RESPONSE

OF

THE IRISH MEDICAL ORGANISATION

TO

"THE CONSULTATION ON GUIDANCE IN RESPECT OF COLLECTIVE NEGOTIATIONS RELATING TO THE SETTING OF MEDICAL FEES" – issued by the Competition Authority 31st JANUARY 2006

Introduction:

The Irish Medical Organisation is a Registered Trade Union holding a Negotiating Licence whose registered office is 10 Fitzwilliam Place, Dublin 2. The principal object of the Irish Medical Organisation is to represent Doctors in Ireland and to provide them with all relevant services and to this end the I.M.O. represents almost 6,000 Medical Practitioners, the majority of whom practise within Contracts of Employment.

The exceptions relate to the Common Contract for Consultants, which allows Consultants to practise privately, and those Consultants who operate in full time Private Practice and General Practitioners who have Contracts for Service in addition to or apart from the General Medical Services Scheme participants with a Contract for Services with the State.

The I.M.O. wishes to make a detailed response to the Consultation Document furnished by the Competition Authority replying to each of the individual questions posed by the Authority however prior to doing so, the I.M.O. wishes to address a number of the points set out in the Consultation Document.

The I.M.O. will also seek to address points in relation to the Irish Health Sector which have a significant bearing on the various markets contained in that Sector and which must be borne in mind in the preparation of any Guidance Documents relating to medical fees. This is particularly important given what is frequently referred to as the "Iron Triangle" of Health Care.[1] The vertices of the triangle are quality, cost and access to care. It has been stated that when Health Analysts refer to an "Iron Triangle" they mean that any change in the Health System in respect of one of these three aspects, has the potential to compromise the other two areas regardless of spending.[2]

In responding to the Competition Authority's Consultation Document the I.M.O. proposes to adopt the following structure:

1. Regulation of the Medical Profession - Legislative Background

2. A general response to the C.A. Consultation Document examining:
   (i) Aspects of the Irish Healthcare System.
   (ii) The principal factors inhibiting competition in the Irish Healthcare System.
   (iii) Collective Negotiation in relation to Professional Fees

3. Response to the particular questions raised by the Competition Authority.

4. Specific Proposals in relation to the collective negotiations relating to the setting of medical fees in Ireland.

[1] William L. Kissick, Medicines Dilemmas: Infinite Needs v Finite Resources (1994).
[2] Improving Health Care: A Dose of Competition FTC Department of Justice Report 2004.

1. Legislative Background:

Section 4 of the Competition Act 2002 provides that certain activities are prohibited and void if they have as their object or effect the prevention, restriction or distortion of competition in trade in any goods or services in the State or in any part of the State. Quite apart from the saver provided in Section 4(5) it is clear that no activity is to be regarded as prohibited or void until such time as it has been established that it has the object or effect of the prevention, restriction or distortion of competition in trade. The IMO notes that the Authority's Consultation Document does not point to any economic analysis of the market or markets in Ireland which suggest that the price or fees payable for medical services or any arrangements in relation to same have as their object or effect the prevention, restriction or distortion of competition in trade in any goods or services in the State. Furthermore, as outlined later in this document, such economic analysis as exists of the markets in Ireland, while suggesting that there may be certain restrictions operating, does not suggest that the price or fees payable for medical services is one such restriction. In the absence of such economic analysis it is not open to the Authority to conclude that any of the activities of the IMO operate so as to restrict or distort competition in trade in the manner prohibited by Section 4(1) of the Act of 2002.

In any event, such of the activities of the IMO as are under consideration by the Authority fall within the saver provided by subsection 5 of Section 4 in so far as they are in the interests not only of doctors but also more importantly in the interests of the patient.

The 1978 Medical Practitioners Act provides for the establishment of the Medical Council. It is the function of the Medical Council to establish a Register of Medical Practitioners to be known as the General Register of Medical Practitioners.[3] Section 27 of that Act sets out those persons who are entitled to be registered in the Register. The Medical Council is also responsible for the establishment of the Register of Medical Specialists.[4]

In Ireland the numbers of Consultants in Public practice is regulated by the State. Under the 1970 Health Act Comhairle na nOspidéal was set up.[5] Its executive functions included the regulation of the number and type of appointments of Consultant Medical Staff in Hospitals providing services under the Health Acts and to specify the qualifications for such appointments. Following the assumption by the Health Service Executive of a responsibility for the Health Service, Comhairle na nOspidéal is now under the auspices of the Health Service Executive and is known as the National Hospitals Office / Comhairle. All publicly funded Hospital Authorities are obliged to abide by the Directives and Decisions of Comhairle na nOspidéal. Senior / Specialist Registrars also come within the remit of Comhairle na nOspidéal.

