Consultation on Guidance in respect of Collective Negotiations relating to the setting of Medical Fees

BUPA Ireland welcomes this opportunity to respond to the Competition Authority's Consultation Paper, and believes that the market will benefit from clear guidance, including certainty as to what forms of negotiation arrangements are considered to be acceptable by the Authority. We are especially mindful of the outcome of legal proceedings recently settled between the Authority and the IHCA which precludes any further collective negotiations between independent providers of health services. BUPA Ireland is very concerned to ensure that guidance issued by the Authority does not, although not intended to so permit, result in the renewal of historic practices based on medical service providers setting rates collectively.

In its submission, in addition to answering the questions posed by the Authority, BUPA Ireland wishes to address connected issues such as the evolution of the market, BUPA Ireland's view of how the procurement of medical services is likely to evolve, and an elaboration of its reasons for favouring or disfavouring particular negotiation models.

Historical Context

The Authority has noted the practice in the market whereby insurers effectively provide cover for all doctors and consultants, either on a participating or non-participating basis, and has queried why insurers have not instead moved to more selective contracting.

BUPA Ireland expects to see a gradual move towards more selective contracting, but for so long as the VHI's dominance remains intact and it continues to effectively cover all providers, then it is very difficult for another insurer to compete on the basis of a less comprehensive list of medical service providers. That is so, even if VHI's competitors are capable of realising certain efficiencies of higher levels of service through more selective network contracting. When BUPA Ireland first entered the market, it encountered marketing efforts designed to raise concerns that it was not covering all medical service providers. Not surprisingly, any entrant into the Irish market must first attempt to replicate the scope of the VHI's cover.

However, despite that competitive constraints, it is clear that there is room for contractual innovation in the Irish market. When BUPA Ireland entered the market, hospital reimbursement in terms of accommodation, drugs and medical supplies was on an item by item basis. BUPA Ireland pioneered the concept of 'per diem' reimbursement in Ireland, whereby an all-in daily rate was negotiated with hospitals, instead of separate line item billing. This initiative, in addition to 'length of stay' guidelines which BUPA Ireland has also developed, has been effective in controlling medical costs. Together with allowing for better control of BUPA Ireland's claims costs, these initiatives have incentivised the hospitals to control their own costs and to leverage off their purchasing power.

At this moment in time, network contracting is very limited, but it is something that BUPA Ireland would wish to see advanced. In particular, BUPA Ireland would wish to encourage:

- greater contract differentiation. In other words, BUPA Ireland would wish to encourage best practice and to reward clinical innovation by individual practitioners by engaging in 'best in class' contracting; and,
- greater package contracting. BUPA Ireland would wish to purchase care packages, to include the requisite professional care and expertise, accommodation and medical supplies, including drugs. However, these are not readily available on the market, not least because hospitals, which would be best placed to aggregate such packages, do not seem to be in a position to put such packages together.

BUPA Ireland considers that greater contract differentiation was largely impossible under the conditions that prevailed up until very recently in the Irish market. Any system based on collective negotiation is likely to stifle any possible service innovation, and in effect reduces contract negotiation based on service levels to one based on the lowest common denominator. BUPA Ireland considers that provided that in all cases best practice and the necessary precaution is observed, then there is considerable scope in the Irish market for further competition based on service levels through greater contract differentiation.

In terms of 'contract packaging' BUPA Ireland understands that substantial changes will be required to existing market practice in order for such contracting to become prevalent. It will necessarily involve hospitals negotiating more differentiated arrangements with consultants, which would then allow them to put together packages for insurance providers and other payors. Such a change would amount to a significant change to the 'consultant-led' approach to healthcare provision that currently characterises the Irish PMI market.

Specialist Groupings

In BUPA Ireland's experience, medical groupings are a common feature of the market. However, few of the groupings encountered by BUPA Ireland show any substantial degree of integration or sharing of business risk.

Based on experience in other jurisdictions, medical groupings which involve collective setting of fees should only be permitted where there is a likelihood of substantial sharing or business risk. In those circumstances, substantial efficiencies can be expected to arise. Alternatively, a substantial degree of practice integration has been accepted, particularly in the United States, as also giving rise to sufficient efficiencies to warrant safe harbour treatment under competition law.

