Independent Hospital Association of Ireland (IHAI) Response to Competition Authority Consultation on Guidance in respect of Collective Negotiations relating to the Setting of Medical Fees

The Independent Hospital of Ireland (IHAI) is the representative organization for the independent hospitals in Ireland. Members are in private ownership and operate separately as stand alone entities. The IHAI is affiliated to IBEC.

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?

Answer 1
There are 1,947 consultants with public hospital appointments and a further 227 in full time private practice. Mostly consultants have admitting privileges only to IHAI member hospitals and are not employees; such consultants are mainly Category 2 post holders and a minority are full time private consultants. Many of these consultants practice in several IHAI hospitals. For this reason the IHAI does not have accurate information on the actual numbers involved. One important exception is the IHAI member psychiatric hospitals where consultants are directly employed by the hospitals.

As far as the IHAI is aware only a small minority of consultants are in partnerships. The IHAI has no information on the situation regarding GPs.

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?

Answer 2
The IHAI does not have any knowledge of the nature of partnership arrangements or their precise legal status or basis.

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

Answer 3
The most common partnerships that the IHAI is aware of involve pathologists and radiologists. The IHAI does not have a comprehensive overview of consultants' partnership arrangements so can not comment in any more detail.

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

Answer 4
The IHAI is not aware of any such partnerships but they may exist.

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

Answer 5
The IHAI is not aware of the legal basis of partnerships among doctors.

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.

Answer 6
The IHAI has nor information on the motivation of consultants or GPs forming partnerships.

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.

Answer *7*
The IHAI has never had commercial discussions with bodies of this sort. There is no situation known to the IHAI 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. There may be occasions when clinical considerations dictate that technical guidance be given as to quantity of service provided exclusively for reasons of patient safety and welfare e.g. in a hypothetical example recommended dosages of medication, of radiotherapy etc.

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.

Answer 8
This is an extremely difficult issue to assess. IHAI member hospitals are mainly involved in elective admissions, some of which involve very complex treatment and procedures (e.g. heart surgery, PET scans, radiotherapy). In some situations a patient can be referred from another hospital or referred between consultants. The IHAI does not know to what extent is the selection of a consultant by a patient is typical of decisions made in commercial transactions every day throughout the country by economic actors. The issue is very serious issue so market research should be carried out to establish how patients select the different type of consultants they require (e.g. anaesthetic, medical, pathology, psychiatric, radiological, surgical etc.) and what key criteria they would use in selecting consultants in arrange of admission situations (i.e. elective surgery, emergency, initially for diagnostic tests that may lead to a procedure) for themselves or for family members (i.e. minors, those not compos mentis etc.) . It would be useful to ascertain through research whether or not patients know the functions of consultants involved in their care other than that of the lead consultant. Research should also be undertaken on the capacity of patients to cope with any alternative arrangements contemplated by the Competition Authority to those currently in situ between health insurers and consultants.

The members of the IHAI are very concerned at the scope for commercial damage to their hospitals should the Competition Authority change the current arrangements and inadvertently create a confused situation. If a consultant decides for perfectly valid clinical reasons on treatment which is inherently expensive in terms of hospital inputs (e.g. theatre time, equipment, consumables, drugs etc.) but is not explicitly approved by the health insurer through clear and predefined arrangements, who is to pay the hospital for the costs it incurs? The health insurer could well be able to refuse to cover all or much of the cost. It is not in keeping with the ethos of IHAI hospitals to aggressively pursue patients in such circumstances. The hospital would be in an invidious position if it sought to avoid such situations by second guessing consultants on the treatments they envisage for individual patients and insisting on prior approval. In such circumstances consultants would forcefully argue that their clinical independence was being infringed and patient welfare compromised. This would be aggravated by the fact that mostly consultants have admitting privileges only to IHAI member hospitals and are not employees, the exception being the psychiatric hospitals that are in IHAI membership. The hospital would then be in conflict with the consultant and indeed possibly the patient.

Currently a health insurer will only settle a claim from a hospital for expenses incurred by the hospital in treating a patient (e.g. bed and board, theatre time, equipment, consumables, drugs etc.) if both the claim from the hospital and the claim from the consultant are fully compliant will all its rules and supported by all requisite

documentation. If in dispute with the consultant, the health insurer will also refuse to settle with the hospital even if the claim from the hospital meets all its requirements.

The IHAI urges caution and extensive research before decision are made by the Competition Authority.

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

Answer 9
The IHAI does not have the expertise in competition law to answer this question, particularly as it is not a party to discussions between consultants and the health insurers.

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?

