DJC\1191357.2

10 March 2006

Emily O'Reilly
The Competition Authority
Parnell House
14 Parnell Square
Dublin 1

BY POST AND E-MAIL
eor@tca.ie

Vhi: Response to Consultation Document on Guidance in respect of Collective Negotiations relating to the Setting of Medical Fees (January 2006)

To the Authority:

Vhi has considered the Authority's Consultation Document and thanks you for the opportunity of commenting upon it. It has asked that we make this submission on its behalf having regard to the fact that much of what it thinks requires to be said has already been the subject of submissions made by us on its behalf in the course of the Authority's investigation which has preceded the Document.

1. *Preliminary*

1.1 It is right to note at the outset that having regard to what the Consultation Document acknowledges (at 6.3) is the role that Vhi has had in developing the existing Fee Schedule and conducting the discussions that precede modification of the Schedule, the whole of the Document insofar as it addressed current actual or possible fee setting arrangements must be read as addressed to Vhi's current practice in this respect.

1.2 Section 4 of the document sets out what are described as *'Permitted Fee Setting Mechanisms'*. At 4.3, it outlines the approach that has been adopted by Vhi when dealing with both the IHCA and the IMO, but the Authority remarks that assumptions incorporated in this text *"do not necessarily describe current market facts"*. What the Authority regards as the relevant *'current market facts'* appear to be taken up in section 6 (see 6.5), which addresses what are described as *'Issues that arise generally in Negotiations between Consultants and Private Health Insurers'*.

1.3 There are several misunderstandings as to fact contained in section 6. These underlie the way in which the discussion there is developed so as to suggest, at 6.9 in particular, that Vhi's general approach and expressed need for discussions with consultants' representative bodies is not rational and to allow it to be inferred that the discussions conducted by Vhi may not really be necessary or perhaps may not be directed to their ostensible purpose. The Consultation Document goes on to say that, while discussion of codes and descriptions and ground rules are appropriate, there is *'no need for consultants to collectively discuss or agree on the actual fees to be paid by the insurers or the terms and conditions under which they offer such procedures'* (6.12 & 13). That seems reasonable having regard to the law as summarised at 2.10 to 2.20 of the Document – indeed discussions between consultants with the aim of deciding such matters on their own behalf would seem to be prohibited by the undertaking that the Authority has received from the IHCA. This statement however is followed by Question 33, which inter alia invites views on whether discussions can take place between consultant speciality groups and health insurers without requiring discussion of fees or other terms or conditions. Section 4.5 may also imply that such discussion is in some way wrongful, but neither in section 2 nor elsewhere does the Consultation Document explain on what basis the Authority considers this to be so – unless the Authority intends it to be inferred from the discussion in section 6 that Vhi's objects in relation to its product or the discussions referred to are generally not sensible.

1.4 It therefore seems important to first address those elements in section 6, leading to 6.9 that we think are mistaken. We will at the same time comment upon a number of what seem to be ancillary points raised in the Document as to which the Authority requests information.

We will then summarise the reasons why what we shall refer to as '*fee discussions'* involving consultants' representative bodies are regarded as necessary by Vhi. These discussions have already been explained in evidence and in written submissions to the Authority made on behalf of Vhi in February 2005 in the course of the investigation which has given rise to the Consultation Document. Since the discussions and in particular the '*fee discussions'* were the stated object of the investigation and are one of the objects (if not in fact the predominant one) of any intended guidance (1.9, 2nd point), it is difficult to understand the absence from the Document of any statement of the reasons for them offered by Vhi or of any criticism or challenge to them, if the Authority considers that such criticism or challenge may be deserved.

2. *Various Issues discussed in Section 6*

2.1 Although it may not much affect the discussion that follows in the Consultation Document, we do not think that it is valid (at 6.2) to characterise the demand for private health insurance (PHI) as related simply to perceived deficiencies in State-provided medical care. In economic terms, the two systems are of course substitutes and their relative costs or accessibility will affect choices of use between one and another. We believe however that a great many consumers have an underlying preference for being able to exercise control as customers over health services being provided to them rather than relying upon services under a State system – since these will ultimately and inevitably always be significantly affected by Government decisions as to the allocation of resources and priorities. Among Irish consumers who have had the financial means to do so, there is no evidence to suggest that large numbers of them have ever assumed that the State could or ought take over responsibility for the provision of care for acute illness, or that PHI is therefore something which should be regarded as operating only to the extent that the State does not provide such services.

