THE ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS

January 19, 2007

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

Dear Mr Gregson,

The Australian Competition and Consumer Commission (ACCC) request for further information regarding the Royal Australian College of General Practitioners (RACGP) application (A91024)

Thank you for your letter dated 5th January 2007 concerning the ACCC request for further information regarding the RACGP application (A91024) for revocation and substitution of the 2002 ACCC authorisation (A90795) in respect of agreement to set, control or maintain fees at a certain level within a practice.

We are pleased to have an opportunity to provide further information to support the application mentioned above. The requested information is outlined below under the following headings:

1. The current situation regarding GPs appointed as VMOs
   - The process by which GPs are appointed and arrangements regarding fees.
   - The numbers and geographical distribution of VMOs.
2. The possible implications of the proposed authorisation.
   - Details about how the proposed hospital agreements will work in practice.
   - The possible public benefits and detriments, which may flow from the proposed hospital agreements.

In the process of preparing this response, the RACGP has contacted health departments in all Australian states and territories.

As requested, we also include the Summary Report of the RACGP members Price Setting Survey (PSS) for your perusal.

1. The current situation regarding GPs appointed as VMOs

a) The process by which GPs are appointed and arrangements regarding fees

A VMO is a medical practitioner appointed by the hospital board to provide medical services for hospital (public) patients. From a legal viewpoint, a VMO is most likely to be an independent contractor

In Australia, most VMOs are appointed on an honorary, sessionally paid, or fee for service basis. However, the current processes by which GPs (and OMPs) are appointed may vary in different states and territories and between different hospitals within the same state or territory. For

example, Victorian data indicate that in 2005-2006 almost all VMOs positions (99%) were sessional[1]. Average hours per GP (per person) in metropolitan hospitals was 7.6 hours and average hours per a GP (per person) in rural and regional hospitals area was 9.3 hours[2]. Other states do not collect or report such information.

In addition, there is some variation among a range of organisations dealing with VMO related issues. For example, workplace relations among VMOs and hospital in ACT were addressed by the *ACT VMOs Association* while in Queensland similar issues were dealt with by the Queensland branch of the *AMA*.

At present GPs (or OMPs) negotiate contractual and fee arrangements with hospitals on individual basis because collective arrangements between VMOs and a local hospital may be seen as anti-competitive under the Act. For example, VMOs are likely to breach the Act if they bargain collectively or agree with the local hospital for:

- a common fee structure
- a particular after hours roster
- the delivery of specific services such as anaesthetics, obstetrics and surgery
- an arrangement not to provide surgical services on the weekend.

The numbers and geographical distribution of VMOs

This is important to emphasise that information relating to VMOs in Australia is not consistent among the states and territories. This is largely associated with the fact that Australian hospitals are funded by the state and territory governments. The RACGP's consultation with state health departments confirmed that the current data collection process varies among the states and territories.

For example, in Victoria data is collected with regard the total numbers (headcounts) of GPs engaged as VMOs in metropolitan, rural and regional hospitals and the numbers of hours worked. While in Tasmania[3], data collection is based on the numbers of Full-Time equivalent (FTE) paid employees by award. These numbers do not reflect the numbers and distribution of GPs appointed as VMOs. Several state health departments indicated that they do not collect any VMOs related information and/or did not make this information available to the RACGP.

Victorian data[4] indicate that in 2006, a total of 401 GPs were engaged as VMOs in metropolitan (N=80) and rural and regional hospitals (321). As data from Victoria demonstrate, the proportion of GPs working as VMOs in rural and remote Australia is much more significant that in metropolitan Melbourne. In Tasmania, a total number of Full-Time equivalent (FTE) paid employees by award in 2005 was 51[5].

The only VMOs related information available on national basis is data regarding time spent on different aspects of work in general practice. This data demonstrate that GPs spent only a small fraction of their time (2.7%) as VMOs in hospitals[6]. Although not current, this data supports the

[1] Department of Human Services, Victoria, 2006 Annual Report
[2] Department of Human Services, Victoria, 2006 Annual Report
[3] Department of Health and Human Services (personal communication)
[4] Department of Human Services, Victoria, 2006 Annual Report
[5] Department of Health and Human Services, 2007 (personal communication)
[6] IBISWorld Pty. Ltd., *General Practice medical Services in Australia*, IBISWorld Industry Report, Report No O8621, 29 December 2006

RACGP view that there is only a small number of GPs are appointed as VMOs and require provision of the ACCC coverage.
While provision of the ACCC authorisation would provide coverage for a very small number of GPs it would benefit greatly marginalised Australian health consumers.

