NSW HEALTH

D07/20

The General Manager
Adjudication Branch
Australian Competition and Consumer Commission
PO Box 1199
DICKSON ACT 2602

Dear Mr Gregson

Royal Australian College of General Practitioners (RACGP) A91024 – Application for revocation and substitution

I refer to your letters dated 20 December 2006 and 3 January 2007 enclosing a copy of the application by the Royal Australian College of General Practitioners (**the College**) for revocation and substitution of authorisation A90795 granted by the ACCC on 19 December 2002.

You have requested comments from NSW Health in relation to the likely public benefits and the likely effect on competition (or any other public detriment) from the proposed arrangements.

I note that the ACCC has granted interim authorisation to that part of the substitute authorisation currently covered by authorisation A90795, but has denied the request for interim authorisation regarding hospital agreements.

As noted in the RACGP submission, General Practitioners (GPs) appointed as Visiting Medical Officers to a hospital are independent contractors. They are appointed as individuals based on skills and qualifications they possess and the clinical service needs of the hospital and community. It is individuals, not GP practices that are appointed to a hospital, and there may be situations where not all GPs from a single practice are appointed to a hospital or where GPs from more than one practice are appointed to a hospital to provide a service. A summary of the arrangements that are in place for Visiting Medical Officer appointments in NSW is provided at Attachment 1.

NSW Health does not support the extension of the authorisation to cover agreements between GPs and public hospitals in NSW. NSW Health's position is that there is no public benefit arising from the proposed arrangements, and for this reason the authorisation should not be granted. An outline of the reasons for this view and other comments are at Attachment 2.

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NSW Health has no information on the number of eligible practices that have relied upon the 2002 determination to set practice fees. It is difficult, in the absence of more rigorous qualitative and quantitative assessment, to determine if the benefits of allowing these arrangements in practices outweigh the costs. Detailed comment on the RACGP submission is relation to GP practice fees is at Attachment 3. It may be appropriate for a more detailed and comprehensive analysis to be undertaken.

Should you require further information please contact Dr Linda MacPherson Medical Adviser workforce Development and Leadership Branch on (02) 9391 9107 or e-mail LMACP@doh.health.nsw.gov.au.

Yours sincerely

Robert D McGregor AM 9/2/07
Deputy Director-General
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Attachment 1

Framework for visiting medical officer (VMO) appointments in NSW

Chapter 8 of the *Health Services Act* 1997 (NSW) regulates VMO appointments within the NSW public health system. VMOs are independent contractors and are remunerated on the basis of:

- Sessional hourly rates in teaching hospitals;
- Sessional hourly rates or fee for service arrangements in metropolitan district hospitals and regional base hospitals; and
- Special fee for service arrangements in smaller rural hospitals under the Rural Doctors Settlement Package negotiated in 1988/89.

The additional information provided by the RACGP on the numbers and geographical distribution of GP VMOs does not accurately reflect the situation in NSW. VMO General Practitioners are, in the main, employed in smaller rural hospitals and in regional base hospitals in NSW. NSW Health data from 2004/05 show that 19 % of all Visiting Medical Officers appointed to NSW public hospitals were VMO General Practitioners. In rural Area Health Services however they comprised a larger component of the VMO workforce, ranging from 25 % to 50 % of the total Visiting Medical Officer workforce.

A VMO is a kind of visiting practitioner defined in s.78 as a medical practitioner *appointed under a service contract* (whether the practitioner or his or her practice company is a party to the contract) to provide services as a visiting practitioner for monetary remuneration for or on behalf of a relevant public health organisation.

Under the Health Services Regulation 2003, VMO appointments are to be advertised and are for a term of up to 5 years. Merit selection processes are applied to VMO appointments. There is no automatic entitlement to an appointment or reappointment.

A service contract is defined in s.80 so as to embrace both agreements between a public health organisation and a medical practitioner and a public health organisation and a practice company. The service contracts include fee for service contracts, sessional contracts and honorary contracts (see s.81).

In NSW standard rates and conditions for fee-for-service and sessional service contracts have been established and are varied by NSW Health from time to time following consultation with the Australian Medical Association (NSW) (**AMA (NSW)**) or, as the case may be, with the Rural Doctors Association (NSW).

For a VMO to be validly appointed the terms and conditions of their service contracts are required to be in writing (s.86).

Service contracts may contain sets of conditions (including remuneration) recommended by the AMA (NSW) (s.87 (1)). Section 87(2) provides for a "standard service contract" in relation to the various types of service contracts, such standard service contract containing the set of conditions approved for the time being under s.87 (1). Where a standard service contract for sessional or fee-for-service arrangements has been established, section 88 mandates its use.

Division 3 within Part 2 of Chapter 8 provides for arbitrations concerning VMOs working under fee for service or sessional contracts. Section 89(1) provides that the Minister or the AMA (NSW) can apply for the appointment of an arbitrator to determine:

> "(a) The terms and conditions of work, the amounts or rates of remuneration and the bases on which those amounts or rates are applicable, in respect of medical services provided by visiting medical officers under fee for service contracts or sessional contracts (or both)."