Such sharing of business risk or practice integration is very unusual in Ireland, although BUPA Ireland does not have full visibility of the arrangements underpinning many of the current groupings. In terms of the variety of groupings that are encountered, many seem to operate solely for billing and division of fees. The collective setting of fees seems to be inherent in their operation.

The existence of practice groupings seems to be especially prevalent in areas of consultant which are not customer-facing, i.e., specialist support consultancies such as pathology, radiology etc. In that sense, competition among these specialities is subject to less competitive constraints than occurs for the selection of the primary treating consultant - where competition is already very limited. Although these specialities may be viewed as secondary or supporting by

patients, there is no reason why there should not be competitive choice. In addition, absent substantial practice integration, these groupings should not be permitted.

BUPA Ireland's note the practice in other jurisdictions, especially in the UK concerning partnerships. However, several of those precedents, and in particular the OFT's consideration of anaesthetist groupings is not without difficulty. In those cases the OFT seems to have accepted the partnership context as definitively deciding the issue of whether or not there was sufficient sharing of business risk. However, both under Irish and English law, a partnership is the default form of business organisation where several people engage in business together but without incorporating a separate legal entity. The legal test for the existence of a partnership is whether the partners carry out business in common. However the existence of a partnership, whether expressly or by operation of law should not automatically give rise to the inference that there is sufficient sharing of business risk. Accordingly, the Authority may consider it appropriate to issue guidance on what the requisite features of the partnership that would be necessary so that risk is shared or that integration is likely.

In BUPA Ireland view, substantial practice integration is not likely to be encountered that frequently in Ireland, with its consultant led model of medical service delivery. Strong professional and clinical interdependence also militate against substantial integration. However, such integration might well emerge if hospitals were to emerge as providers of packages of medical services. In BUPA Ireland's view, it is only a hospital, which is likely to possess professional management expertise and the necessary information systems and other management tools that are likely to be able to bring about the requisite degree of integration to deliver real practice integration. Experience from the United States indicates that it is possible for physical/consultant groupings to achieve a substantial degree of clinical integration, but other than through hospital led initiatives, that is unlikely to be the case in Ireland, at least for the foreseeable future.

Should the Authority consider that consultant/physician led groupings which offer the potential for sufficient integration are capable of qualifying as independent undertakings, then BUPA Ireland would urge the Authority to ensure that participating consultants remain free, and in practice, exercise freedom to treat patients independently of such groupings.

Questions

7.2 The incidence of medical partnerships (para 2.14):

Question 1: How widespread are partnerships amongst doctors satisfying all of the criteria listed in paragraphs 2.11 and 2.12 in Ireland? Roughly what percentage of (i) consultants and (ii) GPs are engaged in partnerships of this kind? How significant a percentage of (i) consultants and (ii) GPs are involved in any single partnership?

BUPA Ireland has encountered instances where a group of consultants get together and purchase equipment and offer this service to our members. BUPA Ireland negotiates an all inclusive fee basis with these groupings where both the professional and technical fees are paid as one negotiated fee. An example of this would be the Advanced Radiology Group. The incidence of this is very small.

We have seen a trend where GPs come together in a group practice and bill individually for consultations, but as a group for services such as pathology and

radiology. Although we have noticed this trend it is not possible to provide statistics as we register GPs as individuals, not as groups.

Question 2: How widespread are partnerships amongst doctors just sharing offices and overheads but not sharing commercial risks or profits in Ireland? Roughly what percentage of (i) consultants and (ii) GPs are engaged in "administrative" partnerships of this kind?

111 of our consultants are involved in 41 registered groups. We have in excess of 2000 consultants registered with BUPA Ireland/

As a percentage of consultants involved in any single partnership:

27.92% of consultants in groups are Pathologists

50.45% of consultants in groups are Radiologists

6.3% of consultants in groups are Obstetrics/Gynaecological

8.1% of consultants in groups are Anaesthetists

4.5% of consultants in groups are in Paediatric Medicine

1.8% of consultants in groups are Cardiologists

In BUPA Ireland's experience, most groupings of consultants appear to operate solely for the purpose of sharing offices, overheads and for the purpose of centralising billing arrangements. For its part, BUPA Ireland does not consider that combinations of consultants should be given a safe haven under competition law where there is no real integration or sharing of business risk, a position that we have elaborated on above.