[3] Medical Practitioners Act 1978, Section 26(1).
[4] Medical Practitioners Act 1978, Section 30.
[5] The statutory functions of Comhairle na nOspidéal are set out in Section 41(b) of the Health Act 1970 and apply to all Consultant Appointments in publicly funded hospitals.

2. Response to the Competition Authority's Consultation Document.

(i) Review of several aspects of the Irish Healthcare System.

Registration of Doctors

The Medical Council is responsible for the Registration of Doctors in Ireland and the I.M.O. plays no role in either the registration or disciplining of physicians. In Phillips v The Medical Council [[1991] 2 I.R. 115 .] Costello J. stated :

> *'The Council is not a body established to manage the affairs of the medical profession or to protect its interests; it is a statutory body entrusted with important statutory functions to be performed in the public interest.'* [6]

While the I.M.O. represents its members it does so without compelling them to act in a particular way and takes no sanctions against members who do not act in accordance with its recommendations.

[6] [1991] 2 I.R. 115 at 119.

The Nature of the Private Medicine Market

The nature of the market for private medical treatment reflects situations where:

- A person chooses to subscribe to a private health insurer which has an arrangement with participating doctors whereby fees decided by the insurer are paid for treatment of the scheme member – this full cover option replaces the balance billing scheme for the overwhelming majority of Consultants. In this instance the competitive choice for the consumer arises when choosing which health insurer to join. The economic activity precedes the illness or treatment and the competition which we would submit ought to be the interest of the Competition Authority is as between the variety, range and cost of services offered by the health insurer. We acknowledge that a separate public consultation exercise on competition in the private health insurance market has been announced by the Competition Authority on March 16th, 2006.

- A person attends a doctor in a private capacity and pays for treatment in accordance with a fee determined solely by the doctor. There has been no role for any third party in determining such fees. Interestingly, as recently as 2004, the IMO had been in discussions with the Department of Enterprise and Employment to give effect to the decision of the Tanaiste, Mrs Mary Harney, to introduce a Price Display Order for doctors and dentists' services, in accordance with Section 19 of the Prices Act, 1958.

However, as confirmed in a Dáil question on December 16th, 2004, the Minister for Enterprise and Employment, Mr Micheal Martin (previously the Minister for Health and Children) confirmed that "for reasons both legal and practical, I have now decided not to proceed with the making of such an order." He explained that he believed it would not be possible to enforce such orders.

- A person attends a doctor to obtain an expert medical report e.g. a private medical attendance report to satisfy the requirements of a third party such as a prospective employer or a life insurance company. This is an area where we believe it would be appropriate and beneficial (to the medical profession and the consumer) to allow collective bargaining on such rates, as is recognised by the OFT in Britain, for example.

- A person is treated privately by a doctor in association with some medico-legal matter, police duty or post-mortem examination where the fees for such work may be determined by a state agency or another third party.

Price Determination and the Doctor / Patient Relationship

Agreed fees between the payor and the provider have different nuances according to the case in question. Generally, if the payor is a commerical profit-making organisation, it will negotiate the lowest acceptable fee and this fee will be renegotiated at agreed intervals. In this case the patient is left out from the negotiations and the doctor-patient relationship is primarily one of service and health outcome.

If the payor is a state controlled operation (as is the case for the VHI and various Government Departments such as the Departments of Justice, Department of Social Welfare or other Government agencies), the payor is acting on a not for profit basis and will negotiate the lowest acceptable fee for a period, sometimes using an agreed provider clause to encourage providers to accept their terms. The agreed provider clause is a clever method of protecting the patient from balance billing by the provider. Again, the doctor-patient relationship is not concerned with finance but instead health outcomes. The patient shops around for the best service from a payor.

In the case of Private Medical Attendance reports, the payor negotiates a price which leaves the patient out of any fee confrontation. The industry has a history of tight and competitive negotiations as it is profit oriented.