2.2 We note the Authority's view (at 6.3) that Vhi's schedule of benefits has traditionally been followed by BUPA and Vivas. We have suspected this to be the case but have not known it to be so. It suggests that the schedule is probably a good instrument. The HIA in its most recent reports regards BUPA as having 20% (rather than 15%) of the market and

VIVAS as having 1%. In measuring Vhi's particular experience in fee setting, it is right to note however that, due to the higher risk profile of Vhi's insured population, Vhi is at present responsible for meeting about 85% of claims for the insured costs of health care.

2.3 At 6.7, the Authority acknowledges that it is in consumers' interests that consumers be able to obtain insurance that fully covers the cost of consultants' charges. The Authority also recognises the value for consumers of the agency role of insurers providing such cover. At 6.6 however the Authority suggests that *"there appears to be a belief among some private health insurers that offering full cover schemes is necessary for the effective provision of private health insurance cover and for meeting customers' needs."* The tone of this comment suggests that the Authority may think that, despite the value to consumers of full cover policies, insurers believe that full cover schemes are essential to consumers' needs and welfare and that insurers are mistaken in this belief. We should stress therefore that Vhi's view of the importance of full cover is born of customer demand rather than of a view on Vhi's part as to the requirements of consumer welfare. Equally, however Vhi's assessment of customer demand is not merely a matter of 'belief'. 'Balance billing' constitutes the most consistent single source of complaint that Vhi has received and still receives from its customers. Until 1991, 'balance billing' in one form or another was the norm. Until that time, Vhi provided only specified levels of monetary indemnity in respect of most insured medical services. Vhi changed its approach because of the dissatisfaction that so many customers expressed with their insurance not providing for the full cost of the services required. To make this change Vhi was obliged to make a very considerable investment (which is ongoing, although at a lower relative level) in establishing a pricing system for medical services - without which of course, the provision of full cover would be impossible. The significant growth in the Irish PHI market commenced following the introduction of this type of cover and it is significant that both of Vhi's competitors have adopted it as their standard model.

2.4 The reasons for consumer demand for full cover is fully understandable and since the Authority acknowledges consumers' proper interest in it, it is unnecessary to argue it. The Authority's assumption however that Vhi treats full cover as a welfare requirement or an

absolute aim is incorrect. There is no absolute need for full cover insurance and, from the point of view of an insurer a requirement that in place of full cover, the consumer share a proportion of the cost of treatments at point of supply is a valuable constraint upon the moral hazards associated with health insurance - particularly where some out-patient treatments are concerned. Vhi's policies therefore generally require cost-sharing either in the form of an excess or payment of a balance bill in respect of many such procedures - despite protests from customers and, in some cases, the offering of wider cover by Vhi's competitors who understand the attraction to customers of full cover. Vhi therefore aims to provide full cover policies for its members, but it has no interest in reducing balance billing as such.

2.5 It follows of course that Vhi's offers to consultants to contract for the provision of full cover care are not aimed at reducing 'balance billing'. Vhi's offers aim to engage a sufficient number of consultants to provide fully covered services to meet the needs of the large numbers and geographical spread of Vhi's membership. Vhi has presented to the Authority evidence showing the location of different specialities of medical consultant around the country and it has shown its member numbers in each region - (the latter information is of course confidential). Even at a national level, of the 86 consultant specialities represented by consultants registered with Vhi, 48 specialities comprise 10 or fewer consultants and 38 specialities are comprised of 4 or fewer people. Vhi has also provided the Authority with comparative information regarding consultant numbers in other countries, from which it is clear that the numbers in Ireland are low. The evidence demonstrates that Vhi's conclusion that, in order to provide service to its members, Vhi needs to provide its members with cover in respect of the services of most of such consultants is completely reasonable. Where members' strong preference is for full cover, then Vhi must therefore endeavour also to engage consultants to provide services on that basis.

2.6 It is however potentially misleading to characterise Vhi as *"aim(ing) to ensure that 100% of consultants… are participating consultants"*. The only way of 'ensuring' that result (or therefore aiming to do so) would be to offer the prices charged by the most demanding consultant - acting in fact if not necessarily in the form described by the Authority as the 'messenger model' (at 4.10). Vhi has presented the Authority with detailed evidence as to

the way in which Vhi conducts its negotiations and it is clear that Vhi does not act with this purpose or effect. Vhi aims to set a price which is objectively reasonable and which Vhi considers is likely to be accepted by most consultants on that basis. This approach is generally successful - obviously in part because of Vhi's agency power – but Vhi has never achieved 100% acceptance.