The *Independent Contractors Act* 2006 (Cth) ("IC Act"), the substantive provisions of which have not yet commenced, may impact on the *Health Services Act* so as to render the arbitration arrangements inapplicable. This will depend on whether area health services, which are currently the parties to service contracts with individual VMOs, are constitutional corporations, and whether the statutory framework in NSW continues to provide for VMO contracts to be with area health services.

Regardless of whether arbitration provisions exist, there is no current intention to depart from the position whereby the types and terms of service contracts that area health services may offer to VMOs are regulated by NSW Health.

Depending on the nature of the appointment, the requirement to provide on-call services in accordance with a roster established by the relevant area health service is part of the medical services required to be provided by a VMO under his/her service contract.

Attachment 2

NSW Health does not support extensions of authorisation to include hospital arrangements

In addition to the documentation provided by the ACCC to NSW Health, NSW Health has also obtained from the ACCC's website a copy of a further submission made by the College to the ACCC dated 19 January 2007. That further submission sets out in greater detail the College's submissions relating to the possible public benefits and detriments which may flow from the proposed hospital agreements.

NSW Health understands the College is applying for authorisation to allow GPs working in one practice who are appointed or seek appointment by the same area health service or hospital as a VMO General Practitioner to be able to negotiate collectively with the area health service or hospital in relation to:

- a common fee structure; and
- other workplace relations issues, such as:
    - after hours roster and weekend
    - an arrangement to provide the delivery of specific services

The College's further submission dated 19 January 2007 sets out a number of public benefits that it is claimed would flow from the authorisation. These claimed benefits, and NSW Health's response to each of these, is set out below:

- *Increasing the time available for clinical activity*

  The College's submission claims that the authorisation would "enable more efficient utilisation of GPs valuable time (which is currently used for individual negotiations) for providing primary health care". The College further submits that if GPs were able to devote more time to clinical work, it would lead to more GP services, particularly in regional and rural areas, which would in turn constitute a public benefit.

  Individuals GPs do not negotiate fee arrangements with area health services prior to their appointment as VMOs. Rather, the types and terms of service contracts that area health services may offer to VMOs are regulated by the NSW Health. It is therefore incorrect to suggest that negotiation of fee structures on a collective basis would obviate the need for individual doctors to negotiate these matters for themselves.

  Depending on the nature of the appointment, GPs and area health services may directly negotiate certain other matters, such as roster arrangements. However, the ACCC's position is that genuine rosters do not breach the anti-competitive conduct provisions of the *Trade*

Practices Act 1974.[1] There is therefore nothing to prevent GPs (whether from the same general practice or not) who are appointed as VMOs at the same hospital from discussing roster arrangements amongst themselves, and no authorisation is required to allow this to occur.

- *Reducing stress of uncertainty in their practice*

  For the same reasons as those provided above, GPs currently have certainty in relation to their fee arrangements when working in NSW hospitals. This certainty would be diminished if GPs were able to negotiate collectively.

  Further, the College's submission dated December 2006 refers to research suggesting that uncertainty or stress suffered by GPs can result in poorer quality of care being delivered to patients. The College suggests that, without an authorisation, GPs would suffer stress as a result of "consistent concern about a major investigation by the ACCC". By this reasoning, any person or business who is subject to the anti-competitive conduct provisions of the *Trade Practices Act* could seek immunity if the "stress" of a potential prosecution for anti-competitive conduct may be detrimental to the public. This reasoning should be rejected.

- *Improving working relationships among GPs in a practice*

  Again, there is no evidence to support this claim. In addition, the appointment by area health services of GPs as VMOs is dependent upon the needs of the clinical service requirements of the area health service, and on the qualifications and skills of the applicants. In the event that two or more GPs from the same general practice were to be appointed as VMOs by the same area health service, it would be entirely coincidental. There is no basis for suggesting that if the dealings of each of the GPs with the area health service was conducted on a collective rather than an individual basis, that it would affect working relationships between GPs within their general practice.

- *Promoting a culture of teamwork*

  For the reasons stated above, there is no evidence to support this claim. To the extent this refers to roster arrangements, as stated above the ACCC's position is that genuine rosters do not amount to anti-competitive conduct.

A further public benefit identified in the College's submission dated December 2006 is that authorisation would "positively influence morale, and subsequently the retention of GPs in those areas, by reducing red tape, saving on transaction costs and time". This submission is not developed by

[1] ACCC, Determination, Authorisation Number A90795, 19 December 2002, page 2.

the College, however as explained above given that VMO General Practitioners are not currently negotiating fee arrangements individually with area health services, there is no basis for arguing that efficiencies or costs savings would arise from GPs collectively negotiating these matters. On the contrary, such an outcome would be likely to result in more "red tape" and "transaction costs" for GPs because it would result in the negotiation of matters that are currently the subject of regulation by NSW Health.