Private Health Insurance in Ireland – an OECD Review

The most recent authoritative review of private health insurance in Ireland was carried out by the OECD in 2004[7]. The OECD study offers a comprehensive overview of the PHI sector and makes no suggestion of any concerns about the manner in which provider payments are determined.

It notes that "*private fees are unregulated and established competitively by physicians. This is especially the case for outpatient services, where individuals settle their bills directly with providers, and may subsequently claim a reimbursement by insurers if they hold a PHI policy. For inpatient services, most consultants' private income originates from treating patients covered by private health insurance. Nearly all consultants accept as full payment the professional fee schedules negotiated with insurers in private hospitals*[8]."

The OECD goes on to note[9] that for insurers, *cost controls have focused upon negotiation of scheduled procedure prices. Nearly all consultants accept as full payment the professional fee schedule negotiated with insurers. If they do not accept such rates, insurers pay them a lower schedule (about 25-30% lower, coinciding with minimum benefits), and the doctor has to collect any extra billing from the patients themselves.*

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[7] Private Health Insurance in Ireland: A Case Study, Francesca Colombo and Nicole Tapay, OECD Health Working Papers (2004)

[8] The OECD notes that "Insurers hold discussion with the Irish Health Consultants Association (IHCA) (and the Irish Medical Organisation) on a periodic basis to negotiate fully participating fee levels (involving full cover by insurers with no payment needed by patients). After such negotiation, insurers write to each consultant, who may or not agree to accept the fully participating rates. If a consultant does not accept such rates as full payment, then insurers reimburse consultants' standard benefits (coinciding with minimum benefits prescribed by law, which are lower than fully participating fee levels; see section 3.1.1 for a description of minimum benefit requirements). Patients are liable to pay consultants any extra amount over and above the standard benefit. About 99% of consultants accept the negotiated rates as full payment. Smaller insurers, including BUPA, tend to be price followers based on rates negotiated by VHI."

[9] OECD (2004) Para 89

This process of negotiation of fee levels may have limited fee escalation in the private sector (emphasis ours), although it has not diminished utilisation.

The OECD also identifies the main reasons for buying private cover in Ireland as follows:

The main reasons for buying private cover seem to be risk aversion (88% of a sample of insurees bought PHI cover in order to "avoid large bills") and timely access to care (85% bought PHI cover to be sure to get into hospitals quickly). Choice of doctor and securing doctors' time are also important reasons in about half of the cases, while having private or semi-private accommodation is perceived to be of lesser importance. Reasons for buying private cover are linked to perceptions and anxieties over the quality of the public system, although the people most critical of the public system are those who never used it.

Differentials in perceived quality between the public and the private sectors seem especially to relate to the length of waiting times, and are strongest among young people, those with private insurance, and upper socio-economic groups[10].

The Organisation would caution that whatever guidance is provided by the Competition Authority ought to satisfy itself that, given the acknowledged importance of PHI, any recommendations which fatally jeopardize the current full cover scheme will likely cause the introduction of balance billing which will have profound effects on both public and private healthcare provision and cause massive consumer anxiety, given that 88% of insurees buy PHI cover to avoid large bills.

[10] OECD (2004) Para 47

2. (ii) The Nature of the Market and the Principal factors inhibiting competition in the Irish Healthcare System.

The Irish health market[11] for Consultant provided care can be characterised as:

- Monopsonistic
- Segmented
- Asymmetric

Monopsony

A monopsony exists where the demand side of a market is effectively in the hands of a single or small number of individuals or companies. The labour market for consultants is an example of just such an arrangement. The HSE is a near monopoly employer of consultants. The number of purely private practitioners of consultant status is extremely small. The private sector is dominated by a small number of PHI carriers and hospital groups.

Theory tells us that where a labour force faces a monopsonistic demand for its services, then less of that labour force will be employed and at lower rates of pay than under competitive conditions. As far as Ireland is concerned, there is little opportunity to test the first aspect because entry to medical school is restricted. However, the number of doctors in Ireland is the lowest amongst Western industrialised countries per head of population and one of the lowest in the OECD as a whole.

[11] Adapted from Health Markets and Private Consultant Fees, British Medical Association Health Policy and Economic Research Unit, Briefing Note 15, April 2004.