BUPA Ireland has been making efforts to satisfy itself as to the precise nature of the groupings with which it contracts. However, in almost all cases, it has not been able to obtain satisfactory information as to the level of integration or sharing of business risk.

Question 3: Are partnerships more prevalent amongst certain specialities of consultants in private practice? If so, what specialities and why?

There are 41 groups registered as follows:

Radiology 48%

Pathology 29%

Obstetrics/Gynae7.3%

Anaesthesia 7.3%

Paediatric Medicine 4.8%

Cardiology2.4%.

However, for the reasons mentioned above, BUPA Ireland cannot be certain that these are 'bona fide' partnerships in the sense of either amounting to a partnership under Irish law, or that even if they do, that there is sufficient sharing of business risk, or the requisite element of integration.

In this regard, BUPA Ireland would suggest that considerable precision is required to ensure that parties do not use the label or form of a partnership when in practice, there is no real integration or sharing of business risks.

Question 4: Do (or could) partnerships exist amongst consultants of differing specialities? If so, please give specific examples.

We do not have any registered as such, but they could be out there. An example could be when a group of differing specialists set up their own clinic/service. There also appears to be a natural complimentarity between certain specialities, for example surgical and anaesthetist services, where it is conceivable that partnerships among consultants would be viable. However such combinations would not constitute a full service. Therefore, we consider that bundled services is more viable option.

Question 5: Are partnerships amongst doctors in general reduced to written agreements or do they also incorporate other types of co-operation? Please explain.

In general, BUPA Ireland has no way of knowing, and as indicated, its attempts to understand the nature of the combinations have not been successful.

Question 6: Are partnerships amongst doctors in general formed with the express intent of fixing prices or is the setting of prices generally necessary to realise efficiencies arising from such partnerships? Please explain.

In our experience the consultants who do not have direct contact with the patient and where the patient does not choose this consultant generally establish the consultants groups. Therefore the groups identify private patients and bill each patient accordingly. The lack of a direct relationship with the patient seems to be a principle driver for the existence of these groups. It is our experience that pathologists and radiologists make up 78% of consultant groups.

7.3 Medical ethics and fee setting (para 2.16):

Question 7: Are there circumstances where a body formed to promote medical professional standards and ethics must discuss or recommend fees, quantity of services offered or other commercial terms to its members as part of this mandate? If so, please give specific examples.

BUPA Ireland does not consider that there are any situations where a body formed to promote professional standards and ethics should ever discuss or recommend fees, the quantity of services offered or other commercial terms. While relevant ethical considerations could have an indirect effect on the quantity or even availability of certain medical services, care is required to ensure that legitimate ethical and professional standards do not become a clandestine method of restricting output, innovation or entry.

7.4 Can Section 4(5) be a safe haven for price fixing? (para 3.9):

Question 8: Please identify instances when the prohibited fee setting mechanisms identified in paragraphs 3.1 to 3.7 in your view satisfy the provisions of Section 4(5) of the Competition Act.

In BUPA Ireland's view, none of the circumstances mentioned in Section 3.1 to 3.7 appear to meet the requirements of Section 4(5).

Question 9: Please set out how these practices satisfy each of the conditions of Section 4(5) of the Competition Act.

In our opinion they could not.

7.5 Fee setting by the payor (para 4.7):

Question 10: Is fee setting by the payor a feasible model for the determination of consultant fees in Ireland? If not, what steps can be taken to improve its operation to make it more effective?

At present, the Irish market operates in large measure based on a 'payor model' with BUPA Ireland and the other insurers publishing their own schedule of benefits. We agree with the assessment of the Authority that in the main, a 'payor' model gives the insurers both the incentive and means to control medical costs. In BUPA Ireland's case, it can draw on BUPA's worldwide experience to benchmark the costs of procedures and the potential for increased efficiency in line with clinical advances.

Arrangements based on fee setting by payor also avoid the transaction costs that would result from a series of individually negotiated arrangements. However, they have tended to produce 'one size fits all' type contracting, which tends to limit more individualised for the best performing professionals.

