IRISH HOSPITAL CONSULTANTS ASSOCIATION

HERITAGE HOUSE
DUNDRUM OFFICE PARK
DUBLIN 14

TELEPHONE: 298 9123
FAX: 298 9395
e-mail: info@ihca.ie
Website: www.ihca.ie

15th March, 2006

Ms. Emily O'Reilly,
Economist/Case Officer,
Monopolies Division,
The Competition Authority,
Parnell House,
14 Parnell Square, Dublin 1.

Dear Ms. O'Reilly,

I attach herewith the IHCA response to the queries posed in the Competition Authority Consultation Document. I have been requested by the National Council to highlight the following matters, many of which are not addressed in the Queries in your Discussion Document:

(1) The supply of hospital consultants within this jurisdiction is determined by the Department of Health and more recently, the Health Service Executive. The policy promulgated by the Department and HSE determines:

  (1) The number of consultants in the public hospital system

  (2) Their area of speciality or sub-speciality

  (3) Their geographic location

  (4) The overall number of consultants in our hospital services and the overall number per speciality

(2) The supply of particular services is also determined by the Department of Health and HSE.

  (a) The location of general hospitals is a matter of Government policy.

  (b) The location of tertiary referral hospitals is also a matter of Government policy.

  (c) The availability of particular consultant services is confined to specific hospitals as a matter of Government policy.

(d) Specialities such as Orthopaedic Surgery, Obstetrics and Gynaecology, Cancer Services, Neurosurgical Services, Cardiac Services, Burns and Plastic Surgery Services are centered in specific hospitals as determined by National Health Policy.

(e)

- Each hospital in the private sector grants admitting privileges to consultants.

- It is a matter for each privately-owned hospital to decide on the number and mix of consultants/specialities it will accommodate.

- A private hospital may decide to discontinue a speciality. The Bon Secours Hospital, Cork and Clane General Hospital have both discontinued obstetrics in recent years.

(f) Consultants, with very few exceptions, must have a hospital base, whether public or private, to practice. Unlike other self-employed professionals, their ability to practice is dependent on hospital owners (public and private) to accept referrals.

(3) The public hospital system is driven by emergency admissions. Statistics produced over successive years by the Department of Health illustrate that 72% (approx.) of admissions to our public hospitals are emergencies.

(1) According to the same source, 20% of admissions to our public hospitals opt for private care. In the majority of instances, this 20% of patients are emergencies and are not in a position to shop around or negotiate professional of other fees with consultants or hospitals.

(2) It is not unusual for a public hospital to "come off-call" due to overcrowding in its A&E Unit. In reality, emergency patients transferred by ambulance to hospital will frequently find that it is the ambulance service which will determine the hospital to which they are admitted. Therefore, notwithstanding the competition legislation, debates regarding competition, choice of outlet of service (hospital) or the opportunity to shop around are unrealistic in the case of a very significant number of patients.

(4) The Irish Hospital Consultants Association represents hospital consultants only. Therefore, very little reference is made to the position applying to general practitioners other than in matters such as their gatekeeper role and involvement in referring their patients to specific consultants or hospitals.

(1) According to the Comhairle na nOspideal figures (January 2005) the Consultant Establishment in our public hospitals stands at 1,947.

(2) According to the same source, there are 227 consultants who operate exclusively in the private sector.

(3) It is estimated that 34% of consultants with public appointments hold contracts which, should they choose to do so, allows them to admit patients to private hospitals.

(5) The Hanly Report (2004) recommended that there should be 3,200 consultants appointed to our public hospitals by the year 2013. Obviously, it is a matter for the Department of Health/HSE to decide whether or not this target is reached.