Segmentation

Market segmentation is the process of dividing a market into a distinct group of buyers that require different products or marketing mixes. The HSE offers universal (though not effectively comprehensive) health care to the Irish population and secondary care treatment is consultant-led. The private sector on the other hand is small and complementary, providing the population with an alternative source of specific treatments and a larger proportion with sources for treatments not offered within the HSE hospitals.

As far as secondary care is concerned, the private market concentrates on common elective procedures and consumers are funded for the most part from insurance taken out on their and their families' behalf by employers. Within the private sector, treatment is consultant-based (rather than led), an important consideration when considering relative fees.

Asymmetry

Asymmetry is present in many markets. It is most usually to be found in the areas of information or costs. Asymmetry exists if all the participants in a market do not have access to the information they need to make decisions or if cost differences can persist into the long term. Economists most commonly ascribe asymmetry in health markets to the imbalance in medical knowledge, which enables doctors to induce demand in otherwise competitive environments.

This only holds in largely unregulated fee for service environments, though, and powerful public sectors and managed care arrangements have eroded this position in many countries.

In the context of the private sector in Ireland, asymmetry is typified more by a lack of available information to consumers to judge between competing insurers or to consultants to judge the profitability of their work to a given insurer.

Indecon Study on Key Restrictions to Entering Medicine

The Indecon report identified seven possible "Key Restrictions" in the Medical Practitioners Profession in Ireland.[12] Of these four related to alleged restrictions on entry, one to the absence of a Limited Liability Structure and two related to Restrictions on Conduct. As detailed further below not one of the key restrictions identified by Indecon centred upon the price of or the fees payable for medical services.

The alleged restrictions on conduct involve the referral of Patients to Specialist Consultants and the ban on advertising both of which are the recommended practice of the Medical Council, the statutory body charged with the oversight of the Medical Profession. The setting of Professional Fees and the means by which this may be done was not identified by the Indecon Report as constituting a restriction on Competition. Indeed while it was noted that the perception of both the public and Doctors alike was that there was very little competition in fee setting this was not borne out by the studies carried out by Indecon itself which noted:

"Regarding the nature of competition on the market, our analysis of professional fees charged by doctors for typical services such as a standard attendance at a doctor's clinic and a home visit points to the presence of some price dispersion in each case."[13]

[12] Indecon's Assessment of restrictions in the Supply of Professional Services. Indecon March 2003.
[13] Para 9.96 Indecon Report March 2003.

The study identified the reason for the perception of a lack of competition as reflecting *"a lack of transparency regarding the level of fees charged to patients in addition to the increase in medical cost inflation in recent years".*[14]

The I.M.O. shares the view that there is a lack of transparency in medical fees but this is inevitable to some degree in Healthcare where there are so many treatments available and developments are ongoing.

A number of principal factors directly affecting the prospects of greater competition generally in the Irish health care system can be identified, falling into three broad headings:

- control and ownership of supply;
- capacity to meet demand, and;
- the nature of rising demand.

The first two categories identify the principal inhibitors of greater competition while the third category shows that notwithstanding the existing limited competition and subscription patterns determined in an uneven PHI market, demand for private healthcare is rising significantly.

[14] Para 9.97 Indecon Report March 2003.

Control and Ownership of Supply

The main private health insurer (PHI) i.e. the state-controlled VHI, has over 80% of the share of this market. As has been stated by current and would-be health insurers and is currently being investigated by the Health Insurance Authority, there are significant grounds for concern among current and prospective PHI competitors as to the nature of state-directed barriers to entry by PHIs.

Typically, 80-90% of the income of private hospitals comes from the insurer (recall that the state-controlled VHI alone holds over 80% of the market) and it is usually capped.[15]

The accreditation of most public hospitals is decided by the state-controlled VHI.

In principle, 50% of private provision takes place in public hospitals which are funded, managed and controlled by the state.[16]

The main private health insurer (i.e. VHI) has a market share in excess of 80% and has limited competition from a small number of other insurers which tend to follow the lead of the main insurer in determining the level of increase in fees payable to participating consultants.

[15] Mark Moran, Chief Executive, Mater Private Hospital, "Expanding the private sector: a new generation of privately funded hospitals for Ireland? In Acute Healthcare in Transition in Ireland, (ed: Ray Kinsella), Oak Tree Press, Dublin, 2003.
[16] Mark Moran (supra)

In addition, it must be recognised that the state, which funds and controls the main insurer (VHI), also determines directly or through its agencies, the numbers entering the medical profession at undergraduate and postgraduate level.