Question 11: Are there any valid reasons for a representative organisation such as the IHCA to play a role in fee setting in this model in such a way that does not breach the Competition Act? If so, please explain what role the representative organisation would play in this model and why this does not breach the Competition Act.

Other than by way of assisting with the communication of the arrangements set in place by the payors, we do not consider that there is any legitimate way for the IHCA or any other representative organisation to be involved in the setting of fees in a model where fees are set by the payor.

However, BUPA Ireland would support the IHCA's continued involvement of the IHCA in providing general feedback to insurers and other payors on clinical developments, and of course in their representative capacity for individual members.

Question 12: What efficiencies, if any, are forgone by the payor setting the fees compared to the payor entering into collective negotiations with a representative body of consultants?

BUPA Ireland does not consider that there are any efficiencies foregone by a payor setting the fees as opposed to a payor entering into collective negotiations with a representative body of consultants. In fact, by definition the transaction costs (leave aside the welfare loss from price co-ordination) associated with a payor setting fees are likely to be less than those arising from collective negotiations.

7.6 The messenger model (para 4.15)

Question 13: Would the messenger model (or some variation) work in Ireland to cover negotiations between private health insurers and consultants? If not, why not?

In our opinion the messenger model is more appropriate to a large-scale market and would be especially difficult to manage in a market such as Ireland. It may prove difficult for the messenger to be independent. It would be especially difficult to operate in a market where most specialists would know each other. In some specialities there are very few practitioners (e.g., there are only 12 neurosurgeons in the Republic of Ireland).

We understand that there are many forms in which the messenger model could be implemented but in our opinion each of these forms would prove difficult in this market. We feel that:

(a) the administrative costs of allocating and training an independent messenger may be inflationary and the resulting uncertainty could be damaging to consumer confidence. In addition, due to the size of the Irish market, we also feel that the strains on remaining independent (such as fielding questions on the fee levels that would be acceptable to the other party) would require the messenger to continue such training and have constantly available representation to refer to. Each of the above would drive up operating costs of such a measure;

(b) on top of the training period there would also be a significant delay while the new messengers carry across any proposals/counter-offers/acceptances and it can take some time to establish an efficient network of consultant-payor relationships. These delays would then be passed onto the customer and the treatment process. Models that impose time limits or allow offers to be termed in the form of a range of prices can limit this delay but these often cause administrative difficulties for consultants that would either cause their costs to rise or, given the familiarity of the recent anti-competitive practices, may encourage them to discuss their options horizontally. Administrative problems may also occur as the payor must implement a new claim processing infrastructure for variable terms between consultants and consultant networks. We feel these new systems would be inefficient, costly and potentially cause confusion, errors and further lost confidence within the market;

(c) historically, the messenger system often reverts back to the anti-competitive practices it was installed to prevent. The messenger often begins to be selective as to which offers it will pass on and begins to negotiate on terms of price. As a deal arranger the messenger has an inherent incentive to assist each party as much as he can, and his ability to assist will increase with experience. This incentive will be increased by the pressure created by the familiarity of the Irish market. Furthermore, if some consultation on non-price terms is allowed, the distinction between acceptable negotiation and anti-competitive negotiation will not be clear, which may lead back to illegal practice and another review of the fee setting mechanism; and

(d) the messenger system will not actually regulate the conduct of the consultants themselves. Within this new model consultants may continue, or may eventually return to, their practice of conferring on the levels of fees they should accept or propose, and indeed, as outlined above, the confusion caused by the initial transition process may encourage them to do so from the outset.

Consequently, we feel that any form of messenger model is unsuitable for the Irish market as it stands and could well lead to a renewal of practices which by agreement between the Authority and the IHCA are no longer to occur. In a market where the full application of the competition rules is just beginning to be felt, and where what the Authority considers unlawful behaviour to have occurred up to very recently, it may not be prudent to immediately initiate a safe harbour which is based on respecting very nuanced distinctions. Even in markets with an established history of rigorous competition law enforcement, such as is the United States, messenger models have proven to be very troublesome. In many cases the messenger has, either willingly or unwillingly, become a negotiator, thereby depriving the model of its essential saving feature under competition law. The messenger would ultimately need to be paid and this may affect its incentives.