2.7 Vhi does have a 'selective', though wide, provider network incorporating all, but also only, participating consultants – that is, consultants who agree to accept as total remuneration the prices offered by Vhi. The Authority may have it in mind to suggest some smaller network. In the face of the evidence identified at 2.5 above, if that were feasible at all, such arrangements would actually consist of de-selecting limited numbers of consultants. Vhi doubts if this could produce any efficiency. On the contrary in Vhi's case, because health service suppliers who are not selected by Vhi are invariably tempted to threaten claims for abuse by Vhi of its market power, it would require the setting up of a costly selection/de-selection system to no necessary purpose.

2.8 Clearly, any restriction of an insurer's members' choice of consultants would require primary health care providers such as GPs to act as 'gatekeepers'. GPs might object that this was an inappropriate constraint on their own and their patients' proper range of choice, but it would not seem to present any major organisational difficulty. The Document seems to suppose that some such difficulty may account for the fact that consumers, inadvertently, find themselves being treated by non-participating consultants. The Consultation Paper also assumes that benefit is paid for treatments for non-participating consultants in order to provide for this kind of unplanned consequence of a referral. These assumptions are mistaken.

2.9 General practitioners are the ordinary 'gate-keepers' responsible for referring private patients to Vhi's participating consultants, and Vhi periodically circulates all GPs with an up-to-date list which identifies all those consultants. It also offers to supply this list to any of its members who ask for it and it encourages its members to telephone to Vhi so as obtain the answers to questions such as, what consultants are providing fully-covered care. As far as 'admitting consultants' are concerned therefore, Vhi believes that its members when being

referred to a consultant are usually aware whether or not the consultant is a participating consultant. Members are certainly in a position to ask their GP to recommend participating rather than non participating consultants – and we believe that members often do so.

2.10 The Authority also seems to misunderstand Vhi's relationship with non-participating consultants. Vhi has no contractual relations with such consultants. The amounts that Vhi pays in respect of their services constitute benefits to members – not sums contractually due to the consultants. The reason that payment is made to the consultants rather than to the members is because insurers are statutorily required to do so.

2.11 Vhi provides benefit in respect of the services of non-participating consultants because, despite the range of Vhi's consultant network, a patient may be obliged to have recourse to a non-participating consultant in some circumstances. This can arise where a patient is admitted to hospital under the care of a participating consultant, but where the services of other 'non-admitting' consultants are thereafter required and where these consultants may not all be participating. This may happen for example, in the case of a pathologist or an anaesthetist - in which specialisms the proportion of participating consultants have sometimes been lower than the average. Occasionally also, Vhi members in a particular locality or who have an especially urgent requirement for treatment may find it difficult to gain access to a participating consultant. Needless to say, Vhi has to take care to ensure that benefits paid in respect of services provided by non-participating consultants do not disincentivise consultants from agreeing to provide fully covered care.

3. *Bundled Provision of Services*

3.1 It is convenient to refer here to the Authority's suggestion (at 4.16 and 4.17) that insurers might purchase bundled hospital/consultant services. Vhi has done this to a limited extent in the past – purchasing services from some hospitals which were inclusive of certain consultant services – in particular pathology and radiology. These arrangements have not survived because the hospitals concerned were unable to maintain satisfactory agreements with the consultants in question. Vhi believes that the underlying difficulty is that health care services provided by hospitals are led, and for the most part inevitably led, by the consultants

with admitting privileges whom hospitals attract to work there. Where a patient requires hospital treatment, they see themselves as establishing a relationship with a consultant on referral from their GP. While the hospital environment is critical to the provision of consultant services, it is the consultants' role that is seen as primary. This analysis is consistent with what has been Vhi's ability to seek bundled services in respect of procedures (such as MRI) where, although consultant services form an essential part of them, the predominant cost and capacity to provide the service is comprised in the expensive equipment involved. It is likely that the number of such technology-driven services will increase, but it is not foreseeable that they will do so to the extent of reducing the overall role of consultants in the provision of hospital care for acute illness.