(6) The ratio of consultants to population in Ireland is 50% (approx.) of international norms:

Speciality	**Number***	**Ratio**	**International Norm**
• Rheumatalogy	20	1:200,000	1: 85,000
• Neurology	14	1:290,000	1:100,000
• Cardiology	30	1:135,000	1: 35,000
• Cardiac Surgery	10	1:405,000	1:250,000
• Dermatology	16	1:250,000	1:100,000
• Nephrology	15	1:270,000	1:120,000
• Orthopaedic Surgery	65	1: 62,000	1: 20,000
• Ear, Nose & Throat	32	1:126,500	1: 70,000
• Ophthalmology	32	1:126,500	1: 80,000
• Old Age Psychiatry	20	1:25k plus 65	1: 10k plus 65
• Maxillo Facial	7	1:580,000	1:200,000

*Comhairle Establishment January 2005

(7) Notwithstanding your letter of clarification of February 17th, the IHCA remains uncertain regarding the Competition Authority's definition of partnerships as against group practices which exist to a limited extent among hospital consultants.

(1) Partnerships, as understood in this submission, are similar in legal standing to those applying in legal firms, accountancy practices etc.

(2) Group practices in the hospital sector do not have the same legal standing as applies to those groups referred to at (a).

- There is the matter of the doctor-patient relationship which is recognised in many court judgements.

- A patient or next-of-kin will sue the individual doctor rather than a group practice. In instances where more than one consultant has had responsibility for the care of a patient, each individual consultant will be sued on a personal basis rather than as a group.

- Group practices in medicine do not have the same corporate entity as applying in the business world.

(8) Due to the Finance Act 1988 which obliges the health insurance provider to pay the professional fee directly to the hospital consultants involved in a patient/members' care, the (financial) relationship between doctor/patient and insurer is inextricably linked.

(9) The role of the Medical Council in governing the practice and behaviour of consultants is a factor which cannot be ignored.

(a) Doctors are precluded from advertising other than in a very minimalist way with regard to practice notices and signs.

(b) Referral practices, both from GP to consultant and between consultants, are governed by the Medical Council.

(c) Fee splitting is prohibited by the Medical Council.

(d) The GP (family doctor) is seen as the primary carer of the patient and consultants are precluded from accepting (patient) self-referrals other than through A&E Units.

(10) The Competition Legislation fails to recognise that inpatients and day case patients are rarely treated by a single hospital consultant.

(1) The elective patient will have had a consultation with his/her admitting consultant prior to being admitted as an inpatient or day case patient and therefore will have had an opportunity to discuss fees.

A team of other consultants may become involved in that patient's management who will not be known to the patient prior to admission. Therefore, the patient will not have any opportunity to discuss fees with the majority of consultants involved in his or her treatment, even in cases of elective (non-emergency) admissions.

(2) Consultant Radiologists, Consultant Pathologists and Consultant Anaesthetists will play crucial roles in the management of a patient, yet the patient will not have a choice of which consultant from those specialities will be involved in his or her management nor will the opportunity present itself for any direct meeting between the treating Consultant Radiologist or Pathologist and the patient.

(3) Therefore, to presume that the patient may gain an advantage by shopping around does little more than exhibit a lack of knowledge of how patients are managed (to the best international medical standards) in hospitals.

(11) It is the view of the IHCA National Council that the undertaking signed on September 27th, 2005 and which is reflected in Query 35, effectively precludes any representative organisation or group of consultants from not only negotiating but even discussing any aspect of fee schedules with health insurance providers. Our legal advice is that it could be virtually impossible to prove that any form of discussion with a health insurance provider does not **"indirectly impact on price or other commercial terms"**.

(12) It is the view of the IHCA National Council that the provisions of the Competition Act (2002) Section 4 (1) is such that it is not possible for any representative organisation or group of consultants to have meaningful discussions either among themselves or with health insurance providers regarding fee schedules or conditions attaching thereto without breaching the provisions of Section 4 (1). This section of the legislation presumes that "consumers"/patients are in a position to shop around for medical services in a manner similar to that applying to any other services or items which they may wish to purchase from day-to-day.

The section does not take account of the protocols established by the Medical Council regarding the referral of patients nor does it take cognisance of the very real fact that a patient is treated by a team of consultants across a number of specialities rather than by the admitting consultant alone.