Answer 10
In some situations the payor could be the hospital. Examples could include cosmetic surgery or where an individual is paying for an operation on a family member who is not covered by private health insurance (e.g. a hip replacement for a parent). In these situations the person paying the bill wants a reasonable level of certainty as to the cost and would not commit to an open ended liability. In such situations offering the patient a definite combined fee is essential. It should also be noted that that the National Treatment Purchase Fund insists on a combined fee.

Question 11
Are there any valid reasons for a representative organization 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 organization would play in this model and why this does not breach the Competition Act.

Answer 11
The IHAI can not see any valid reasons for a representative organization to play a role in fee setting in the situation referred in Answer 10 above.

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?

Answer 12
Has the payor the ability to impose a fee? If not the fee the payor sets may be unacceptable and cause a substantial number of consultants to refuse to treat patients under its terms and conditions and simply impose balance billing or else demand that patients pay them directly and seek reimbursement from their health insurers. Currently a health insurer will only settle a claim from a hospital for expenses incurred by the hospital in treating a patient (e.g. bed and board, theatre time, equipment, consumables, drugs etc.) if both the claim from the hospital and the claim from the consultant are fully compliant will all its rules and supported by all requisite documentation. If in dispute with the consultant, the health insurer will also refuse to settle with the hospital even if the claim from the hospital meets all its requirements. The members of the IHAI are very concerned at the potential for their businesses to be disrupted because of such a dispute and urge extensive consultation with the principals.

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?

Answer 13
The IHAI is not in a position to predict whether or not the messenger model would work in a jurisdiction such as Ireland. It is an unusual concept being neither arbitration nor conciliation nor negotiation. It would appear extraordinarily difficult for any individual(s) acting as the messenger, no matter how scrupulous and competent, to add value in any real sense while simultaneously successfully respecting in the eyes of a court of law the limitations of his role. The IHAI urges caution with regard to the messenger model, urges the compilation of research on any difficulties encountered in its operation in other jurisdictions and also urges extensive negotiation between the various stakeholders subsequent to this consultation process should the messenger model be under serious consideration. The IHAI is not a principal in the relationship between consultants and health insurers and has not discussed the messenger model with them. Should the messenger model be under serious consideration the IHAI wishes to reserve the right to comment in more detail based on a review of the submissions received by the Competition Authority to this consultation process and the Authority's subsequent comments. The members of the IHAI would be very concerned at the scope for commercial damage to their hospitals should messenger model type arrangements be mandated by the Authority that subsequently prove unworkable.

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

Answer 14
The IHAI is not in a position to predict whether or not the messenger model could be successfully used in negotiations between doctors and other payors because there is not adequate information to hand to make an assessment. Again the IHAI urges caution with

regard to the messenger model, urges the compilation of research on any difficulties encountered in its operation in other jurisdictions and also urges extensive negotiation between the various stakeholders subsequent to this consultation process, should the messenger model be under serious consideration. The members of the IHAI wish to reiterate that they are very concerned at the possibility of commercial damage to their hospitals should messenger model type arrangements be mandated by the Authority that subsequently prove to be unworkable in practice.

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

Answer 15
The IHAI is not aware of efficiencies that the messenger model could achieve between doctors and payors. Again the members of the IHAI are very concerned at the scope for commercial damage to their hospitals should messenger model type arrangements be mandated by the Authority that subsequently prove to be unworkable.

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?

Answer 16
The IHAI is unable to identify any suitable candidate to be the messenger as, like all parties to the consultation process. Its understanding of the messenger model is very imperfect. Again the IHAI would point out that is an unusual concept being neither arbitration nor conciliation nor negotiation. Ireland has a very extensive range of industrial relations mechanisms and structures but none remotely resemble the messenger model. It would appear extraordinarily difficult for any individual(s) acting as the messenger, no matter how scrupulous and competent, to add value in any real sense while simultaneously successfully respecting in the eyes of a court of law the limitations of his role.

Question 17
Who should engage and pay the messenger?

Answer 17
The IHAI has no views on this issue. However care should be taken not to establish an expensive bureaucracy.

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?

Answer 18
The IHAI can only surmise why health insurers infrequently purchase services as a bundle including consultants' fees from hospitals. Intuitively it would seem easier to do this for more straight forward investigations than for complex operations, which are very variable across a range of criteria. Hence such purchases tend to take place for MRI, PET, CT etc. rather than for complex operations. A further factor is that consultants are not direct employees of IHAI member hospitals (except in the case of psychiatric hospitals).

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

Answer 19
In theory direct contracting with hospitals on the basis that the hospitals discharge the consultants' fees could provide an alternative to the present Schedule Benefits. Individual negotiations would have to take place at local level between individual consultants and hospital management in the independent hospitals. At the moment it is necessary when the health insurers go to tender.

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?

Answer 20
The IHAI is not aware of 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.