Question 14: Could a messenger model be used in negotiations between doctors and other payors? If not, why not?

We feel it is too cumbersome, may not achieve efficiencies, and carries with it a substantial risk of anti-competitive conduct.

Question 15: Is a messenger model necessary to achieve efficiencies in contracting between doctors and payors? If so, please specify the efficiencies achieved.

Provided that a payor is able to maintain sufficient insight into the needs and preferences of providers, a messenger model would not appear to be necessary or essential for the realisation of efficiencies in the market. It will be recalled that messenger models are primarily intended to avoid price fixing, so its extraneous efficiency potential is necessarily limited. The principal advantage is that the payor is potentially given full visibility on prices across the market, which it can then use to minimise costs.

Question 16: If a messenger model could work in Ireland, who should be the messenger? Is it appropriate for representative bodies or speciality groups to be permitted to act as messenger or would such bodies be conflicted? What measures, if any, can be taken to prevent conflicts of interest arising?

In our opinion the messenger model, in any of its variants would not work or be appropriate at present in Ireland. Separately, considering the recently concluded legal action by the Authority concerning the role of the IHCA, we feel that any messenger model arrangements could well place the IHCA in a difficult position where its members believe that the Authority has sanctioned a return to the previous *status quo*.

Question 17: Who should engage and pay the messenger?

BUPA Ireland understands that the identity and terms on which the payor is remunerated is important in terms of determining its incentives etc. However, even if an acceptable solution was found to that problem, experience from other jurisdictions, especially the United States indicates that messenger models frequently go wrong in terms of day to day operations and the inevitable evolution of any system. For that and other reasons stated, BUPA Ireland opposes the messenger model mechanism.

7.7 Feasibility and extent of purchasing bundled hospital/consultant services (para 4.17)

Question 18: Why do health insurers infrequently purchase services as a bundle including consultants' fees from hospitals?

Historically, bundled offering have not been on offer in the Irish market. As we note above, the availability of such packages will involve considerable changes to the model of medical service provision prevalent in this country. BUPA Ireland is keen to move to a bundled model for services. Such packaging or bundling of services would:

- Allow for standards, best practice and evidence based care to be integrated into the process on a contractual basis
- Maximise efficiencies in the service
- Encourage cross best care
- Ensure accountability

BUPA Ireland has a tender process for several benefits based on all-inclusive fees. We have negotiated all-inclusive fees with certain hospitals in the Northern Ireland. It is our aspiration to contract with all new providers to be on an all-inclusive basis. All-inclusive pricing allows for standards to be put in place and

outcomes measured. It facilitates service levels guarantees, leads to greater budgeting certainty and reduces administration costs.

Question 19: Could direct contracting with hospitals on the basis that the hospitals discharge the consultants' fees provide an alternative to the present Schedule of Benefits? If not, why not?

We agree that this is a viable alternative subject to the willingness of consultants to participate in such arrangements.

7.8 Other permitted fee setting mechanisms? (para 4.18):

Question 20: Are there other feasible fee setting mechanisms to those outlined in section 4 of the Consultation Document that could be used to set fees but are consistent with competition law?

We are not aware of such mechanisms.

7.9 Rotas (para 5.6):

Question 21: Do you agree with the above characterisation of medical rotas? If not, please furnish your view(s).

We agree with the legal characterisation of rotas, and in particular with the view that agreement on fees are not a necessary element to what is a beneficial practice.

Question 22: Are there circumstances which require doctors involved in a rota to agree fees between them? If so, why is such agreement on prices indispensable to the primary object of the rota which is to achieve sustainable working hours and facilitate continuous access to health care?

While supporting the need for rotas, it does not appear to be in any way necessary for doctors involved in a rota to agree on prices. The only matter that needs to be co-ordinated between or among doctors is their hours of availability.

The co-ordination of an output (e.g. hours of availability) is in principle an agreement to co-ordinate output, which per se offends Section 4(1) of the Act. BUPA Ireland does not consider that the creation of a rota amounts to the creation of a new product (in the sense contemplated in the US BMI case), which could take the practice outside the terms of Section 4(1), if the Authority was to take a similar view to the US Courts.[1] However, the restriction on output can be regarded as benefiting consumers (and therefore qualify for an exemption under Section 4(3)), since it provides continuity of cover, in the sense of ensuring available medical expertise at all time.