3.2 While the National Treatment Purchase Fund has, as the Authority points out, contracted with hospitals for the provision of medical services, the arrangement cannot really be described as 'bundled' for the purposes discussed by the Authority since the consultants providing the services are, we understand, actually remunerated by reference to Vhi's professional fee schedule.

3.3 Section 5 of the Consultation Document refers to partnerships and rotas. Vhi is not aware of the existence of legal partnership arrangements among consultants – although it understands that GPs have in some instances established partnership arrangements between themselves. Vhi does have arrangements under which it deals with what it describes as 'group practices' of consultants. These arrangements permit a group of registered consultants of the same specialty to collectively bill Vhi for the provision of services by any consultant member of the group. This is convenient in respect of services such as pathology where it is unusual for the consultant to have a direct personal relationship with the patient and where work can be conveniently shared among the relevant consultants attached to a hospital by reference to their availability or sub-specialism. These arrangements are not known to involve the creation by the groups of consultants concerned of a single economic entity between them.

4. *Involvement of Consultants and Representative Bodies in discussing Vhi's fee setting*

4.1 As noted at the opening of this letter, the Authority says at 6.9 that it is not satisfied that the involvement of consultants representative bodies in the setting of fees is necessary to obtain high consultant participation rates and, while at 6.11 to 6.14 the Authority accepts that consultants can legitimately work collectively in establishing codes and descriptions for procedures and ground rules to be incorporated in the contracts for services that consultants are to be invited to provide, the Authority suggests by its Question 33 that there is no need for consultants collectively to discuss the fees to be paid by insurers, or the terms and conditions under which they offer such procedures.

4.2 The Authority must find it tiresome that we emphasise at the opening of each debate on these topics the fact that, despite the breadth of meaning to be attached to the term 'agreement' in a competition law context (as explained by the Authority at 2.10 to 2.20 of the Document), the discussions that take place between Vhi and the consultant members put forward by the representative bodies (which the Authority has scrutinised in depth) do not lead to any agreement between Vhi and these bodies or the consultants put forward by them, nor do those consultants there agree on their own behalf or on behalf of anyone else to the fee schedule to be offered. If that is true, then it follows that nothing in these discussions deserves or requires interdiction or control by the Authority. Even if an agreement for the purposes of section 4(1) could be regarded produced by such discussions, Vhi believes that it is clear on the evidence that no 'price fixing' occurs. The Consultation Document does not discuss these facts. It is of course conceivable that somehow either within the discussions that we have described consultants (or their representative organisations) are themselves 'fixing' prices. If that was what the Authority was fearful of, then it might suggest steps to avoid this happening and might invite others' suggestions on the question.

4.3 In summarising again for the Authority the contents and purpose of the discussions referred to and the reasons for Vhi's involvement of the representative bodies in them, there is probably no important distinction to be drawn between the topic of procedure codes and descriptions and that of ground rules. The procedures (and the codes attached to them) describe and bundle services and prescribe the remuneration to be attached to them. The ground rules generally incorporate what might be described as wider 'bundling' rules – in

that they regulate the claims for fees that can be made where the services or bundles comprised in the specified procedures are provided in conjunction with one another or in particular types of environment. The ground rules are therefore as integral to Vhi's price setting as are the fees fixed by reference to the procedure codes and descriptions, and it is incorrect to interpret them as designed to create some other or optional level of *'certainty for insurers as well as consultants'* (6.14). Equally, they are no more prone to result in '*excessive tests and treatments'* or to *'limit the provision of more innovative services'* than are the procedure codes and descriptions. In emphasising this lack of distinction, we should of course add that, while Vhi has lively debates with consultants on the contents of both types of provision, it is not aware of consultants having ever managed to impose upon it an obligation to pay for obviously over-extensive tests or treatments.

