Heath and Environment Committee
Queensland Parliament

Dr Chris Jackson
MBBS, FANZCA
[redacted]

Wednesday, 9 March 2022

Dear Honourable Members of the Committee,

I would like to draw your attention to manoeuvres by the private health insurance industry to alter funding models in ways which are likely to prove detrimental to patient-centred health care. I consider that this matter falls within the scope of your current inquiry and ask that the Committee accept this correspondence as a late submission.

It's not news to you that the Australian medical profession - and the Australian community more generally - has well-justified and longstanding concerns about the US managed health care system, in which patient choice is limited and the interests of the insurers are accorded primacy. Recent events in Australia make plain the desire for Australian health insurers to alter the Australian private health system to better suit the priorities of the insurers and their shareholders. We are at risk of managed care by stealth, and the insurers are playing a long game, taking advantage of the complexity of our health system.

The Australian private health system is paid for by a weird hybrid of public and private funds, with patient contributions or 'gaps' a frequent component. The history of how the system arose is not pertinent to this email, but it's worth noting that core components have always been the primacy of the patient-doctor relationship; the freedom of the patient to choose their doctor and their treatment; and the independence of the clinical decision-making process from private insurers in particular.

Our system is well-regulated, and international studies of health outcomes show that we get good outcomes for the proportion of GDP that we spend on health. In contrast, the health system in the US consumes a far higher proportion of GDP for significantly

poorer population outcomes. [1] Managed care is not the only reason for this, but it's a significant factor.

In 2020, the private health insurer NIB, in tandem with the US corporation Honeysuckle Health, sought to form a buying group to collectively negotiate with health care providers (hospitals and practitioners) on behalf of insurers.[2] The medical profession and media opposed this strongly, but in 2021 the ACCC granted approval with conditions.

More recently, health insurers have been setting up 'no gap' packages of care. A current example is St Vincent's Hospital in Chermside, Brisbane, which last Friday informed its specialist anaesthetist visiting medical officers of a new funding arrangement to be implemented the following Monday. In summary, the insurer would pay the hospital a fixed fee for hip and knee replacement surgery, the surgeon would be paid AMA rates for their care of the patient, the anaesthetist would be paid around half AMA rate for their work, and the surgical assistant would be paid some smaller proportion. Whilst the hospital had been negotiating this package with the surgeons since October 2021, there was no consultation with anaesthetists, assistants or patient groups.

Similar packages are already up and running at other sites - Westside Private in Taringa, part of the Montserrat group, has an arrangement with Medibank Private; and there are also packages on the Sunshine Coast and interstate.

Anaesthetists have numerous concerns about this approach -

- this sort of packaged care might work well initially for medically healthy patients who have few co-morbidities and lower likelihood of complications, but more complex patients might find that hospitals or insurers start to refuse them under this model; and if there are complications (some of which can be longterm with this commonplace but still complex surgery), it's not at all clear who would pay for them

- hospitals using the current funding model might find that surgeons are sending their complex patients there for surgery, transferring risk and expense, and keeping their medically simpler patients for the packaged care hospitals

- patient choice is utterly peripheral in all of this

- the clinical independence and primacy of the patient-doctor relationship are sure to be eroded as the insurers, and the private hospitals they increasingly control, limit choices

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[1] https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly

[2] https://www.accc.gov.au/public-registers/authorisations-and-notifications-registers/authorisations-register/honeysuckle-health-and-nib

- little thought seems to have gone into the way this model's funding will change in the future

The views above aren't mine alone. They reflect discussions I have had with numerous other anaesthetists in Brisbane. I have good reason to believe that if my profession were consulted formally - say by an approach to the Australian Society of Anaesthetists [3] - a similar position would be expressed.

I'd be grateful if the health committee - and its equivalents interstate and federally - could look into this. If there is a change of federal government later this year, then there will be some sort of systemic changes as policy settings are altered. It could be perfect timing for a root-and-branch examination of the ways in which health care is funded and paid for.

What can't be done is nothing, because if we are inattentive the insurers will gradually shift us towards managed care, with the insurers' interests and those of those of their shareholders prioritised above the needs of the patients and the community.

Yours faithfully,

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