** the business dealings of partners as defined by Honeysuckle Health and nib, and their American based Cigna Corporation was defined as “Managed agreements” in their original Application under 2.32. In RACS's opinion this is merely a euphemism for ‘managed care’ a U.S. styled healthcare system which differs greatly from Australia’s blended system. Once an adequate number of practitioners are contracted to this entity, with limited competition from other PHIs, a preferred provider list would be created effectively creating a boycott for non-participating specialists. Based on data from other countries, including New Zealand, new specialists may not be granted a contract at all, and if they are, at a reduced rate forcing previously contracted specialists to reduce rates to remain competitive, or otherwise they would not be offered new contracts. As such this is simply an attempt to create a monopoly to contract specialists, drive down amounts payable to specialists to maximise profits for the PHIs and the Applicants. Under the current arrangements, specialists can have the autonomy to choose which patients can be treated on a no-gap scheme and which patients may be required to pay an out-of-pocket gap. This autonomy for the specialists is removed in the application and may have the detrimental effect that if specialists choose not to participate due to the uncertainties of future arrangements with the buying group, that many disadvantaged patients and pensioners currently treated on a no-gap scheme would potentially be forced to pay out-of-pocket expenses, which was acknowledged by ACCC in 4.112 of their original determination. .
- **Inadequate risk assessment:** there lacks an independently scrutinised clinical data analytics risk assessment. A major flaw in all data analytics in medicine is the lack of accurate risk adjustment and independent oversight of data. Public release of flawed data will mean that contracted surgeons are likely to avoid high risk procedures that could affect their outcomes, placing greater pressure on surgeons willing to take on these cases or on the already strained public system. In addition, data relying solely on length of stay will mean that patients are forced out of hospital faster than they are ready to be discharged, and does not take into account the needs including psychosocial of our patients As such a cartel group could manipulate data and reward surgeons for reducing inpatient care, by not pursuing complex procedures, and forcing early discharge in an attempt to reduce the cost of hospitalisation
- **Dominate market share:** if ‘managed care’ were to be introduced where one particular buying group has a dominant market share presence, this will lead to public detriment as indicated above. The ACCC even stated this themselves in the original determination, highlighting the need for a re-evaluation at 5 years, rather than 10 years as originally proposed. ACCC stated in 4.111 that “implementation that includes major PHIs is likely to result in public detriment by increasing insurers bargaining power to such an extent that it leads to inefficient outcomes and the provision of health services by medical specialists.” As such, RACS contends that this application does constitute a form of managed care. Whilst hospitals and specialists have the right not to sign and contract, this would be difficult and potentially non-viable with a buying group of this proposed size including all major PHIs. This would then have the effect of not reducing the cost of health care but simply redistributing it by reducing payments to specialists and hospitals and maximising profits for PHIs and the Buying Group. In the meantime, patients would potentially have a reduced choice of specialists and hospitals, those attending non contracted practitioners may perversely face increased out of pocket costs, quality of care will reduce due to the reduced funding of hospitals and reduced services able to be provided as a result, younger specialists will potentially struggle to be offered contracts and will then be used as a tool to drive specialist fees down even further.

RACS contends that the original ACCC determination did not take these factors leading to patient detriment into account, and this becomes even more critical with the proposed amendments sought by the Applicants.

3. Managed Care in the United States, a Critique

As Australia have yet to experience a fully developed U.S. style managed care health system, all that RACS can go by is research conducted in the U.S. In effect the United States healthcare system is our primary case study. A definition of managed care or Medicaid Managed Care in the United States is effectively a health coverage arrangement where an entity contracts to provide third-party coverage and deliver covered services to members "through a network of providers selected and controlled by the entity."[iii] It is a standard of care which has emerged in the United States. Critics have argued that it has-

- restricted patient choices,
- reduced quality healthcare; and
- limited a medical practitioner's autonomy

The typical motivation for Medicaid Managed Care in the United States is to improve healthcare quality and reduce healthcare expenditure relative to the traditional fee for service model.[iv] In the published literature, there are mixed findings of the cost savings of Medicaid Managed Care[v] [vi] however the findings of a US National Study (as opposed to State by State) by Duggan and Hayford[vii] suggested that shifting Medicaid recipients from fee for service (FFS) into managed care did not reduce spending in the typical state. In contrast, the results suggested that the shift to managed care increased Medicaid spending.[viii] In addition, published literature has found that the key method in which managed care reduces spending in the private health insurance market is by reducing provider prices rather than in reductions in the utilisation of medical care.[ix] [x] [xi]

A further concern regarding Managed Care is that there are potential "spill over" effects which can affect patient care and also technology advancements and infrastructure.[xii] Baker[xiii] in a commentary discussed the potential of increased Managed Care enrolment to induce structural changes in healthcare markets, primarily through capacity reductions and lower levels of technology investments. Stating that "if plans work to limit the amount they will pay for some services, the likelihood that providers will offer those services will tend to fall". In line with this statement, Baker[xiv] found a negative relationship between Health Maintenance Organisations penetration and the availability of Magnetic Resonance Imaging.