The state also determines the numbers who can operate as general practitioners or consultants.

State funded hospitals also account for the overwhelming majority of private hospital beds.

The state also determines the number of private beds in public hospitals as well as the number of beds in private hospitals overall.

The VHI, as the predominant insurer, also decides on which private hospitals to recognise / accredit and thereby controls demand for private medicine.

In addition, VHI is now involved in financially supporting community-based clinics which are competing with general practitioners.

Capacity

In 2005, Ireland had 2.96 acute hospital inpatient beds per 1,000 population, compared to an EU15 average of 4;[17]

In 2001, Ireland had 3.13 beds per 1,000 population, when the Government's health strategy identified a need for an additional 3,000 acute hospital beds over a ten-year period;

Growth of population and the HSE's redefinition of some hospitals as non-acute have reduced the ratio of acute beds to populations since the publication of the Health Strategy in 2001;

The increase in in-patient beds in hospitals, defined as acute by the Department of Health and Children, has been 535 between 2001 and August 2005 but with the increase in population the number of beds per capita has fallen, as we see above;

Based on current population growth forecasts, without increased acute bed numbers, Ireland's overall bed capacity ratio would fall to 2.7 per 1,000 population in 2016 and Ireland's ratio of beds to population over 65 would fall from 25.9 beds per 1,000 population in 2002 to 19.3 per 1,000 by 2016.

[17] The Health Report, An Agenda for Irish Health Care Reform, A. Dale Tussing and Maev-Ann Wren, ICTU, Dublin, 2005.

Ireland has one of the lowest numbers of Consultants and General Practitioners per capita and control of both cohorts rest with the state. Ireland has 5 Consultants per 10,000 people (and 13 Specialists if NCHDs are included) in contrast to an EU average ratio of 18 Specialists per 10,000 people.[18] Only the Netherlands and Portugal reported fewer general practitioners per capita than Ireland in an OECD survey of 13 EU member states in 2005[19]

Demand and PHI Subscriptions

The rate of increase for PHI membership has not slowed since the withdrawal of the IMO and the IHCA from consultative discussions with health insurers in the past couple of years; in fact the single biggest increase in VHI subscriptions of 19% was announced by the company in 2005.

VHI subscription rates are expected to increase by 15% per annum and to rise by 50% between 2006 and 2009.[20] This prediction has been published many years after the withdrawal of the IMO from consultative discussions with the health insurers.

Notwithstanding a 98% increase in VHI subscriptions over the last eight years, the overall health insurance market has grown by 37%[21]

[18] The Health Report, An Agenda for Irish Health Care Reform, A. Dale Tussing and Maev-Ann Wren, ICTU, Dublin, 2005.
[19] OECD Health Data, 2005 quoted in The Health Report 2005 (supra)
[20] VHI prices to rise despite any change to risk equalisation, Irish Times, Health Supplement, March 21, 2006.
[21] VHI prices to rise despite any change to risk equalisation, Irish Times, Health Supplement, March 21, 2006.

The I.M.O. submits that the principal barrier to Competition in the Health Sector results from the levelling off of the number of physicians on the Medical Register while at the same time the Irish population has increased significantly.

In addition the Government has failed to provide an increase in capacity in Hospital Beds and in fact the level of beds per thousand of the population has effectively decreased. [22] It is interesting that Ireland ranks 17th among 25 European nations in relation to Health spending as a percentage of G.D.P. [23]

2. (iii) Collective Negotiation in relation to Professional Fees.

The I.M.O. is an authorised Trade Union holding a negotiating licence under the 1941 Trade Union Act and as such is entitled to negotiate on behalf of its members in relation to their terms and conditions of employment. This is so as an employee is not an undertaking.[24]

However it is also the case that in so far as the Union itself is concerned it is not an undertaking as regards its industrial relations activities where it acts on behalf of its members;[25]

"and collective labour agreements concerning conditions of work and employment fall outside the scope of Article 81(1)"[26]

[22] Eurostat "Health in Europe – Data 1998-2003 " Pocketbook 2005 Edition.
[23] Eurostat 2002 figures reproduced in 2005 ed. " Health in Europe " p 81.
[24] Bellamy and Child 2001 European Competition Law para 2.007
[25] Bellamy and Child 2001 European Competition Law para 2.008
[26] Ibid

On this basis such agreements would also fall outside the scope of s.4(1) of the 2002 Act which replicates Article 81(1).