4.4 As the Authority is aware, Vhi's practice is to invite the consultant representative bodies concerned to arrange for the discussion of a draft schedule and ground rules. Vhi has a preliminary discussion with consultants from a number of different specialisms put forward by the organisations concerned (usually along with the officers of the relevant body) as to what amount of 'medical inflation' should be generally be allowed for in the proposed new schedule: the participants try to persuade one another of the correctness of their arguments, and Vhi ultimately decides the rate that it will apply. What can be quite numerous meetings and communications thereafter take place between Vhi and groups of specialists put forward by the representative body concerned - the relevant groups being selected by reference to the sectors in the schedule where Vhi proposes or consultants wish to press for changes. These discussions include discussion as to the appropriateness of the economic values being proposed in respect of particular services or bundles of services in the schedule although, because Vhi generally insists on measuring changes by reference to the relative valuations included in the Harvard Valuation (which has been reviewed by the Authority and discussed with it), much of this discussion involves the balancing of values between different procedures rather than what might otherwise be expected to consist simply of demands for increases in values. No agreements are reached, although the people involved may express more or less satisfaction with the level of understanding reached in respect of particular items. Vhi decides on the final contents of the schedule that it will offer and it sends this to

the representative organisation for information and to each individual consultant, inviting them to agree to the terms offered.

4.5 As Vhi has explained to the Authority, although (and perhaps to an extent because of) Vhi's use of the Harvard Valuation as an objective reference point for fees, it is unrealistic to suggest that you can discuss the bundling of one service with another through a procedure description or a ground rule without discussing changes in relative values of its different components – as to which there can be legitimately different views which Vhi requires to hear. Indeed it must be pointed out that while in constructing and modifying the schedule, Vhi has to be concerned to ensure effective treatments for its members and to avoid their being provided with unnecessary or inappropriate treatments – its influence on these matters is through the procedures for which it does or does not agree to pay, the payment conditions imposed and the amounts of fees payable. The primary object of the schedule and its design is therefore to identify the economic values to be attached to each procedure. To try to discuss proper bundles for fee setting purposes without discussing the value relationships that they bear to one another would be impossible.

4.6 The Authority naturally does not have an intimate knowledge of any of the procedures or their relative importance or how they relate medically to one another or how the procedures themselves develop and change or change in relationship to one another in medical terms. Unfortunately, it is only when one is equipped to consider these matters at that level of detail that the validity of Vhi's approach becomes evident. Vhi has therefore selected as examples two types of procedure in which the necessary discussion involved can be summarised reasonably briefly. The Authority will appreciate that a detailed description of each element of the discussion would involve a considerable essay.

(a) The retina (the neurosensory tissue that lines the back of the eye and is responsible for creating the images that one sees) can become damaged due to disease and can then become detached from the back of the eye. A number of different procedures are available to treat this kind of condition and these have been separately listed in the fee schedule with separate fees applied to each. More serious retinal detachment may require a number of these procedures to be undertaken at the same time. The boundary definitions between some of the individual procedures were however very difficult to express concisely so that it was difficult to establish norms which could fairly measure differences in the

difficulty and therefore the value attached to particular procedures when provided discreetly as distinct from in conjunction with one another, or which could encompass additional work that might be required when procedures were provided in conjunction with one another or when some were provided in conjunction with others. Without being able to fully analyse the situation itself, Vhi became concerned that it was in many cases remunerating for a greater level of overall complexity than was actually justified.

Vhi sought a debate on the questions with the ophthalmic surgeons representative group within the IHCA. There was a great deal of debate about the difficulty (or relative economic value) of different elements in the services as related to one another - what factors could be identified as characterising particular levels of difficulty? When these points had been established, it was necessary to establish whether it was reasonable to try to link some of them together as bundles which might be valued by reference to pre-established bundles of services, while making allowances for factors which had not been taken into account in those bundles. There were on the other hand some procedures whose economic value allowed them to be bundled or provided for separately at a lower price.

For ease of claims administration, Vhi needed to establish straightforward criteria for applying higher or lower prices to different bundles, but it could not conceivably have done so without debating the economic values of the work to be done and the measurement of the values to be attached to that work both with and among a group of consultants.

United States basic Medicare multiple surgery payments rules (that is, multiple procedures performed by the same surgeon during the same operative session), state that the first procedure is paid at 100% of the allowable benefit and the next four procedures are paid at 50% of the benefit allowable up to five procedures. If more than five procedures are performed then the matter is referred for individual consideration by a medical advisor to the payor.

The Harvard Valuation provides separate codes for repair detachment with scleral buckling for a pars plana vitrectomy. However, separate additional codes are used for vitrectomy combined with endoscopic focal laser photocoagulation, endoscopic panretinal laser photocoagulation, membrane peeling and retinal detachment repair to reflect the higher expense and more complex work associated with these procedures. These codes, which may be used in various combinations, are reimbursed in addition to the pars plana vitrectomy.