2. The possible implications of the proposed authorisation.
Details about how the proposed hospital agreements will work in practice.
If authorisation is granted GPs working in one practice who are appointed by the hospital board to provide medical services for hospital (public) patients would be able to negotiate with hospitals collectively. It is envisaged that a practice representative would reach an agreement with the hospital board to provide medical services for hospital (public) patients on fee for service basis and other workplace relations such as

- a common fee structure
- an after hours roster and weekend
- an arrangement to provide the delivery of specific services, for example
  - anaesthetics
  - obstetrics
  - surgery.

The possible public benefits and detriments which may flow from the proposed hospital agreements.
The RACGP envisages that provision of the ACCC coverage for VMOs engaged in collective arrangements between themselves and local hospitals would benefit GPs (and OMPs) and Australian public.

Provision of the ACCC coverage would benefit GPs (and OMPs) by

- increasing the time available for clinical activity
- reducing stress of uncertainty in their practice
- improving working relationships among GPs in a practice
- promoting a culture of teamwork.

The ACCC coverage would enable more efficient utilisation of GPs valuable time (which is currently used for individual negotiations) for providing primary health care.

This is particularly valuable in the context of significant medical workforce shortage and continues problems associated with recruitment and low retention of GPs (and OMPs) in rural and remote Australia. Various initiatives have been implemented by key stakeholders including government, academic, public and private health sectors to address various aspects of medical workforce deficiency. These initiatives were supported by the key professionals stakeholders such as the AMA and RACGP. Despite all the effort, rural and remote areas in Australia are still medical workforce deficient.

Of grave concern is that medical workforce shortages in rural Australia create health risks for Australian health consumers, in particular after hours and on the weekends. Importantly, patient access to specific services such as anaesthetics, obstetrics and surgery in rural hospitals is also limited.

In addition, shortages of GPs (and OMPs) are emerging in outer metropolitan areas.

Therefore, provision of the ACCC coverage for VMOs engaged in collective arrangements would benefit marginalised Australian consumers, in particular those residents of rural and geographically remote areas as well as economically and socially disadvantaged communities in outer metropolitan areas.

The only detriment that we have identified is possible rise in costs to the public hospitals and the need for the hospitals to stay within the existing budget.

The RACGP concludes that the authorisation that it requests would bring benefits for both patients and GPs by promoting a culture of safety, quality and teamwork while preventing the risks of further health disparities among Australians from various socio-economic groups while there is no evidence of any detriment to the public may flow if authorisation is granted.

As the peak professional organization representing the interests of GPs and OMPs, the RACGP aims to achieve and maintain the highest quality primary health care in urban and rural Australia. Therefore, the RACGP requests to extend the ACCC authorisation to provide coverage for GPs (and OMPs) who have visiting rights to a local hospital as VMOs in response to the needs of marginalised Australian consumers.

The RACGP looks forward to the completion of the ACCC's considerations. Should the ACCC receive further submission, the RACGP would be pleased to provide comment.
As noted previously, I have attached a hard copy of the RACGP's 'Application to the Australian Competition and Consumer Commission on behalf of general practitioners and other medical practitioners for the authorisation of certain intra-practice price-setting arrangements'.

Should you need to be in touch or request further information, please do not hesitate to contact me on 613 86990544.

Yours Sincerely

Ian Watts
National Manager GP Advocacy and Support

The Royal Australian College of
General Practitioners

The Royal Australian College of General Practitioners

Price Setting Survey

Summary Report

January 2007

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Definitions

General practitioners

- Fellows of the Royal Australian College of General Practitioners
- Medical practitioners who have vocational recognition as Australian general practitioners.

Other Medical Practitioners (OMPs)

- are Medical Practitioners
- Who are not Vocationally Registered, are not Fellows of the RACGP and who render Group A2 Other Non-Referred Attendance Items in the Medicare Benefits Schedule (MBS)
- OMPs include a group of Medical Practitioners who were in general practice prior to the introduction of vocational registration, and who have not become vocationally registered. OMPs also include a group of who are international (rather than Australian) medical graduates, who are working in general practice, and who have not been assessed for Fellowship of the RACGP.

Associateship

A medical practice which is an associateship where two or more doctors, either incorporated or not incorporated, are co-located and share an interest in a service entity responsible for managing and/or maintaining a common reception, common fee collection, common bank account, common trading name, common medical records, common policy and procedures and has been or is registered to be accredited as a single entity.