Indeed this is in accordance with Irish case law on the matter in which the High Court has held that the Association of Secondary Teachers of Ireland, being a Trade Union was not:

"engaged in any commercial activity, rather it is providing a service for its members for a common purpose. I am satisfied therefore that the Fourth Defendant (The Association of Secondary Teachers of Ireland) is not an undertaking for the purposes of the Act of 1991."[27]

More recently, the Irish Congress of Trade Unions, to which the Irish Medical Organisation is full affiliate member, has raised with the International Labour Organisation concerns regarding the application Ireland of Convention No 98, the Right to Organise and Collective Bargaining – International Labour Organisation Convention, 1949.

[27] Greally -v- Minister for Education [1995] 3 IR 481

3. Response to Competition Authority questionnaire

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: *The only information available to the IMO in relation to the prevalence of partnerships amongst medical doctors arises from a survey conducted by the Irish College of General Practitioners in 1997 in relation to General Practitioners. This survey found that 51% of GPs were in single handed practice, 35% in partnerships, 7% were assistants, 4% were sessional, 1% trainees and 2% locums. This finding is reinforced in Section 9.92 of the Indecon Report prepared for the Competition Authority in March 2003.*

The IMO is not aware of any information in relation to the prevalence of partnerships amongst Consultants.

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: *As outlined in response to Question 1, the IMO does not have any information on partnerships amongst Consultants. As outlined above, the ICGP survey found that 35% of GPs claimed to be in partnership. The precise nature of such partnerships is not clear from the survey.*

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

Answer: *The IMO does not have any information as to whether partnerships are more prevalent amongst certain specialties of Consultants in private practice. It is our understanding that groups of Radiologists, Pathologists and Anaesthetists may have administrative practices which are established to enable processing of billing and fee payments.*

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

Answer: *The IMO is not aware of any information on whether partnerships exist amongst Consultants of differing specialties.*

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 IMO would be of the view that partnerships amongst doctors would in general be by way of written agreement.*

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: *The IMO would be of the view that partnerships amongst doctors are not formed with the express intent of fixing prices. Partnerships are formed for a variety of reasons including the need to enhance the level of service available to patients by affording a greater choice of doctor and services, the need to ensure better rota arrangements for on-call work, access to time off and cover arrangements, sharing of overheads, ensuring that there is not professional isolation etc.*

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: *The only body with an express role in promoting medical professional standards and ethics is the Medical Council of Ireland. It has no role to play in regard to recommending fees or the quantity of services. Its most recent Guide to Ethical Conduct and Behaviour (sixth edition) does deal with issues impinging on commercial terms such as restrictions regarding advertising.*

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: *It is our view that the arrangements which had pertained between the IMO and PHI firms satisfy the provisions of Section 4(5) of the Competition Act 2002.*

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

Answer: *The arrangements contribute to the provision of services by simplifying and bringing certainty of information to scheme members and providers; they allow a benefit to consumers who would otherwise face uncertainty and quite probably higher levels of professional fees and they do not pose a threat to competition.*

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: *The setting of fees by payors, as had obtained for many years, does seem an appropriate model.*

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

Answer: *The IMO is a registered trade union and as we contend elsewhere is entirely justified in seeking to discharge its constitutionally recognised right to represent its members. In addition we believe that fee setting which involves consultation of a representative organisation such the Irish Medical Organisation is more likely to enjoy the confidence of the medical profession, to increase the likelihood of sufficient numbers of doctors deciding privately and individually to choose to contract as a preferred provider and thereby to reduce the numbers of doctors who might otherwise consider a balance billing approach. In turn, this will satisfy the established needs of PHI scheme members as identified elsewhere (i.e. having reasonable certainty of meeting their costs through PHI membership). Another consequence will be to avoid the inevitable delay for PHI organisations and scheme members in awaiting the deliberation of individual doctors who will otherwise engage in bargaining with PHI organisations and which will cause uncertainty among PHI scheme members who will be unaware of the status of their treating doctor for the duration of so many individualised bargaining discussions between doctors and PHI organisations. Reflecting the breadth of its membership (770 Consultants and over 2,000 general practitioners), the IMO can bring an unrivalled knowledge of the needs and concerns of doctors to PHI organisations which will separately decide thereafter on the fees they choose to offer to doctors who may choose to participate as preferred providers.*