The Harvard Valuation also provides that when treating complex retinal detachment by vitrectomy with membrane peeling (for example, proliferative diabetic retinopathy with tractional retinal detachment or

proliferative vitroretinoplasty), reimbursement for separate procedures is allowable. Two codes are combined for this purpose. For pars plana vitrectomy and other vitrectomy codes combined with a cataract extraction with insertion of an intraocular lens, both procedures are paid with the highest at 100% of the allowable benefit and the remainder at 50% of the allowable benefit.

We discussed with the consultants the surgical interrelationship between the procedures. It transpired that there were a variety of ways in which a number of them could be carried out, some of these ways being more demanding than others and some being mandated by the detail of the injury caused by the disease. Having taken into account of these points, Vhi proposed to adopt the relative value of the three Harvard Valuation codes to arrive at a value for a new complex procedure description for retinal detachments. This did not at first seem to present any difficulty. The three codes and their descriptions were as follows:

67036 *Vitrectomy with epiretinal membrane stripping*

and

67108 *Repair of retinal detachment with vitrectomy , any method, with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique*

and

66850 *Removal of lens material phacofragmentation technique (mechanical or ultrasonic)(eg, phacoemulsification), with aspiration.*

However, on closer examination and following further discussion it was acknowledged that these codes arguably ought not be combined in this way, as two of them incorporate vitrectomy elements in their code description and a value component is therefore arguably duplicated.

Following further discussion of the character of the surgical elements involved, it appeared that it might be possible to define the new complex by reference to its requiring “membrane dissection” (or - membrane peeling). By defining the new procedure thus, we avoided both ambiguity as to what constituted a complex case and possible duplication of benefit. The benefit value was computed based on the Harvard Valuation. Under the Ground Rules Vhi reimburses for a maximum of three procedures as follows:

100% of the highest valued procedure
50% of the second highest valued procedure
25% of the third highest valued procedure

Unlike the United States system, if another procedure (or more than one) is performed at the same time, no Vhi benefit is paid.

There was no argument or further debate regarding this final step of the process as the Vhi benefit value became a foregone conclusion as a result of the discussion described.

(b) There are a number of urological investigative procedures available for assessing bladder function. Sometimes only one or two of these tests may be required. In other circumstances, a number of them may be indicated. When this pricing was initially established, the circumstances in which it was justified were described in a relatively general way. Reviews of claims suggested to Vhi that what were actually limited assessments were being characterised as 'complex assessments', but individual consultants responded claiming that they were now performing additional procedures to those originally comprised in the complex assessment or that descriptions that had been applied to one procedure were now used in practice to describe different ones.

Vhi re-bundled a number of separate procedures together and priced them collectively at a discount against the individual components. It did not discuss the change with consultants because consultants collectively regarded themselves as prohibited from such discussion at the time. There was uproar among the consultants most concerned when the revised schedule was published. Vhi succeeded in identifying one consultant (who was probably the busiest in the particular field) who agreed to discuss what were seen as the problems. The discussion satisfied Vhi that a number of new evaluation techniques were emerging and were probably going to continue to develop – some under existing rubrics and others under new ones, so that an economic evaluation or re-evaluation for the different kinds of treatment was required. It seemed ultimately that different forms of assessment might reasonably be bundled under one of two headings while other specific methods might be left discreetly priced. Again however, the comparative economic value of the different procedures involved was an integral part of what was discussed while, again, due to the application of the Harvard Valuation, there was ultimately no significant discussion about the totals of the economic values to be applied to each of the resulting bundles. Vhi revised the schedule and the result appeared to satisfy most consultants in the field, but the transaction costs of the whole process were high and Vhi could not afford to replicate them, or expect to be able to find a lead consultant in another area prepared to take on the role accepted by an individual consultant in this case.

4.7 It is the nature of discussions of the type just described which Vhi believes in practice makes it essential that it should involve the representative organisations in the process. The factors listed by the Authority at 6.9 must certainly be relevant to a consultant's decision as to whether or not to agree to provide fully covered care, but they do not contradict or qualify the reasons that have already been put forward by Vhi explaining the importance of the involvement of the representative bodies.