Corporate (Practice)

The Australian Bureau of Statistics (ABS) defines a corporate practice as a GP medical business contracted to a corporate administrative entity for a fixed period[1]. Generally, in general practice, however, it is the medical business, which contracts the corporate administrative entity to provide the medical business with services, resulting in many 'corporate' GPs being associates.

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List of abbreviations

ACCC	The Australian Competition And Consumer Commission
ABS	The Australian Bureau of Statistics (ABS)
GP	General Practitioner
GPs	General Practitioners
OMPs	Other Medical Practitioners
RACGP	The Royal Australian College of General Practitioners
the Act	The Trade Practices Act 1974

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Background

1. The ACCC authorisation of certain intra-practice price setting arrangements

1.1. In January 2002, The Royal Australian College of General Practitioners (RACGP) – on behalf of GPs and OMPs in general practice made application under sub-section 88 (1) of the Trade Practices Act 1974 (the Act).

1.2. In the last 4 years, the 2002 ACCC authorisation provided broad coverage for GPs and OMPs to enable them to engage in conduct which might be defined as 'anti-competitive' within the meaning of the Act.

1.3. The current ACCC authorisation enabled GPs and OMPs to control or maintain fees at a certain level within a practice in the context of various general practice business models.

1.4. The current authorisation ceased on 10 January 2007.

1.5. In December 2006, the RACGP submitted an application to the ACCC for revocation and substitution of the 2002 ACCC authorisation and request for interim authorisation while an adjudication of the application occurs.

1.6. Several strategies were put in place to ensure utmost transparency of the application process. Members were

- advised about the ACCC application processes
- invited to participate in the RACGP Price Setting Survey (PSS).

1.7 On 20 December 2006 the ACCC granted the RACGP interim authorisation to the parts to substitute the 2002 authorisation.

2. The grounds for the RACGP authorisation request

2.1. The RACGP is seeking revocation of authorisation on the basis that

- the public benefit of so-called anti-competitive activity substantially outweighs possible detriment
- the authorisation brings benefits to patients through
  - enhanced safety of care
  - enhanced continuity of care
  - improved access to GPs, in particular among socially marginalised and/or disadvantaged patients and communities
  - predictability of prices.

2.2. There have been no demonstrated detriments for patients from the 2002 authorisation.

2.3. The authorisation brings benefits for GPs (and OMPs) and, ultimately, the broader Australian health care system, by providing positive impact on medical workforce through

- reduced red tape
- reduced stress
- improved retention of GPs
- promotion of team environment and open working relationships in general practice.

2.4. While revocation and substitution of the ACCC authorisation is important for GPs (and OMPs) working under various business arrangements, it is particularly crucial for those in associateships that represent a substantial number of medical workforce.

3. The 2002 Survey

3.1. In 2002, the RACGP undertook a survey of the business models being used by general practitioners around Australia. The survey results showed that the business models for which the RACGP is seeking authorisation covered an estimated 83.3% of all general practitioners:

- Associateship – 28%
- Incorporated company with more than one shareholder or director – 18.5%
- Partnership – 17.3%
- Short or long-term employment/engagement of contractors or locum – 10.7%
- Unit trust – 1.2%

3.2. In 2002, 7.6% of business models combine two or more of the above practice structures. The remaining 16.7% comprised unincorporated solo general practitioners or salaried general practitioners working with corporations or with organisations such as the Royal Flying Doctor Service and Aboriginal Medical Services. Aboriginal Medical Services are often incorporated companies, where the GPs are employees.

3.3. The findings from the 2002s survey suggested that associateship was the most frequently used business model.

4. The 2007 PSS principal aim and specific objectives

4.1. Aim

The aim of the 2007 PSS was twofold:

- to investigate the current business structures/models used in Australian general practice
- to explore attitudes of GPs and OMPs towards possible benefits and/or detriments associated with the proposed fee setting activities between GPs in a practice.

4.2 The specific objectives were to

- survey the current business models currently being used by GPs around Australia;
- compare the current general practice business models with those used in 2002 to establish current trends in contemporary general practice;
- explore GPs perspectives about possible influences of an agreement between GPs in one practice on a single set of fees in terms of
  - the quality and safety of patient care
  - GPs and relationships among GPs working in a practice
  - patient access to care;
- develop and evaluate methods/instruments to enable data collection of relevant information in the future.