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: *Setting the fees in the absence of any collective negotiations with a representative body runs the risk that the payor will have to be prepared to assume extra time and cost in persuading Consultants to participate. The benefits outlined in the answer to question 11 will be missing and the net effect will be pronounced uncertainty and delay for patients seeking to establish their likely costs in attending their doctor.*

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: *The IMO feels that it ought to be possible to allow a collective bargaining role in such negotiations as we explain elsewhere..*

Furthermore, it is our view that the messenger model would not be appropriate in view of

- *the likely number of messenger engagements for up to 2,000 geographically dispersed consultants;*
- *the practical difficulties associated with such arrangements;*
- *the degree of uncertainty and delay associated with so many messenger engagements,*
- *the likely lack of confidence amongst Consultants in such a model where no advocacy or representation of their views is allowed, and;*
- *the real likelihood of the return of balance billing which will neither find favour with Consultants or patients.*

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

Answer: *See above.*

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

Answer: *No.*

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: *This is addressed elsewhere in the IMO response.*

Question 17: Who should engage and pay the messenger?

Answer: *The Organisation is not persuaded the messenger model is appropriate and would reserve its position accordingly.*

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: *This question is more appropriately answered by the health insurers. It should be noted that the IMO has not sought to preclude the National Treatment Purchase Fund from contracting directly with hospitals for medical services.*

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: *Given that 50% of private provision currently takes place in public hospitals, we are unclear whether it is being advocated that publicly owned hospitals would engage in discussions with their employed Consultants in deciding such fees and whether the Authority would be satisfied that the representatives for such Consultants including the IMO would be permitted to engage in such discussions on behalf of the Consultants. The Organisation would welcome the opportunity to explore this suggestion further.*

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: *In the limited time available to the Organisation to consider the questions raised in this questionnaire, the IMO is not in a position to comment on alternative mechanisms at this stage. The Organisation would welcome the opportunity to explore this matter in a supplementary submission.*

Rotas (para 5.6):

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

Answer: *The IMO does not agree with the characterisation of medical rotas. Such rotas are agreed, in accordance with the terms of the Common Contract for Consultants (negotiated on their behalf by the IMO and the IHCA) and require the agreement of the employer (Hospital) and the employee (Consultant).*

The Revised Common Contract (1997) states:

6.2 As a consultant, your responsibilities will include, inter alia, responsibility for:

(i) producing a realistic agreed schedule which specifies how you intend to discharge in person your full contractual commitment, over the period from Monday to Friday, taking into account the exigencies of the service and the most effective utilisation of resources,

(ii) supplying adequate advance notice in writing to hospital management advising them of all planned absences, together with their duration,

(iii) ensuring that fixed sessions, in particular Out Patient and Theatre sessions etc., should start as scheduled in order to minimise delays for patients and possible disruption of services,

(iv) <u>providing management with rosters indicating clearly who will be on call and available to the hospital at any given time where approved on-call/emergency services are to be provided.</u>

(v) .....

The rotas are designed to ensure optimal and continuous Consultant availability to treat and supervise the treatment of all patients entering public hospitals, regardless of whether they hold private health insurance or not.

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: *The IMO is not aware of such circumstances.*

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

Answer: *Consultants, as employees of the HSE, are required under Industrial Relations legislation, to arrange ballots for industrial action in legitimate disputes and to serve notice of industrial action prior to withdrawing their services. The rules of the Organisation in regard to the arrangements for balloting members replicate the provisions of the Industrial Relations Act, 1990.*

They are also bound by the Medical Council's Guide to Ethical Conduct and Behaviour (sixth edition) which states s1.7 "if doctors decide to participate in an organised collective or individual withdrawal of services, they are not released from their ethical responsibilities to patients.

They must guarantee emergency services and also such care as may be required for those for whom they hold clinical responsibility."

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: We are unclear as to the practices being alluded to in this question but would be happy to furnish a considered response on the receipt of clarification.