The practical impossibility of negotiating with consultants who provide vital services to patients but with whom the patient does not have direct contact either prior to or during an inpatient stay is not recognised by Section 4 (1).

(13) It would seem that reliance on Section 4 (5) may be the only way to allow a protocol for the negotiation between consultants/their representative organisations and health insurance providers which benefits consumers/patients may be the only practical solution to this matter.

Should this proposal not prove acceptable, it is my view, having the experience of 15 years interaction with health insurance providers, that it is not possible to engage in meaningful discussions/negotiations which avoids influencing fees either directly or indirectly. It may be as well to recognise this reality and to accept that there should be an absolute and total bar on interaction between doctors/hospital consultants and health insurance providers with the many disadvantages which may result for patients/consumers.

Yours sincerely,

Finbarr Fitzpatrick
Secretary General

Encl. IHCA Response to Queries Posed in the Competition Authority Consultation Document

Ms. Emily O'Reilly
Competition Authority
15/3/06

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DUNDRUM OFFICE PARK
DUBLIN 14

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RESPONSE TO QUESTIONS POSED IN COMPETITION AUTHORITY CONSULTATION DOCUMENT

SECTION 7: CONSULTATION QUESTIONS

Introduction

7.1 In the course of the Consultation Document a number of questions and issues have been raised on various topics. The purpose of this section is to bring them together for ease of reference and to ensure that interested parties do not omit responding to a particular question because of an oversight. In view of the number of questions posed the Competition Authority will welcome responses to all or part of the questions set out below.

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?

Answer

(a) Group practices among hospital consultants are confined mainly to consultant radiologists and consultant pathologists. I understand that a small number of such practices may exist among consultant anaesthetists and consultant cardiologists. According to the figures published by Comhairle na nOspideal (January 2005), the consultant establishment for radiology is 183, for pathology 176, anaesthesia 266 and cardiology 25.

(b) *The Comhairle na nOspideal figures for consultants in full time private practice are radiology 12, pathology 9, anaesthesia 17 and cardiology N/A. The consultant establishment in the private sector is quoted as 227.*

(c) *As the IHCA does not represent GP's, we are not in a position to comment on either the number of partnerships/group practices which may exist among such doctors and neither can we comment on the legal basis, if any, of their establishment.*

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

It is difficult to estimate the number of consultants who share offices and overheads, but not commercial risks or profits, with colleagues. I understand that a small number of consultants may rent rooms for (say) weekly sessions from colleagues for a set fee.

Question 3:

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

Answer

(a) *Assuming that the query refers to consultants in full-time private practice, I am not aware of group practices being more prevalent in any specialities than among their colleagues who have public sector appointments.*

Question 4:

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

Answer

Partnerships do not exists among consultants of differing specialties, as far as I am aware. Insofar as such would be practical, partnerships could encompass common overheads for consulting rooms etc but would not extend to fees.

Question 5:

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

Answer

The majority of group practice among pathologists and radiologists are based on written agreements, which may not necessarily have been drawn up by a solicitor.

In both of these specialties a high degree of cooperation exists regarding the provision of services to patients, hospital rosters, rotation of administrative roles, pooling of income, sharing of income, meeting tax liabilities and normal office overheads.

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

(1) Partnerships among hospital consultants are not formed with the express intent of fixing prices. Partnerships are formed to ensure comprehensive service provision. The setting of prices, which are common to a department of radiology or pathology is for patient convenience.

(2) Efficiencies in administration and overheads occur through the operation of a group practice as against the overheads which would occur were each consultant to have his/her administrative overheads within a particular department. The lower administrative costs are likely to result in the members of a group practice accepting a lower level of professional fee than would be acceptable were they to administer their practices on an individual basis.

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.

Answer

Consultant bodies formed to promote medical professional standards and ethics never discuss fees or other commercial terms.

In so far as the quantity of services offered to patients is discussed, it is in the context of patient entitlements to hospital/consultant services within a medically acceptable timeframe, standards of medicine and best practice.