Question 23: Under what circumstances, if any, can doctors collectively decide to withdraw from a rota?

BUPA Ireland would be concerned about any decision to collectively withdraw from a roster which was intended to put commercial pressure on payors. However, since rotas are critically dependent on reliable participation, it may be that due to the withdrawal of one or more persons, the rota is no longer workable, in which case it is not surprising that the other members, either individually or collectively might decide to withdraw from the rota entirely.

7.10 Other permitted practices? (para 5.7):

Question 24: Are there other important and widespread collective practices among doctors that are not likely to come within the scope of Section 4(1) of the Competition Act? Please give reasons for your view(s).

We would refer to the opening sections of this response.

[1] BMI v Columbia 441 U.S. 1

7.11 Participation rates and balance billing (para 6.10):

Question 25: Is the present system of striving for full-cover schemes and using balance billing arrangements unduly restrictive on competition and are they indispensable to producing the Schedule of Benefits? If not, why?

Currently upwards of 95% of consultants are participating consultants, which ensures that these consultants do not engage in balance billing of BUPA Ireland members.

BUPA Ireland is concerned that the way this question is framed that the existing practice within the market of providing full cover, through a Schedule of Benefits, calls into question the legality of that practice. Provided that the Schedule of Benefits are independently determined by insurers there can be no objection to this practice. Therefore, we interpret this question as raising a question of the general effect on competition, outside of the legal context.

In that regard, BUPA Ireland would acknowledge that the principal down-side of a Schedule of Benefits is its 'one size fits nature. As a result, there are probably consultants who would be prepared to provide services for lesser amounts, although the incidence of that may not be that significant. As against that, a single Schedule of Benefits avoids the transaction costs that would arise if insurers were to negotiate arrangements with all consultants individually.

However, clearly there are consultants who would be prepared to enter into separate or differentiated arrangements from the schedule of benefits. Such arrangements could include advanced reporting commitments, or other commitments to service excellence with corresponding financial reward. BUPA Ireland considers that the existence of a Schedule of Benefits arrived at through collective negotiation may have stifled the emergence of more individual contracting. It is difficult to separate the effects of the existence of Schedule of Benefits from past practices based on collective negotiation.

As BUPA Ireland has indicated, it would wish to move to a system of contracting based on 'best in class' and more generally rewarding clinical excellence in terms of the speed and efficacy of treatment, in particular based on patient satisfaction. Furthermore, the availability of more advance IT and contract management systems may facilitate a much greater degree of individual or differentiated contracting. The current system provides no rewards for best practice, quality of care, outcome analysis. We would like to see reward based payment mechanisms.

Question 26: In how many/what proportion of cases are patients referred to consultants through A&E? Can A&E be used as a gatekeeper in some circumstances?

We know the percentage of our members who are treated in private hospitals is 38%. Private hospitals generally do not have emergency admissions. A&E are inappropriate gatekeepers. The methodology for operating A&E in Ireland is resulting in queues and long waiting times. Primary care practitioners are the most appropriate gatekeepers because of the current referral processes, either through A&E admissions or consultant led elective services. The enhancement of current Primary Care services through incentives for best practice would not only relieve some of the problems within public A&E departments but would also free hospital day-care and outpatient beds for more elaborate procedures.

Question 27: How feasible is it for GPs to have a private health insurer's list of preferred consultants and to select a consultant on behalf of their patients from that list? Can GPs be used as gatekeepers in some circumstances?

It is highly feasible and is something that BUPA Ireland is currently considering.

Question 28: How feasible is it for consumers/patients to have their private health insurer's list of preferred consultants and to select a consultant from that list?

As above.

Question 29: What are the main advantages/disadvantage of having selective networks of doctors from the point of view of the payor and the consumer/patient?

- Assurance of quality
- Centres of Excellence
- Competitive tendering
- Best Practice
- Service level agreements
- Customer focused
- Enhanced accountability

Question 30: What factors are inhibiting selective networks from emerging in Ireland? What measures could be taken to address these factors?