Rotas (see sections 5.3 to 5.6):

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

Answer 21
Yes.

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?

Answer 22
IHAI member hospitals are not aware of arrangements between doctors concerning fees for rotas.

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

Answer 23
IHAI member hospitals have never experienced doctors collectively withdrawing from rotas.

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).

Answer 24
The IHAI is not aware of such practices.

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?

Answer 25
The benefit of having as many consultants as possible participating in full-cover schemes is that it maximizes patient choice, thereby ensuring that patients have access to the most appropriate medical skill and expertise for their particular condition. Patients benefit because they avoid exposure to balance billing.

Intuitively it would seem that most patients other than exceptionally well informed or wealthy patients, would tend to confine themselves to a full cover list. Market research should be carried out to determine patient behaviour and attitudes.

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?

Answer 26
The IHAI has no role in the public hospitals' on call A&E services throughout the country and so can not answer this question.

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?

Answer 27
The IHAI does not have the links with GPs or the intimate knowledge of referrals from GP to consultant necessary to answer this question. The views of patients on this issue should also be established.

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?

Answer 28
The IHAI is not in a position to assess this issue. Market research among patients should be carried out to establish they would use in selecting consultants and The issue is very serious issue so market research should be carried out to establish how patients select the different type of consultants they require (e.g. anaesthetic, medical, pathology, psychiatric, radiological, surgical etc.) and what key criteria they would use in selecting consultants in arrange of admission situations (i.e. elective surgery, emergency, initially for diagnostic tests that may lead to a procedure) for themselves or for family members (i.e. minors, those not compos mentis etc.). Research should also be undertaken into whether patients or family members as appropriate would feel competent to make the selection without advice from a medically qualified third party. It would be useful to ascertain through research whether or not patients know the functions of consultants involved in their care other than that of the lead consultant. Research should also be undertaken on the capacity of patients to cope with any type of list arrangement as outlined by the Competition Authority consultation document.

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?

Answer 29
Presumably some albeit small savings would accrue to private health insurers because they would make administrative savings from having to deal with fewer doctors. It is less clear what advantages would accrue to patients/consumers. The market research recommended under Answer 28 above could supply some answers.

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

Answer 30
The IHAI is not in a position to comment on this issue.

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.

Answer 31
The IHAI is reluctant to endorse any restriction on freedom of patient choice. Views should be sought on this very important issue through market research involving a range of groupings – current patients, recent patients, patients' families and those with health insurance who are potential future patients.

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

Answer 32
Ireland needs more consultants regardless.

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.

Answer 33
Codes and descriptions of procedures should be discussed between specialty groups and private health insurers from a purely clinical perspective because private insurers could not be expected to be fully au fait with the minutiae of or rational for leading edge developments across all specialty areas. Otherwise there is a risk that new developments that will benefit patients will not be as rapidly approved by health insurers as otherwise. This would place IHAI member hospitals in an impossible position. If a consultant wants to use a new and superior procedure which is inherently more expensive in terms of hospital inputs (e.g. theatre time, equipment, consumables, drugs etc.) but is not approved by the health insurer who is to pay the hospital for the costs it incurs? It is not in keeping with the ethos of IHAI hospitals to aggressively pursue patients in such circumstances. On the other hand the hospital would be in an invidious position if it sought to forbid consultants from providing such new procedures to patients. Patients and their families would exert extreme pressure on hospital management to reverse their decision; individual consultants would forcefully argue that their clinical independence was being infringed and patient welfare compromised.

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?

Answer 34
The discussion should be confined to clinical criteria only and neither express nor implied discussion of fees should take place.

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?

Answer 35
Question is not applicable.

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?

Answer 36
Discussions on Ground Rules between speciality groups and private health insurers can take place without requiring discussions on fees or other commercial terms. Such discussions should, as stated in section 6.14, in essence focus on defining service level agreements and take account of new clinical developments that benefit patients. Private health insurers can be relied upon to oppose any attempt to impose unnecessary treatments or tests. Universally accepted and understood clear Ground Rules are essential. Otherwise consultants will not be clear what procedures are covered by health insurers and what are not. There is a real risk that consultants acting in good faith may Frequently provide treatment that is expensive in terms of hospital inputs (e.g. theatre time, equipment, consumables, drugs, tests etc.) but is not approved by the health insurers. In this situation who is to pay the hospitals for the costs incurred? The members of the IHAI are very concerned at the scope for commercial damage to their hospitals should the Competition Authority inhibit the development of clear Ground Rules.

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?

Answer 37
Neither express nor implied discussion of fees should take place.

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?

Answer 38
Question is not applicable.

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

Answer 39
The IHAI is not in a position to assess this issue.

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?

Answer 40
The IHAI has no knowledge of 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.

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