5. Data collection and analysis

5.1. The PSS was conducted in December 2006 – January 2007. All GPs (and OMPs) working in Australian general practice were eligible to participate. GPs were informed about the aims of the survey, invited to participate and provided with a choice of submitting a completed survey form either online

or via facsimile. A total of 542 GPs[1] submitted their responses before the closing date for data collection (8 January 2007).

5.2. In 2007, the reported business/legal structures/models were complex with a significant proportion of business models combining two or more practice structures. To address the diversity of business/legal structures/models, and for the purposes of meaningful data management and analysis, a range of categories were aggregated in to larger categories. These categories were as follows:

- Company
- Associateship
- Partnership
- Trust
- Solo trader
- 'Corporate'
- Other

See Table1 for GPs' definitions of their practice legal/business status included under each of the aggregated categories.

5.3. For the purposes of meaningful data management and analysis, group practices were also categorised in to:

- Small – 2 to 4 GPs
- Medium – 5 to 9 GPs
- Large – 10 GPs and over

depending on the numbers of GPs working in the practice and irrespective of GPs' working arrangements (either full-time or part-time).

5.4. GPs were asked to express their views about possible influences of an agreement between GPs in one practice on a single set of fees in terms of

- the quality and safety of patient care
- GPs and relationships among GPs working in a practice
- patient access to care.

5.5. GPs provided their responses in relation to the following statement:

'If all GPs in one practice agree on a single set of fees, this would ...

- *decrease a GP's independence*
- *improve the quality of patient care*
- *limit patient access to GPs*
- *enhance continuity of patient care*
- *improve relationships among GPs*
- *put patient safety/the quality of care at risk*
- *cause fees to rise*
- *enhance team work in the practice*
- *improve patient access to care.'*

[1] For the purposes of this report 'GPs' are defined as General Practitioners (GPs) and/or Other Medical Practitioners (OMPs) working in general practice.

5.6. Respondents were asked to rank their responses on a 5-point scale as 'strongly disagree', 'disagree', 'neutral', 'agree' or 'strongly agree'.

6. Summary of findings

6.1. From a legal viewpoint, the majority of **GPs respondents** (83.6%; N=453) described themselves as 'independent practitioners'(IP). Only 13.3% (N=72) have indicated that they are not independent.GPs described a range of legal/working status of other GPs in the same practice (see Figure 1).

6.2. A significant proportion of respondents (87.1%; N=472) reported working in a group practice[2] and only 10.3% (N=56) reported working as solo practitioners.

6.3. Overall, the numbers of GPs working in a group practice varied from 2 to 26 with an average of approximately 7 practitioners in a group practice.

6.4. The majority of respondents (who work in a group practice) reported working in medium size practices (64%) followed by small (23%) and large practices (13%).

6.5. The composition of business/legal models in contemporary general practice is diverse (Figure 1). GPs offered a diverse range of definitions of existing business models used in their practice[3] (see Table 3). While several GPs provided single responses (i.e. *Associateship* or *Company)* the others provided multiple responses (i.e. *Associateship/Company/FamilyTrust).*

6.6. From a legal viewpoint, the majority of **practices** in the sample were companies (36%), associateship (16%) and partnership (13%) (see Figure 1).

6.7. A substantial number of GPs (N=65, or 12%) were uncertain about 'their practice'[4] legal/business model (see Figure 1).

6.8. A significant proportion of GPs (N=409 or 81%) reported that they currently agree on a single set of fees with other GPs in their practices, with further 2% of GPs wanting to be able to (2%) or planning to (1%) agree on a single set of fees.

6.9. Data analysis revealed, that a large proportion of respondents disagree (and strongly disagree) that the fee setting activities between GPs in a practice limit patient access to GPs and/or causes fees to rise (see Table 2).

6.10. The majority of GPs disagree that fee setting in a practice might have negative impact on patient access to GPs (Figure 3). However, perceptions of possible positive influence on patient access to care were not as straightforward. Thus, GPs most frequently ranked their opinion with regarding the relationship between improved patient access to care and fee setting as neutral (see Figure 4).

6.11. GPs tended to believe that the ability to agree on a single set of fees has positive impact on quality of patient care, in particular enhanced continuity of care (see figure 5).

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[2] The number of GPs working in a group practice should be interpreted with caution as it represents GPs working in a practice irrespective of condition of employment/business arrangements. Therefore the number of GPs may include not only full-time and part-time GPs but also contractors, registrars and locums.

