NOTE FOR FILE

Teleconference between the ACCC and Royal Australian College of General Practitioners (RACGP)

Date: 15 February 2007

Time: 11.00am – 12.00pm

Matter: RACGP – A91024 Application for revocation and substitution of authorisation A90795.

Attendees:

Isabelle Arnaud	Director, Adjudication, ACCC
Ursula Everett	Assistant Director, Adjudication, ACCC
Lauren Roy	Project Officer, Adjudication, ACCC
Ian Watts	National Manager, GP Advocacy and Support, RACGP
Dr Bella Brushin	Program Manager, GP Advocacy and Support, RACGP

1. The ACCC requested a teleconference with the RACGP to discuss issues relating to application A91024 in more detail.

RACGP Survey

2. Ms Everett began the teleconference by discussing the RACGP Price Setting Survey (the survey). Ms Everett sought clarification from RACGP on how many GPs were invited to respond to the survey.

3. Dr Brushin confirmed that there were 14,500 members of the RACGP. She stated that while the survey was widely advertised among members via the RACGP FridayFax and website, the RACGP cannot confirm how many GPs it reached. She commented that as a part of the survey process, the RACGP also provided copies of the survey to Practice Managers and asked them to distribute the surveys to the GPs in the practice. Dr Brushin commented that the RACGP has no control over what happens to the information once it is provided to the Practice Managers. The RACGP cannot confirm the representativeness of the responses received.

GP Practice Structures

4. Ms Everett sought clarification on what business structures are encompassed by the term "group practice" in the survey.

5. Mr Watts defined a group practice as more than one GP within a practice, and explained this could take place under any business structure. Mr Watts explained that in the last five years there has been a trend away from solo practices, towards group structures. Mr Watts explained that encompassed in this trend has been the growth of corporate GP practices, and he noted that many of these corporate practices have been structured as associateship-type practices.

6. Mr Watts explained that based on the data collected by the RACGP, it is difficult to determine the number of GPs operating in particular business structures. In addition, the survey does not provide information as to how the number of entities relate to the number of GPs. For instance, a small number of corporate practices have a large number of GPs.

7. Mr Watts indicated that there is a significant variety of practice structures available and they are largely determined by tax and liability issues.

8. Ms Arnaud commented that the results of the survey indicate that 16% of respondents operate in associateships and 36% in companies. Ms Arnaud asked whether the companies may also operate under an associateship structure. Mr Watts confirmed that this was the case.

9. Mr Watts explained that the term "company" may fall into two categories:
- service entities
- company structure

10. Mr Watts explained that many GPs might have limited understanding of the legal difference between the two structures, so it is difficult to determine from the data collected by RACGP the comparative size of companies and structures that use a service entity. He indicated that when using a service entity, the GPs generally operate in an associateship structure.

11. Ms Everett noted that in the ACCC's determination it is considering using a simple description of the business structures that are the subject of the application, and which encompasses common features of those structures. Mr Watts was supportive of this approach. Mr Watts confirmed that the sharing of patient records and a common trading name were key features of the type of practices that would fall under the authorisation. Mr Watts noted that these structures usually also share common facilities. Mr Watts emphasised that maintaining a common policy and procedures is more significant to the team structure than the financial aspects, such as the sharing of a common bank account.

VMOs

12. Mr Watts explained that generally, VMOs are sessional arrangements. Mr Watts noted that VMOs operate predominantly in rural areas, and while VMOs do operate in some metropolitan regions, only a small number of GPs provide VMO services in these areas. Mr Watts explained that where there is a group practice, GPs may share a weekend, or share after hours VMO services.

13. Mr Watts indicated that in larger rural centres VMO services would be supplied to a hospital by multiple GP practices. Mr Watts explained that smaller areas are less likely to have multiple practices operating.

14. Mr Watts noted that the main issue in this area is to what extent VMO arrangements at the state level can be varied at the local level. While it would appear that VMO arrangements created at the state level have limited room for variation, feedback at the local level suggests there is some variation, but this is small.

15. Mr Watts explained that each state differs regarding how VMO agreements are regulated. Mr Watts indicated that while there may be room for GPs to negotiate at the local level in some regions, this may not be the case in other states. Mr Watts stated that the feedback the RACGP has received from the states confirms that activities vary by state, as do VMO agreements. Mr Watts indicated that the extent to which GPs would benefit from the authorisation of collective VMO negotiation will vary depending on the state and region.