The College's submission dated December 2006 also submits that the authorisation would also facilitate greater continuity and consistency of patient care, in the following terms:

> *Fee structures that were different, depending on the GP, could create real barriers to a patient attending a practice, and thus maintaining continuity of care (e.g. a patient being unable to afford to see one GP, but not another). Such fee arrangements could also create perceptual barriers (e.g. a patient believing that they might be billed differently, and thus not attending a practice, though, in reality their bill would have been the same). It is important, where possible, to provide predictability in the arrangements within a practice.* (Page 14)

Later in the same submission, the College submits that the authorisation would bring particular benefits to socially isolated and disadvantaged community groups, as follows:

> *Fee structures that were different, depending on the GP, may prove difficult and create a barrier to healthcare among patients who are marginalised structurally, socially, economically, linguistically or culturally.* (Page 15)

Whatever the merits of these arguments in relation to GP fee arrangements within general practices, they do not apply to patients treated by VMO General Practitioners in public hospitals, for two reasons. First, as explained above, terms and conditions of appointment are regulated by NSW Health. Second, and more importantly, under the Australian Health Care Agreement patients can elect to be admitted as a public patient, in which case they will not be charged for the treatment.

The College identifies a potential public detriment of the proposal as "possible rise in costs to the public hospitals and the need for the hospitals to stay within the existing budget". It is correct that under the Australian Health Care Agreement all States and Territories receive fixed funding for the provision of public hospital services. The determination of the fee arrangements that apply to all VMOs (not just VMO General Practitioners) in NSW takes place within these budgetary constraints. To allow VMOs to negotiate on a collective basis may produce inefficiencies and inconsistencies in the remuneration of VMO General Practitioners within the NSW public health system.

NSW Health also notes that GPs who are appointed or seeking appointment as VMOs to NSW public hospitals are likely to fall within the recent amendments to the *Trade Practices Act* containing new collective bargaining and collective boycott provisions for small businesses. These provisions should allow individual GPs or groups of GPs (whether working in the same general practice or not) who wish to collectively negotiate with an area health service to seek immunity by lodging a collective bargaining notification with the ACCC. NSW Health submits that the availability of this mechanism is a further argument against granting the authorisation.

Attachment 3

Comments on RACGP analysis on impact of costs to General Practice Services

The RACGP assert on page 15 that the "*2002 authorisation has no negative impact on costs, and therefore access and equity of general practice services*" and that "*the average patient contribution per service of patient and bulk-billed services out of hospital was $3.89 (Sept 2006 quarter)*". This is misleading for the following reasons.

- The quoted figure of $3.89 reflects out of pocket expense for GP/VRGPs and uses September 2006 quarterly Medicare data. Using quarterly data is inaccurate due to seasonal fluctuations as highlighted in the RACGP submission.

- The more accurate measure, as it is more comprehensive (taking into account both GP/VRGPs and the provision of enhanced primary care and other GP services) is the total out of pocket expenses for seeing a GP (excluding practice nurses) on a financial year basis (this removes the quarterly fluctuations).

- At the end of the 2005/06 financial year average out of pocket payments were $3.81 ($3.92 in the Sept 2006 quarter), a rise of 32% (or $0.93) since the 2001/02 level of $2.88 (2001/02 is the full financial year prior to the December 2002 authorisation).

However, the use of patient bulk billed services as the only measure is also misleading. The other measure that should be taken into account is total out-of-pocket expenses for non-bulkbilled services. In 2005/06 this was $15.82, a rise of 35% (or $4.14) since the 2001/02 outcome of $11.68.Over the period 2001/02 to 2005/06:

- the total GP bulk-billing rate has risen from 74.9% to 75.6%, however 2005/06 is the first year that the bulk-billing rate has been higher than the 2001/02 level, only beginning to rise from 2004/05 onwards.
- out of pocket expenses have increased as shown above
- services per capita have fallen from 5.1 to 4.9 GP visits per head of population
- the number of services provided has risen by 1.2%.
- total benefits paid have increased by around 39% from $2.742 billion in 2001/02 to $3.815 billion in 2005/06.
- benefits paid per capita have increased by around 33% from $139.61 to $185.43

The combination of these movements in core data suggests that access to General Practice services has not been enhanced in terms of service provision despite growth in outlays and fees charged. Of note is the fact that the growth in outlays is significantly higher than the growth in the provision of services.

Given the above, the key question is to what extent has the 2002 authorisation, created this situation. It would be difficult to attribute the outcome described above solely to the 2002 authorisation. Since 2002 the Australian Government has introduced the Medicare Safety Net that has proven to be inflationary, as well as a range of bulk billing initiatives, and practice costs have undoubtedly increased.

However it can also be argued that the price fixing arrangements within a General Practice have had the potential to contribute to these outcomes as they may:

- Decrease consumer choice due to lack of competitive pricing by clinicians within a practice
- Mean that quality of service is not price responsive. Consumers will pay the same price for any doctor at a practice regardless of whether that clinician provides a service of quality
- Distort price signals within a practice

GP fees should be realistic and not force some patients, who are unable to afford GP fees, to seek treatment in a public hospital Emergency Department.