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.

Answer

Agreements between hospital consultants and medical insurers, which are prohibited by section 4 (1) of the Competition Act are to the benefit of patients/insurance subscribers in a wide range of instances.

a. Emergency Admissions

- *It is estimated by the Department of Health that 72% of admissions to public hospital are emergencies.*
- *It is estimated that 20% of these emergency admissions opt for private treatment.*
- *Arising from their state of health, patients who are admitted as emergencies and who opt for private treatment are not in a position to negotiate professional fees with any consultant.*

- *In normal circumstances such patients maybe admitted under the consultant from the appropriate speciality who is on call.*

- *Indeed, in many circumstances such patients (for example RTA's) may not even have a choice of hospital as this decision will rest with the ambulance service.*

Comment

Assuming an average annual attendance at A&E units of 1.25M of whom 72% are admitted as emergencies and 20% of whom opt for private treatment, a total of 180,000 inpatients may not have either choice of admitting consultant or even a choice of hospital in a lesser number of cases. Here, Section 4 (5) rather than Section 4 (1) would benefit these patients.

b. <u>Radiology and Pathology Services</u>

- *In the vast majority of instances, patients whether emergency or elective, will not have an opportunity to meet with or discuss fees with either consultant radiologists or pathologists.*

- *Therefore patients are not in an advantageous position either to discuss fees or, in many instances, even to know the quantity of medical services which their suspected condition may require of consultant radiologists and consultant pathologists.*

c. <u>Specific Illnesses/Conditions</u>

- *An estimated 95% of paediatric admissions are emergencies. In general the average length of stay tends to be short but, as with adult emergencies, the opportunity for parents to negotiate fees or shop around for a particular specialist or hospital is not a practical proposition.*

- *A significant number of consultants across all specialties who treat/manage cancer patients find it inappropriate and insensitive to discuss professional fees even when the topic is raised by patients or next of kin.*

- *Consultants in palliative medicine in particular believe such discussions to be entirely inappropriate.*

- *Consultant geriatricians and other specialists who manage older patients find that it is to the advantage of the patient to have comprehensive insurance arrangements in position. Not infrequently, older patients may suffer from a number of illnesses and it can be very difficult to estimate their length of stay or the range of tests or other interventions which may be required in an effort to restore them to good health.*

- *It is obvious that very many psychiatric patients may not be in a position to reach an informed opinion on any number of matters including professional fee levels.*

- *Cardiac patients, both those seeking medical intervention or surgery, may not be in a position, when admitted as an emergency, to discuss fees with their admitting consultant.*

- *A significant number of patients, both emergency and elective, are admitted to hospital for "tests". In these instances a patient's illness may be diagnosed through a process of elimination. Therefore the admitting consultant is not in a position to estimate and neither is the patient in a position to negotiate on fees in any definitive manner.*

- *It is not unusual for a patient, whether emergency or elective, who is admitted under one consultant to be transferred to the care of a consultant in another speciality. It is obvious that the patient is not in a position to negotiate fees in such instances and certainly is not in a position to "shop around" regarding either a specific consultant or a particular consultant charging a specific level of fee.*

- *Not infrequently, the admitting consultant may request a colleague with expertise in a particular specialty, to have a major or minor consultation with a patient. Again the suggestion of negotiating fees is not a practical proposition*

- *In some cases, a patient admitted under one consultant may during part of his/her hospital stay be under the joint care of two physicians or surgeons. When such a decision is taken the patient is already in hospital and is not in a position to shop around.*

Comment

In the vast majority of the above examples the patient is either not in a position or is at a significant disadvantage in the matter of negotiating fees. In cases involving medical decisions on inpatients, the patient is not in a position to select a second consultant where such arises.

Question 9:

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

7.5 ***Fee setting by the payor*** (para 4.7):

Answer

(a) Customer/patient convenience is satisfied through the above arrangements.