There is a huge necessity to increase competition in the market. In the majority of towns outside Dublin there is little or no competition across providers. This does not promote innovation in service development such as network development. Competition in the market is the key with increased hospitals step-down facilities, consultants and GPs. There is a perception amongst consumers that waiting times equate to the value of service. However, it is really an illustration of supply shortages which if addressed would also help with the emergence of selective networks.

Question 31: How necessary is freedom of choice of consultant? While in certain instances the number of specialists may be limited, for many standard procedures a commensurate level of skill is attained by many consultant doctors.

In many countries, such as the UK, customers may access consultant's information. Waiting times are published on http://www.nhsdirect.nhs.uk/ and it is the aspiration of the NHS to also publish clinical outcomes in the near future.

Question 32: Is an increase in consultant numbers a pre-requisite to selective providers' networks emerging?

The emergence of selective provider networks is not only constrained by the number of consultants. As we note above, prior market practice and the hegemony of the VHI has been a constraining factor in the market. However, we consider that a significant increase in the number of consultants would be of huge assistance in fostering the emergence of selective provider networks. .

7.12 Codes and descriptions (para 6.13):

Question 33: Can discussions on codes and descriptions of procedures (i) amongst consultants and (ii) between speciality groups and private health insurers occur without requiring discussions on fees or other commercial terms and conditions? Please explain.

Yes. The existing Schedule of Benefit and procedure codes are not effective when it comes to analysis (especially trend spotting) or transparency. Diagnostic related groups and ICD codes are more effective for analysis used in case mix by

the ESRI. The ESRI use an international coding system (ICD 9 and DRG) that allows for comparison across hospitals in Ireland and across other health markets which can be adopted 'off the shelf' for utilisation in Ireland. Their use is a separate issue to fee setting, and would bring more transparency to the market, which would be of considerable assistance with forecasting and trend spotting. Furthermore, by using international codes, that would avoid the need for any co-ordination between rival insurers.

Question 34: If you answer yes to the above question, please outline how this separation works in practice? What precautions can be put in place to ensure that such discussions do not breach the Competition Act?

It would be more appropriate to do this through the RCSI or the College of Physicians. It is for research and teaching and not commercial.

Question 35: If your answer is no, please outline why this is not possible? At what point would discussions on codes and descriptions for procedures directly or indirectly impact on price or other commercial terms?

See answer to question 33 and 34.

7.13 Ground rules for consultant services (para 6.14):

Question 36: Do you believe that discussions on Ground Rules (i) amongst consultants and (ii) between speciality groups and private health insurers can take place without requiring discussions on fees or other commercial terms and without limiting innovation and choice in such services?

The Schedule of Benefits published by the various insurers effectively amount to the ground rules operated by individual insurers. As the Authority points out, any standardisation of terms and conditions could restrict competition. The key issue here is what is meant by 'ground rules'. In BUPA Ireland's view, basic commercial terms are just as important as price terms, and should not be discussed. BUPA Ireland considers that discussion of permissible ground rules should only extend to matters that need to be standardised for objective medical reasons linked to the welfare of patients.

Question 37: If you answer yes to the above question, please outline how this occurs in practice? What precautions can be put in place to ensure that such discussions do not breach the Competition Act?

As a minimum precaution written notes of all such meetings should be taken.

Question 38: If not, please outline why this is not possible? At what point would discussions on Ground Rules directly or indirectly impact on price or other commercial terms or on innovation and consumer choice?

See answer to question 36

Question 39: To what extent do discussions on Ground Rules determine treatment volumes by consultants?

We are not in position to respond however the Authority may wish to consider how changes in medical practice are reflected in ground rules (if that is permissible) affect volumes.

7.14 Other permitted practices under the Schedule of Benefits? (para 6.15):

Question 40: Are there other discussions that typically take place between consultants and private health insurers in the settling of the Schedule of Benefits, which on the face of it do not impact on fees or other terms and conditions of trade and are thus unlikely to raise issues under the Competition Act?

It is extremely difficult to say with any certainty that any discussions, including permissible discussions, do not impact on price or the terms or conditions of trade.