16. Mr Watts noted that the RACGP is seeking consistency at the national level for the ability of GPs to negotiate VMO arrangements through the relevant application for authorisation.

17. Ms Everett sought clarification about whether VMOs are currently able to negotiate fees for service. Mr Watts explained that it is difficult to sever the fee paid for VMO services from the service itself. Mr Watts explained that the fee paid for VMO services differs depending on the service that is provided by the doctor. The service provided depends on the individual credentialling of the GP by the hospital. Mr Watts explained that the terms and conditions (including the fee) of VMO arrangements are contingent on the credentials of the doctor.

18. Mr Watts explained that hospitals carefully credential doctors for safety reasons and the RACGP supports this process. Mr Watts explained that under the credentialling process GPs will enter into an agreement as to what services they will provide to a hospital and the terms and conditions upon which that service will be provided.

19. Mr Watts indicated that there is wide variability in the scope of services being provided by VMOs for which fees are being paid, but the variability of the fees received for these services is constrained by arrangements at state and individual levels (credentialling by hospital). Mr Watts therefore noted three factors that warrant consideration:

1. state level
2. practice level
3. individual credentials

20. Mr Watts explained that at the state level standard terms and conditions are set, which doesn't allow a lot of room for GPs to negotiate at the practice level. Similarly, at the individual level, GP credentialling with hospitals involves appointment on terms and conditions specific to each GP. He noted that the terms and conditions that underpin the VMO arrangements will depend on the individual skill mix of the VMOs concerned. Mr Watts noted that existing agreements at the state and individual level constrain what GPs can achieve in negotiating collectively at the practice level. Mr Watts submitted that at the practice level, only a very small number of GPs may derive a meaningful benefit if the authorisation sought by the RACGP is granted by the ACCC.

21. Mr Watts explained that the VMO component of the current application for authorisation would allow GPs in the same practice to collectively negotiate similar issues relating to the terms and conditions of their appointment with a hospital. Mr Watts explained that the situations in which a group of GPs would chose to

collectively negotiate would be limited and is likely to arise where the GPs are similarly credentialled and where other common issues regarding their appointment to a hospital arise following their original credentialling process. Mr Watts indicated that opportunities to negotiate collectively may arise at the expiration of individual VMO contracts with hospitals. Alternatively, issues may arise prior to the expiration of individual VMO agreements and the authorisation would allow doctors operating in the relevant business structures and who share similar concerns to collectively raise these issues with the hospital board.

22. Ms Everett sought clarification of whether allowing VMOs to negotiate collectively with hospitals would result in increased time efficiency. Mr Watts explained that hospitals must credential GPs individually, and that while there is an inevitable transaction cost associated with this process, it is necessary and unavoidable. Accordingly, the RACGP is not seeking to circumvent this process through its application.

Rosters

23. Ms Arnaud explained to the RACGP that the ACCC's view on rosters is that genuine rosters do not raise concerns under the TPA. Ms Arnaud explained that an 'arrangement not to provide surgical services on the weekend' as outlined on page 13 of the RACGP's application, may raise concerns under the TPA. Ms Arnaud explained that any agreement between GPs to restrict the service they supply may contravene the boycott provisions in the TPA. Mr Watts appreciated this issue and confirmed that it was not the intention of the RACGP to seek authorisation for boycott activities. Mr Watts suggested that it may be useful to clearly outline in the ACCC determination what is and what is not covered by the authorisation.

Delivery of specialist services

24. Mr Watts explained that the provision of GP VMO specialty services is mostly in rural and remote areas, and their nature and scope will vary depending on the size of the hospital. Mr Watts explained that in rural areas most GPs would provide specialist services, which are most likely to be procedural. Mr Watts explained that many rural centres would also have consultants that visit the hospital.

25. Mr Watts noted that in a small hospital, it is unlikely that there would be an on-staff specialist (consultant). In these instances, it would therefore be more likely that GPs would deal with patient cases that concerned, for example, uncomplicated obstetrics. If a complicated obstetrics case presented, the patient would be transferred to a regional or metropolitan hospital. Mr Watts added that GPs have a scope of skills and services that are developed to compensate for the absence of on-staff consultants.

NSW Health Submission

26. Ms Everett invited Mr Watts and Ms Brushin to comment on the NSW Health submission. Mr Watts drew attention to Attachment 3, which comments on the RACGP analysis on impact of costs to General Practice Services. He affirmed that the RACGP agrees that many external factors have affected pricing and it is difficult to attribute pricing increases to the 2002 authorisation.

End 12.00pm