(b) The customer is not always in a position to negotiate with the service provider

(c) The quantity of service providers (i.e. consultants and their area of sub-specialisation) is decided by government rather than market forces.

(d) HSE policy dictates that patients should be referred to hospitals within their own (former) health board areas other than where referral to other health boards for tertiary admissions or an a consultant-to-consultant basis.

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

*(a) Fee setting by the health insurance provider is neither viable nor acceptable from the consultants point of view **unless** of course there is a formal protocol in position whereby consultants can make representations to insurance providers regarding overheads, medical inflation and a range of related matters. That is to say negotiations on a fullcover proposal.*

(b) It is assumed that in instances where the payor determines the consultant's fees, the determination is the amount of fee payable by the health insurance provider on behalf of a member to a consultant. It would be unacceptable to have a position whereby the health insurance provider could determine the full and final fee payable to a consultant and thereby preclude the right of that consultant to balance-bill the patient in certain instances.

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

(1) *It is the view of the IHCA that any significant involvement in fee-setting on behalf of its members would breach Section 4 (1) of the Competition Act* ***as determined by the Competition Authority.***

(2) *As will be seen from answers to questions further down this document, the Association finds it difficult to envisage any role whatsoever for a representative organization in any matter concerning fee schedules, either directly or indirectly, which would not breach the legislation (Section 4 (1)) as interpreted by the Competition Authority.*

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?

7.6 ***The messenger model*** (para 4.15)

Answer

Where an insurance provider enters into an agreement with hospital consultants which results in the availability of comprehensive insurance for its subscribers, there are a significant number of efficiencies which arise:

(a) *The cost of negotiating arrangements is reduced as a result of centralized negotiations rather than piecemeal negotiations with in excess of 25 consultant sub-groups.*

(b) *Direct billing arrangements, including hospitals and consultants can be put in position which results in a significant reduction in the health insurance providers' administrative costs when examining each patient's claim.*

Note

A patient's claim may consist of the hospital bill as well as separate distinct bills from five or six hospital consultants. Without some form of arrangement, an insurance provider may have to visit a single patient claim on six or seven occasions rather than on one occasion under arrangements that existed in former years. The major health insurer claims to have a level of administration which is 50% lower than other companies. The protocol for administering patient claims is a major contributory factor to this saving.

(c) Comprehensive insurance reduces the level of overhead for hospitals and consultants. It has been estimated in the past by the IHCA that without comprehensive insurance and a direct billing mechanism, a consultant's overheads, including provision for bad debts, would increase by 12%-15% which would obviously have to be reflected in that practitioner's fees.

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

The IHCA does not view the messenger model as practical. We fail to see how an individual can have secret one to one discussions with individual consultants, transfer the relevant information to the health insurer and be the conduit for the response and repeat this process for (approx) 2000 hospital consultants to at least three health insurance providers within this jurisdiction.

The Association also notes that this model, which we are advised operates in the US, has been the subject of a significant number of legal actions with charges that the messenger failed to observe his/her neutral position as a conduit of information rather than becoming a negotiator or broker.

It is not possible to isolate negotiations on fees from the conditions, code descriptions and ground rules governing same. Reference to the VHI Schedule of Professional Fees will illustrate that any messenger is most likely to, whether knowingly or not, become a broker and thereby (potentially) commit a criminal offence.

Question 14:

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

Answer

See 13

Question 15:

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

Answer

See 13

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

- *It is the view of the IHCA that the messenger model, as represented to us by the Competition Authority with US examples, could not work in Ireland and the IHCA fails to see how such a model could be meaningful within the terms of the Competition Act Section 4 (1).*

- *See also answer 13*

Question 17:

Who should engage and pay the messenger?

- *See answer 13*

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

Answer

Fee bundling may turn out to be fee fixing and a disincentive to competition as per Section 4 (1).

Question 18:

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

Answer

Hospital consultants in private practice are independent practitioners. Those consultants who have admitting privileges to private institutions do not have any security of tenure in their posts. They do not receive any form of financial package (either salary, pension entitlements etc) from private hospitals.