Moreover, a large body of research has investigated the effect of Health Management Organisations and Managed Care organisations on the quality of medical care among the privately insured. The findings overall suggest that the quality of care is mixed, with a survey by Miller and Luft[xv] reporting an approximately equal number of studies suggesting improvements in quality of care as there were reductions. However, it has been shown that a 1%-point increase in MA (Medicare Advantage, a managed care plan) market share leads to a 0.94% reduction in hospital costs for FFS Medicare patients (US) suffering an acute myocardial infarction (AMI).[xvi] The FFS cost reductions have been reported to appear to be largely the results of reduced service provision and reduce service intensity accompanying expansion of Managed Care enrolment.

It has been hypothesised that negative treatment spill overs resulting from increased pressure to limit utilisation could be deleterious to the health of FFS patients.[xvii] Callison[xviii] reported that they found that increases in MA penetration have no effect on inpatient mortality for those enrolled in a MA plan but is associated with a small increase in mortality for both FFS and Medicare patients and when examined as a whole, all patients over the age of 65.

4. ‘No Net Public Benefit Test’

Why should Australia adopt such a healthcare experimentation when studies in the US have shown the system to be failing since its implementation in the early 1980s? The managed care backlash in the U.S revolved around the belief that a managed care system is about cost-control influenced by the need to generate profits. Its focus is not about providing quality healthcare. Collectively there has been several studies in the U.S. which reflect consumers and medical practitioner’s extreme dissatisfaction about managed care, and the resulting poor healthcare results.

Due to massive consumer dissatisfaction with managed care in the U.S. nearly 900 state laws had to be passed regulating this healthcare system during the 1990s. This was due to "benefit denials and disallowances of medically necessary services" which led to the public outcry.[xix] In 2007 the U.S. Henry J. Kaiser Family Foundation conducted a Public Opinion Spotlight of the public and their experience of managed care, and consumer protections. Privately insured adults under age 65 commented that “managed care has increased access to preventive health services, majorities believe managed care has decreased access to specialists, the time doctors spend with patients and quality of care for the sick… six in ten feel that managed care has not produced significant health care savings.”[xx]

A survey of 559 primary care physicians expressed concerns about managed care on their relationships with patients (shorter visits due to demands for increased productivity, diminished patient trust) and their abilities to carry out their ethical obligations to patients (negative effects on their ability to respects patient’s autonomy, cost cutting taking priority over quality of patient care). The majority of participants responded that health care is compromised by limitations in location of diagnostic tests, length of hospital stay and choice of specialists.[xxi]

A survey of 12,385 primary care physicians and specialists with low managed care revenue were more likely to report greater freedom in clinical decisions that address patient’s needs, believed they could make decisions in the best interest of their patients without reducing income, have adequate time to spend with their patients, were able to provide high quality care to all patients and maintain the relationship between patient and physician more than those with a high managed care revenue. Low managed care physicians also reported greater levels of career satisfaction.[xxii]

A survey of 1,710 primary care physicians with a high concentration of managed care patients were more likely to report a decrease in: clinical autonomy, time spent with their patients and an ability to remain knowledgeable and current compared to those with less managed care patients.[xxiii] A survey of 766 physicians involved in incentive-based managed care systems noted 57 percent of physicians felt pressure from the managed care organization to limit referrals, of which 17 percent noted it believed compromised patient care; and 75% felt pressure to see more patients per day, of which 24 percent believed it compromised patient care.[xxiv]

A review of studies evaluating patient satisfaction with managed care noted those enrolled in health maintenance organizations (medical insurance group) were less satisfied and reported more issues accessing specialized services than those in traditional plans. Patients who were sick and poor were the most dissatisfied and experienced more problems accessing specialist services.[xxv] A 4-year observational study comparing physical and mental health outcomes of chronically ill adults showed patients who were elderly, and poor were more than twice as likely to decline in health in an HMO than in a fee-for-service plan.[xxvi]

5. ‘Future With or Without Test’

The ‘future with or without test’ will make a comparison of a future in which the conduct the subject of the authorisation application, occurs with a future in which that conduct does not occur. RACS as a training and standards body, and the speciality boards as ‘representatives’ or ‘peak bodies’ of the specialties give the combined ‘entity’ considerable weight as a body that might accurately predict those alternative futures.