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 fail to see how the present system restricts competition in view of the fact that the main private health insurer (i.e. VHI) has a market share in excess of 80% and has limited competition from a small number of other insurers which tend to follow the lead of the main insurer in determining the level of increase in fees payable to participating consultants. In addition, it must be recognized that the state, which funds and controls the main insurer (VHI), also determines directly or through its agencies, the numbers entering the medical profession at undergraduate and postgraduate level and also the numbers who can operate as general practitioners or consultants.*

State funded hospitals also account for the overwhelming majority of private hospital beds. The state also determines the number of private beds in public hospitals as well as the number of beds in private hospitals overall.

The VHI, as the predominant insurer, also decides on which private hospitals to recognise / accredit and thereby controls demand for private medicine.

In addition, VHI is now involved in financially supporting community-based clinics which are competing with general practitioners.

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: *The number of cases referred to Consultants via A&E is extremely significant at just under 70% (most emergency admissions are for medical, not surgical care)*[28]*, reflecting the fact that by the state's own admission a further 3,000 acute hospital beds are required and also the rising population, thereby limiting elective admissions which now stand at barely in excess of 20% of all admissions.*

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 notion fails to recognise that PHI scheme members are entitled to seek treatment by a specific Consultant under whose care they will form an exclusive contract; one of the chief benefits of PHI scheme membership. GPs can advise patients on the Consultants available but ultimately the patient can and will opt to be seen by a specific Consultant.*

[28] The Health Report, An Agenda for Irish Health Care Reform, A Dale Tussing and Maev-Ann Wren, ICTU, Dublin, 2005. (p167)

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: *It is our view that in sufficient cases to decide on this issue, patients will want to have the option of seeking the advice of their general practitioner as to the range of Consultants to whom it may be appropriate to consider referral for specialist care. The absence of such advice by general practitioners would ultimately not serve the interests of the patient or the acute hospital system which would otherwise have to deal with increasing numbers of inappropriate or ill-advised referrals.*

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: *Presumably, the fact of having greater numbers of doctors would offer greater choice and innovation for both payors and the consumer / patient.*

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

Answer: *The single biggest impediment is the fact of having one of the lowest per capita ratios of Consultants in the OECD. The most decisive measure to address this factor would be for the state to significantly increase the numbers of Consultants in accordance with the repeatedly stated wish of the IMO.*

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: *Freedom of choice is necessary to promote the highest standards of patient care and also to reflect the wishes of the increasing numbers of consumers who choose to opt for PHI membership. We are unclear as to the basis for the latter assertion by the Authority and would welcome the opportunity to discuss this matter further.*

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

Answer: *Yes*

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: *Yes, discussions on codes and procedures ought to be possible without requiring discussions on fees or other commercial terms and conditions. This does not obviate the need for a fair and appropriate system for determining fees and such other terms reflecting the relative bargaining positions of all parties and also the entitlement of Consultants to seek a fair level of remuneration.*

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: *Discussions on codes and descriptions of procedures do not necessitate discussions on fees or other commercial terms and conditions. We would be guided by the Authority on precautions that may be deemed necessary.*

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: *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: *It is entirely appropriate that such discussions should take place as they enable Consultants advise on new procedures and treatments which health insurers might consider offering to members and thereby promote innovation ands choice in the consumer interest.*

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: *Health insurers are perfectly free to arrange meetings with Consultants / specialty groups and to hear the views of the Consultants, i.e. the experts in their medical field on innovations in medical science and the extent to which Consultants have the capacity to offer new treatments and procedures. It is entirely a matter for the health insurers to decide whether they wish to offer new treatments or procedures as benefits to their members. On this basis, we fail to see how any breach of the Competition Act would arise.*

Equally, we are unclear how in the absence of such meetings the health insurers can reasonably decide on new procedures and treatments they might consider offering and whether the capacity to offer such innovations exists, i.e. whether the supply of services by Consultants can match the demands that will follow the introduction of innovative benefits.

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: *Not applicable.*

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

Answer: *The Organisation is not aware of any evidence to suggest a link between ground rules and treatment volumes and would remind that Consultants are obliged by the Medical Council's Guide to Ethical Conduct and Behaviour (sixth Edition) to "do their best to preserve life and promote health" (s2.1) and that "regardless of their type of practice the responsibility of all doctors is to help the sick and the injured. They must practice without consideration of religion, nationality, gender, race, ethnicity, age, politics, socio-economic grouping or patient disability. They must not allow their professional actions to be influenced by any personal interest. (s1.3)*

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: *We are unaware of discussions alluded to in this question and can confirm that the IMO is not party to any such discussions.*