Fee bundling would in effect make the hospital consultant an employee of the private hospital with all of the commitments that such an arrangement would entail for the employer. Hospitals are not prepared to enter into these undertakings.

See answer 17.

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?

Answer

For this proposal to work, the hospital consultant would, as stated at Q18, would have to become an employee of the hospital

All of the concerns regarding reduced choice etc. seem to arise under this proposal.

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?

Answer

- *We are not aware of any other feasible fee setting mechanisms other than those outlined in Section 4 of this consultation document. This answer should be read in conjunction with the answer to question 35.*

- *We have yet to be convinced that the mechanisms described in Section 4 are feasible.*

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).

Answer

Consultants who provide on-call rotas in Ireland do so as independent medical practitioners and we are not aware of instances where fee agreements are an intrinsic part of any rostering arrangement other than as set out in Nos 1 to 6 above.

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

We are not aware of any circumstances which require rosters to result in fee agreements. This answer should be read in conjunction to ***answer*** *23.*

Question 23:

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

Answer

Doctors may wish to withdraw from a roster for a wide range of reasons including, for example, industrial action, their own personal health circumstances, changes in the services provided in a particular hospitals etc. The Medical Council places certain obligations on consultants regarding the treatment of patients. These obligations apply irrespective of the status of the patient as between public or private. The Medical Council place an obligation on doctors to arrange an alternative consultant to manage a patient, if for whatever reasons he (the managing doctor) cannot continue to treat a patient. We do not see how the matter of fees arises.

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).

Answer

Not aware

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?

Answer

We do not agree that the position of the consultants vis a vis an arrangement with an insurance company of the absence thereof either restricts patient choice or reduces competition between practitioners.

- *The GP is the gatekeeper for access to consultants for elective patients and in a significant number of cases for emergency referrals.*
- *Hospital consultants are independent medical practitioners and depend on their reputation and skill and resultant standing among referring doctors for patient referrals.*

- *The Medical Council Guides to Ethical Conduct and Behaviour precludes doctors from any form of advertising either of their specialist skills or fees.*

- *The choice of consultant is made by the family doctor in consultation with the patient, based on appropriateness of the consultant's expertise rather than on the (suspected) level of fee charged.*

- *Should a GP decide to refer a patient to a consultant on grounds other than bona fide medical expertise, and should any thing untoward devolve on the patient as a result of this referral, the (referring) GP may be the subject of litigation initiated by the patient/next of kin.*

- *It is possible that the Medical Council (Fitness to Practice Committee) may also take a negative view of a GP referral based on fee levels rather than medical expertise.*

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

(1) The Department of Health and Children estimates that there are 1.25M attendances at A&E units nationally per annum.

(2) It is estimated that 20% of these attendees are admitted as inpatients.

(3) Depending on the hospital in question, up to 40% of attendees may be self-referrals.

(4) Assuming that 50% (approx.) of patients are referred to A&E units by their GP, their referral in the majority of instances is to the A&E unit rather than to a named consultant.

(5) It is a decision for the emergency medicine consultant on-call or his/her team to decide whether a patient should be discharged back to his/her GP, be given an appointment for a further attendance at the A&E unit or be admitted as an inpatient. In the event of being admitted as an inpatient, it is a matter for the consultant/team to decide the speciality of the consultant required to manage the patient.

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

This is primarily a question for GPs. In the event of a private health insurer's list of preferred consultants being made available to GPs from which selections/referrals could be made, the GP would need to be able to justify his choice of consultant on grounds other than fee levels.

GP's are the gatekeepers in the matter of consultants referrals etc.

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

This is partly a question for health insurers in that for example, they may or may not be willing to post lists of preferred providers on websites to which their subscribers could have access. It would then be a matter for the subscriber to select a consultant, bearing in mind the role of the family doctor.

Consultants would need to be reassured that this arrangement was not interpreted by the Medical Council as advertising.

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

I am unsure of the definition of the term "selective networks of doctors".