4.8 Briefly those reasons are as follows:

- Obtaining thorough and useful views from consultants in circumstances such as those described above requires a fully engaged debate between people who have different self-interests and different experiences, whose individual views can be contested and compared with and in the presence of one another. Enlivened argument is what is required to expose all the issues that ought be taken account of in establishing relative economic values. No single negotiation between a buyer and seller can be expected to produce the same level of committed information nor will a multitude of such individual encounters (even if it were practicable to organise them) have the same effect.

- Consultants are generally loath to put themselves forward individually for this kind of exercise first, because they are unwilling to have themselves identified as representative of a class and second, because many of them are reluctant in principle to speak to insurers at all – put in economic terms, they are unwilling to recognise any role for an agent in what they see as their responsibilities towards their principals, those being their patients. If however they are commissioned by their representative body to debate with an insurer, then they can reasonably regard their role as representing a legitimate common interest. A request from a representative organisation to participate in such a discussion (presumably often prompted by a suggestion from one consultant that a colleague has a particular knowledge of or interest in a special area) is therefore probably the most effective way of producing a well qualified group, which is clearly independent of the insurer, to conduct such a debate.

- Tellingly, in listing the factors that a consultant is likely to consider when deciding whether to accept an offer from an insurer, the Authority makes no reference at 6.9 to what most potential vendors would be expected to assess when deciding to accept an offer for their products – namely, the vendor's own evaluation of their products' worth either in the market or by reference to its cost of production. The reason is of course because it is inherently difficult to value medical consultancy services and a scientific evaluation (to the extent that such a thing is possible) would require a level of research that few if any consultants would be competent to carry out or could afford to have carried out by a third party. Some consultants, if they have the market power enabling them to do so, may decide simply that they will not provide services at less than whatever price they chose to name, but the main concern of most consultants when dealing with a single agent acting in fact on behalf of the majority of the consultant's potential private patients will be to ensure that the price offered is not arbitrary – which is to say, that it has been subject to some process whereby its reasonableness has been independently contested. The discussion process that has been outlined does not represent a complete test for this purpose, but it does expose the Vhi to coherent and self-interested argument presented by people not of Vhi's own choosing – and if Vhi actually chose to ignore well made points, that fact is likely to become quickly known. It does therefore provide consultants generally with some confidence that what they are offered is at least not unfair or is anyway the best that can practically be obtained.

4.9 We express these matters in terms of common sense and human knowledge rather than in terms of behavioural psychology or games theory, but we are satisfied that the points made are valid. If the Authority thinks that they are mistaken or can produce evidence to suggest that a different approach will do as well, then we would welcome an opportunity of reviewing such material.

4.10 Footnote 34 to the Consultation Document asserts that the view expressed in 6.9 *"is further supported by a press release issued by Vhi in June 2005 stating that Vhi was confident that it could come to individual agreements with almost all individual consultants"*. (The Document in fact demonstrates no other support for the view expressed). The footnote does not explain how this is thought be so. The press release was issued in circumstances where, because of what was then the ongoing investigation being conducted by the Authority, the representative bodies had expressed themselves as unable to enter into discussions with Vhi about Vhi's new schedule. As is indicated in the press release, there had been speculation in the media as to whether, because no discussions had taken place, Vhi's full cover scheme might collapse. As the Authority knows from the correspondence that we then exchanged with the Authority, Vhi indeed feared that considerable numbers of consultants might either actually lack confidence in the fairness of the schedule where its contents had not been debated in the way that had become established, or that they might take the media commentary as a signal that they should react in that way. Vhi hoped that the confidence that it expressed would be vindicated. One can debate the different forces at work among consultants at that time. In the event, we were glad to be able to report to the Authority that Vhi achieved a very good acceptance level. This does not in the circumstances give the slightest reason to suppose that that such conduct would be repeated in the longer term without discussions of the kind described.

4.11 We should finally briefly comment upon the 'messenger model' described by the Authority at 4.8 to 4.15. We have already explained Vhi's views to the Authority about this model and we have directed the Authority's attention to consultation hearings conducted by the US Federal Trade Commission from which it is clear

- That the model was devised to try to cope with circumstances in the US where health service providers in particular localities had habitually fixed prices between themselves so as to impose them upon third parties such as insurers and where, when these practices were being halted, the health service providers demanded some means whereby they could maintain some organised input into the terms upon which insurers

might make their offers. The model was not devised because of any efficiency that it was thought to possess over other potential legitimate negotiating models.