If Australia were to adopt a U.S style managed care system as proposed by the Honeysuckle Health and nib buying group, speculatively their goal would be to redistribute the costs of healthcare, not reduce them. There is no evidence that costs would be contained, nor PHI premiums reduced. This process will simply lower access to specialists, reduce fees payable to specialists, reduce the quality of care by reducing funding to hospitals (that ultimately provide the resources for specialists to look after their patients), and redistribute profits into the hands of the Buying Group. For this to even remotely be beneficial for the public there would need to be an independent body that determines the value of procedures for both hospitals and specialists so that optimum care is able to be delivered to patients. Independent evaluation of outcomes would be required by experts to provide certainty to data analytics. A unilateral determination of value and data quality, by a Buying Group of this size including all major PHIs, with no independent oversight will undoubtedly lead to public detriment as has been mentioned throughout this response. Reform of health care may be required for a sustainable future, but this has to be carefully considered and implemented by Government, PHIs, Public and private hospital administrators, medical colleges, AMA and consumers with independent oversight.

RACS reiterates that this application is an experimentation, but one which will have problems in a post-COVID world, and within a strained Australian economic climate. In 2021-2022, the Australian Government debt is the gross amount owed by the Australian federal government which currently sits at around A$834 billion. According to the Parliament of Australia the total spending on health in 2021–22 is “estimated to be $98.3 billion, representing 16.7% of the Australian Government’s total expenditure.”[xxvii]

What RACS is hearing from our surgical professionals is that there is an elective surgery crisis with long surgical waiting lists lasting anywhere between 2 years and 5 years. More fluidity in patient choice is required, not the rigidity of managed care by stealth brought on by this application. Both the public and private systems are under stress affecting costs, staffing, resulting in long-term patient healthcare repercussions, and impacting vulnerable indigenous and rural communities. There are nurse retention and nurse exhaustion issues because of long waiting lists on elective surgery, and maldistribution in rural areas which effect patients, nurses and surgeons alike. Under the current economic conditions, health delivery remains a critical issue and a collaborative approach to the challenges are required not a unilateral application that maximises profits for PHIs at the expense of patient choice and care.

6. Conclusion

What Australia needs is to provide patients with a choice of doctors within a flexible and competitive private healthcare environment, and not the introduction of a dominating cartel. What Australia needs is targeted funding support from our government during such dire times, not a commercial venture aimed at streamlining for cost cuts and profit at the expense of one-on-one doctor to patient quality care.

The detriment against the community that Honeysuckle Health and nib buying group will have, far outweighs any short-term financial benefits for the community. The buying group will lessen competition, and diminish quality clinical care. The goal of economic efficiency should never usurp the quality, safety and care of our patients, and the wellbeing of our medical practitioners within our fit for purpose and unique blended healthcare system.

Sincerely,

Dr Sally Langley
President, RACS

Professor Mark Frydenberg
Chair, Health Policy & Advocacy Committee

Co-signed by:

Dr Guy Henry
President, Australian and New Zealand Association of Paediatric Surgeons

Dr Jayme Bennetts
President, Australian and New Zealand Society of Cardiac Thoracic Society

Dr Peter Subramanian
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Dr Sally Butchers
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Dr Rodney Allen
President, Neurosurgical Society of Australasia

UROLOGICAL SOCIETY OF AUSTRALIA AND NEW ZEALAND

Associate Professor Prem Rashid
President, Urological Society of Australia and New Zealand

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[i] Australian Competition & Consumer Commission., *ACCC proposes to authorise Honeysuckle Health and nib buying group*, 21 May 2021 https://www.accc.gov.au/media-release/accc-proposes-to-authorise-honeysuckle-health-and-nib-buying-group

[ii] Royal Australasian College of Surgeons., *Submissions to the Australian Competition and Consumers Commission*, 11 March & 14 June 2021 https://www.surgeons.org/en/News/Advocacy/Submission-to-the-Australian-Competition-and-Consumers-Commission

[iii] Rand Rosenblatt, Sylvia Law and Sara Rosenbaum, Law and the American Health Care System (Foundation
Press, NY, NY, 1997; 2000-2001 supplement). Ch. 2J

[iv] Duggan M and Hayford T. Has the shift to managed care reduced Medicaid expenditures? Evidence from state and local-level mandates. J Policy Anal Manage 2013; 32: 505-535. DOI: 10.1002/pam.21693.