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

Answer

See Question 29

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

The freedom of choice of the consultant by the GP and patient is a core value in the Irish healthcare system

(a) It is correct to state that in some instances the number of specialists in some areas of medicine is extremely limited while in other specialties for example general adult psychiatry, general medicine, general surgery, many consultants will have attained similar levels of skill and experience. In this context, it should be noted that many of the "generalists" in the public sector also have a subspecialty interest. Nonetheless, the final choice of the patient/GP may take account of geographic proximity, waiting lists, personality, previous contact etc. etc. and should therefore remain as it is.

Question 32:

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

Answer

Irrespective of matters concerning fees, there is a dire need for a significant increase in the number of consultants across all specialties within the State. In general terms (see attached) the number of consultants per thousand population in Ireland is 50% of international norms.

7.12 ***Codes and descriptions*** (para 6.13):

Question 33:

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

Answer

Subject to the important proviso contained in answer No. 35, *it is possible for discussions on codes and descriptions of procedures to take place (1) amongst consultants and (2) between specialty groups and private health 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?

Answer

Again ***subject to the proviso set out in answer No 35,*** *it is possible to discuss the detail of a new procedure or medication and in so doing to debate why a similar procedure/medication should be removed from a schedule on the grounds that such a procedure is no longer performed or that the administration of a particular medicine is not seen as best practice. Similarly the recognition by a health insurance provider of (say) a PET Scan can be discussed in the context of comparisons with the less satisfactory images obtained from a CAT Scan. The benefit of microsurgery over open surgery in terms of reduced morbidity, mortality, length of stay, duration of recuperation and return to work can be discussed without direct reference to fees.*

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

The proviso that "discussions on codes and descriptions for procedures should not directly or ***indirectly*** *impact on price or other commercial terms"* ***virtually precludes activities described in answers 33 and 34***

It is impossible to discuss new procedures, technology or methods of managing patients ***without*** *comparing the new with the older established methods or techniques. In so doing one is* ***indirectly*** *indicating the commercial value of the new procedure in comparison to that of the old. Though it may not be intended and while the discussion and comparison may centre on medical expertise, a health insurer will have received an* ***indirect*** *indication and may be quite likely to draw a conclusion with regard to the financial value of a procedure from such a discussion.*

- *The prudent policy to follow to ensure compliance with such an elastic condition as "indirectly impact" is to totally avoid contact.*

- *The IHCA could not recommend discussions with the danger of criminal intent being claimed by the Competition Authority*

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?

Answer

Subject to ***answer*** *35, it is possible for negotiations on Ground Rules to take place.*

(1) Amongst consultants and (2) between specialty groups and private health insurers without requiring direct discussion on fees or other commercial terms and without limiting innovation and choice in such services. Consultants in particular are the drivers of innovation in hospital medicine.

- *Ground Rules as understood by the IHCA, do not reduce the choice of services and do not limit innovation.*

- *Ground Rules bring clarity to circumstances governing payment which may not be contained in the procedure codes and which are of equal if not greater benefit to the patient than the medical practitioner.*

- *Reviewing the VHI Ground Rules, may provide information/clarity for the benefit of the insurer, patient and consultant.*

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

Discussions on ground rules govern the ***conditions of payment*** *not the amount of the fee.*

- ***However this comment must be read against the background of the answer to question 35.***

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

My remarks re this question should be read in conjunction with answer No.35.
Virtually any innocent comment may be interpreted as indirectly impacting on price or commercial terms.

Question 39:

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

Answer

There are instances in the VHI schedule where benefit is payable for certain treatments at certain intervals.

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?