- The operation of the model is frequently abused (as indeed is indicated by legal authorities quoted by the Authority) and has been found as likely to facilitate the evil that it was designed to remove as it is to cure it.

- None of the several very experienced competition law practitioners (representing both enforcement agencies and defendants) seemed able to point to any obviously successful messenger system that was thought desirable of general replication.

4.12 There seems no reason to suppose that such an arrangement would provide any benefit to Irish consumers and there are, on the other hand, several reasons for supposing that it would be tedious and expensive to try to operate and, having regard to its mechanics, would be likely in the Irish market to lead to higher rather than lower prices.

5. *Questions*

In answer to the specific questions that you have raised therefore, Vhi would respond as follows:

Questions 1 to 6: As noted above, Vhi has no experience in dealing with partnerships of consultants.

Question 7: Vhi does not have a view on this question.

Question 8 & 9: Vhi does not know of any such instances.

Question 10: Yes, Vhi believes so and believes that the process whereby such fee setting has been carried out by Vhi is effective.

Question 11: Yes, for the reasons set out above, which also explain the role that the representative organisation plays in this model and (in conjunction with Vhi's submissions to the Authority in February 2005) why it does not breach the Competition Acts.

Question 12: Assuming that such 'collective negotiations' as are supposed by the question are of the type that have actually taken place, then Vhi does not see that any appreciable efficiencies are foregone, provided that consultants have a proper input in debating the fees to be so set.

Question 13 to 17: For the reasons expressed, Vhi does not believe that the messenger model (or any known variation of it) would work in Ireland for the purpose described.

Questions 18 and 19: For the reasons expressed above, hospitals are not generally in a position to bundle consultant services with their own.

Question 20: Where fees to represent the full cost of a consultant's services have to be met by an agent such as an insurer, Vhi has not become aware of any other private fee setting mechanisms that are likely to be useful for this purpose.

Questions 21 to 24: Vhi have not been concerned with the organisation of rotas as such, but group practices (for which Vhi does make special provision) should probably be regarded as incorporating some of the characteristics of rotas.

Question 25: As we have explained, we think that the Authority is mistaken in its characterisation of Vhi as '*striving for full cover schemes'* and in its understanding of the nature of balanced billing arrangements and their purposes. There is nothing in the text of the Consultation Document which would suggest that the steps actually taken by Vhi to procure full cover services for its members or its allowances in respect of balance billing are in any way restrictive of competition. We are not sure how the Authority has reached the view that either of these courses of action could be *'indispensable to producing the schedule of benefits'*. There are clearly different types of benefit which do not entail the provision of full cover, although on first appearances at least it is unlikely that there are any forms of health benefit which would involve <u>neither</u> full cover nor balance billing.

Question 26: Vhi does not have information enabling it to answer this question. There is no reason in principle why A&E Departments would not have some role in referring patients to other consultants. We are not sure why the information should be regarded as important.

Question 27: GPs do have such lists of Vhi's participating consultants and can select from that list. They do accordingly act as gatekeepers in many circumstances.

Question 28: Vhi's members do have access to Vhi's list of participating consultants and are thus able to select a consultant from that list.

Questions 29, 30, 31 & 32: Vhi's participating consultants do form a selective network in the sense that they (as distinct from all consultants) are the only ones the costs of whose services are fully covered by Vhi. The Consultation Document may intend to suggest the desirability of smaller networks and it seems to suggest that there is some lack of clarity in the distinction between consultants who are participating and those who are not. This last assumption is mistaken and, as explained, a smaller network is unlikely to be able to provide services for Vhi's wide membership. If there were more consultants, there would naturally be more scope to select among them. Whether that would actually produce much by way of efficiency is uncertain.

Questions 33 to 38: For the reasons explained, it is not useful in discussions between Vhi and consultants to try to separate discussion on codes and descriptions of procedures (or ground rules) from the economic evaluation of such procedures, nor is there any reason why one should seek to do so unless 'price fixing' is the actual aim or result of such discussions.

Question 39: Ground rules are one of the mechanisms determining how procedures will be paid for and, to the extent that they provide that treatments will not be paid for in certain circumstances, they may be regarded as affecting 'treatment volumes' – but we do not think that volumes in this sense are what the Authority has in mind.

Question 40: No.

Vhi will be glad to discuss with the Authority any of the matters referred to in the Consultant Document.

Yours faithfully

McCann FitzGerald