[v] Franco Montoya D, Chehal PK and Adams EK. Medicaid Managed Care's Effects on Costs, Access, and Quality: An Update. Annu Rev Public Health 2020; 41: 537-549. DOI: 10.1146/annurev-publhealth-040119-094345.

[vi] Sparer M. Medicaid managed care: Costs, access, and quality of care. 2012.

[vii] Duggan M and Hayford T. Has the shift to managed care reduced Medicaid expenditures? Evidence from state and local-level mandates. J Policy Anal Manage 2013; 32: 505-535. DOI: 10.1002/pam.21693.

[viii] Duggan M and Hayford T. Has the shift to managed care reduced Medicaid expenditures? Evidence from state and local-level mandates. J Policy Anal Manage 2013; 32: 505-535. DOI: 10.1002/pam.21693.

[ix] Cutler DM, McClellan M and Newhouse JP. How does managed care do it? Rand J Econ 2000; 31: 526-548.

[x] Dor A, Grossman M and Koroukian SM. Hospital Transaction Prices and Managed-Care Discounting for Selected Medical Technologies. Am Econ Rev 2004; 94: 352-356. DOI: 10.1257/0002828041301786.
[xi] Shen Y-C and Melnick G. Is Managed Care Still an Effective Cost Containment Device? Forum for Health Economics & Policy 2006; 9. DOI: doi:10.2202/1558-9544.1007.
[xii] Callison K. Medicare Managed Care Spillovers and Treatment Intensity. Health Econ 2016; 25: 873-887. 20150511. DOI: 10.1002/hec.3191.
[xiii] Baker LC. Managed care spillover effects. Annu Rev Public Health 2003; 24: 435-456. 20011106. DOI: 10.1146/annurev.publhealth.24.100901.141000.
[xiv] Baker LC. Managed care and technology adoption in health care: evidence from magnetic resonance imaging. J Health Econ 2001; 20: 395-421. DOI: 10.1016/s0167-6296(01)00072-8.
[xv] Miller RH and Luft HS. Does managed care lead to better or worse quality of care? Health Aff (Millwood) 1997; 16: 7-25. DOI: 10.1377/hlthaff.16.5.7.
[xvi] Callison K. Medicare Managed Care Spillovers and Treatment Intensity. Health Econ 2016; 25: 873-887. 20150511. DOI: 10.1002/hec.3191.
[xvii] Callison K. Medicare Managed Care Spillovers and Treatment Intensity. Health Econ 2016; 25: 873-887. 20150511. DOI: 10.1002/hec.3191.
[xviii] Callison K. Medicare Managed Care Spillovers and Treatment Intensity. Health Econ 2016; 25: 873-887. 20150511. DOI: 10.1002/hec.3191.
[xix] U.S. National Council on Disability, Report on Medicaid Managed Care for People with Disabilities, 18 March 2013, p.163
https://ncd.gov/sites/default/files/NCD_ManagedCare_Mar4FINAL508.pdf
[xx] Kaiser Public Opinion Spotlight: The Public, Managed Care, and Consumer Protections Archived 2007-10-22
https://web.archive.org/web/20071022050549/http://kff.org/spotlight/managedcare/index.cfm
[xxi] Feldman DS, Novack DH and Gracely E. Effects of managed care on physician-patient relationships, quality of care, and the ethical practice of medicine: a physician survey. Arch Intern Med 1998; 158: 1626-1632. DOI: 10.1001/archinte.158.15.1626.
[xxii] Stoddard JJ, Hargraves JL, Reed M, et al. Managed care, professional autonomy, and income: effects on physician career satisfaction. J Gen Intern Med 2001; 16: 675-684. DOI: 10.1111/j.1525-1497.2001.01206.x.
[xxiii] The Commonwealth Fund Survey of Physician Experiences with Managed Care. 1997. Commonwealth Fund and Louis Harris and Associates.
[xxiv] Grumbach K, Osmond D, Vranizan K, et al. Primary care physicians' experience of financial incentives in managed-care systems. N Engl J Med 1998; 339: 1516-1521. DOI: 10.1056/nejm199811193392106.
[xxv] Hellinger FJ. The effect of managed care on quality: a review of recent evidence. Arch Intern Med 1998; 158: 833-841. DOI: 10.1001/archinte.158.8.833.
[xxvi] Ware JE, Jr., Bayliss MS, Rogers WH, et al. Differences in 4-year health outcomes for elderly and poor, chronically ill patients treated in HMO and fee-for-service systems. Results from the Medical Outcomes Study. Jama 1996; 276: 1039-1047.
[xxvii] Budget Strategy and Outlook: Budget Paper No. 1: 2021–22, pp. 161–162
https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/BudgetReview202122/HealthOverview