Answer

The following are examples of other discussions which may take place between consultants and private health insurers ***which are not designed to impact on fees etc.***

- *Information regarding the management of the patient required by the insurer to be recorded in the claim form.*
- *The design of the health insurers claim form*
- *Arrangements regarding pended claims.*
- *Arrangements for (say) consultant radiologist, pathologist and anaesthetists when the admitting physician or surgeon fails to complete the insurance claim form.*
- *Dates on which payments are made to consultants*
- *Manner of payment as in electronic transfer or by cheque*
- *Again, the proviso regarding Question 35 applies here also*

* * * * * *

ANNEX A

FULL TEXT OF AGREEMENT AND UNDERTAKING BETWEEN

The Competition Authority ("the Authority")

and –

The Irish Hospital Consultants Association ("the IHCA")

1. In February 2003 the Authority commenced an investigation into the negotiations entered into between the representative bodies for consultants and health insurers which resulted in the Schedule of Benefits being circulated to all consultants registered in the State setting the fees consultants receive from health insurers for the treatment of patients covered by private health insurance. As a result of this investigation, it is the Authority's view that a breach of Section 4(1) of the Competition Act, 2002 ("the Act") has occurred. In the Authority's view the conduct and activities of the IHCA, when engaging in collective negotiations on behalf of its members with health insurers pertaining to price and/or other terms and conditions for the provision of consultant services set out in the Schedule of Benefits, constitutes a decision/recommendation by an association of undertakings, the object and/or effect of which is to either directly or indirectly fix the fees paid to consultants by health insurers.

2a. The IHCA deny that they are in breach of the Act and enter this Undertaking without admission of liability. 2b. In consideration of the undertakings furnished by the IHCA set out in this Agreement, the Authority agrees it will cease this investigation of the IHCA, and for so long as the IHCA complies with the undertakings contained in this Agreement, The Authority will refrain from instituting proceedings against the IHCA under the Act arising from the facts set out in Paragraph 1 herein. 3. The IHCA undertakes that the IHCA, together with its employees and agents (to include all speciality groups formed under the auspices of the IHCA), will immediately cease and desist from and will not in the future engage in any of the following:-

- entering into, adhering to, participating in, maintaining, organising, implementing, enforcing or otherwise facilitating any agreement or concerted practice between consultants, or issuing any decision/recommendation to consultants, regarding the negotiation or agreement of the fee levels and increases sought from health insurers by particular specialities or consultants in general,

- entering into, adhering to, participating in, maintaining, organising, implementing, enforcing or otherwise facilitating any agreement or concerted practice between consultants, or issuing any decision/recommendation to consultants, regarding the responses of particular specialities or consultants as a whole to particular proposals on fees from the health insurers,

- expressing an opinion on contract terms directly or indirectly relating to specific fees offered for a particular procedure or general fee increases by health insurers to the members of the IHCA,

- suggesting to health insurers that a particular fee increase is required to obtain full participation of its members,

- directly or indirectly discouraging its members from individually negotiating with health insurers,

- suggesting to health insurers that its members, or some or all members of a particular speciality, will refuse to supply consultant services to the health insurers if the insurer does not accede to the fee levels and/or increases sought by the IHCA.

- encouraging, suggesting, advising or otherwise inducing or attempting to induce any third party from engaging in any action that would be prohibited if carried out by the IHCA by the terms of this undertaking.

4. The IHCA will provide information, from time to time, as may reasonably be required by the Authority regarding compliance with its undertakings herein contained.

5. The undertakings herein contained shall be binding on the successors and assigns of the IHCA and its employees, servants and agents and further all consultant speciality groups formed within the IHCA.

6. This Agreement and Undertaking shall be and is intended by the parties to be a binding and enforceable agreement which may be enforced by action in any Court of competent jurisdiction in the State.

7. This Agreement and Undertaking is strictly without prejudice to the due exercise by the Authority of its functions, powers and duties under law and in particular under the Competition Act, 2002 and is also without prejudice to the due exercise by the IHCA of any of its rights under law and in particular under the Competition Act, 2002.

Dated 27th of September 2005.

AGREED TO AND ACCEPTED BY

Signed: Finbarr Fitzpatrick
On behalf of and with the authority of
the Irish Hospital Consultants Association

Signed: Dr. Paul K Gorecki
Member for and on behalf of the Competition Authority