[3] In the context of this survey 'this practice' or 'the practice' means the practice where they have first received/completed the survey

[4] In the context of this survey 'this practice' or 'the practice' means the practice where they have first received/completed the survey.

6.12. The majority of participants believed that there is no association between fee setting activities and risk to patient safety (see Figure 5).
6.13. GPs tended to believe that the carrying out of fee setting activities do not diminish a GP's independence (see figure 6).
6.14. A significant proportion of GPs tended to believe that exercising fee setting activities in a practice would improve working relationships among GPs and enrich their team work wwithin a practice (see Figure 6).

7. Tables and Figures

Table 1: GPs' definitions of their practices included under category

CATEGORY	RESPONSE
Associateship	▪ *Associateship* ▪ *Associateship/ Company/ Employee* ▪ *Associateship/Company/Family Trust* ▪ *Associateship/Company/Unit Trust* ▪ *Associateship/Sole Trader* ▪ *Associateship/Unit Trust*
Company	▪ *Company* ▪ *Company/Unit Trust* ▪ *Joint Venture: 2 Companies* ▪ *Shared service Company*
Partnership	▪ *Partnership* ▪ *Partnership/ Company* ▪ *Partnership/Unit Trust*
Trust	▪ *Family Trust* ▪ *Unit Trust* ▪ *Trust* ▪ *Hybrid Trust* ▪ *Service Trust*
Solo trader	▪ *Solo trader*
'Corporate'	▪ *'Corporate'* ▪ *Independent Practitioners Working In A Practice Providing 'Services' Which Is Owned By A Company*
Other	▪ *Government Health Service* ▪ *Independent Practitioners* ▪ *Independent Practitioners with A Shared Service Company Of Which all GPs Are The Directors* ▪ *Service Company Room Business. Each Doctor Has Own Company/ Trust (Family/ Service)* ▪ *University Medical Practice* ▪ *Non-Government Health Service (Salaried GPs)*

Figure 1: Reported current legal/business models

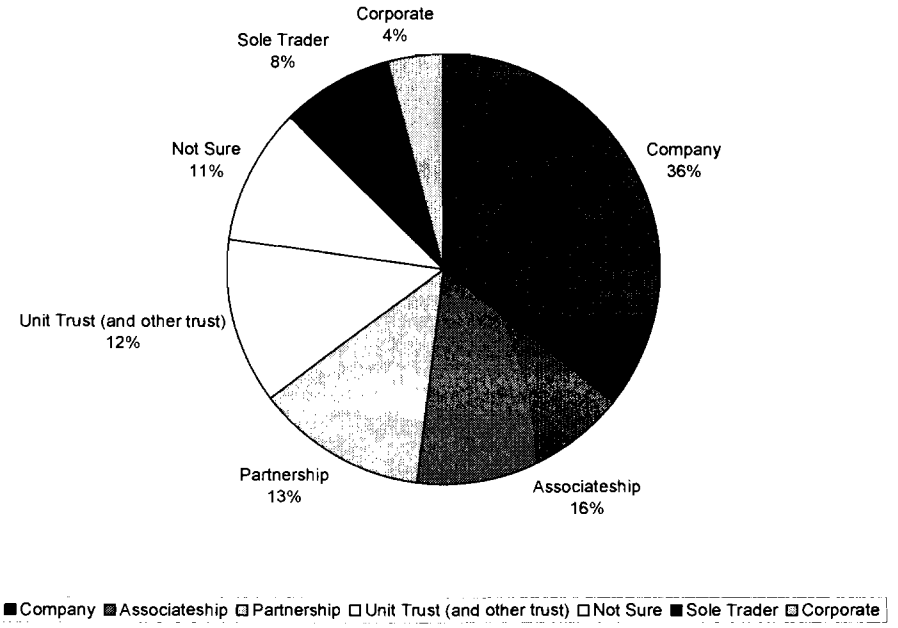

Table 2: Perceived influences of price setting on access to general practice

... *the carrying out of fee setting activities in a practice would* ...	... limit patient access to GPs		... cause fees to rise		... improve patient access to care	
	number	per cent	number	per cent	number	per cent
strongly disagree	220	40.6	182	33.6	37	6.8
disagree	189	34.9	190	35.1	71	13.1
neutral	79	14.6	106	19.6	190	35.1
agree	24	4.4	32	5.9	118	21.8
strongly agree	6	1.1	8	1.5	102	18.8
no response	24	4.4	24	4.4	24	4.4

Figure 2: Legal/working status of other GPs working in the same practice

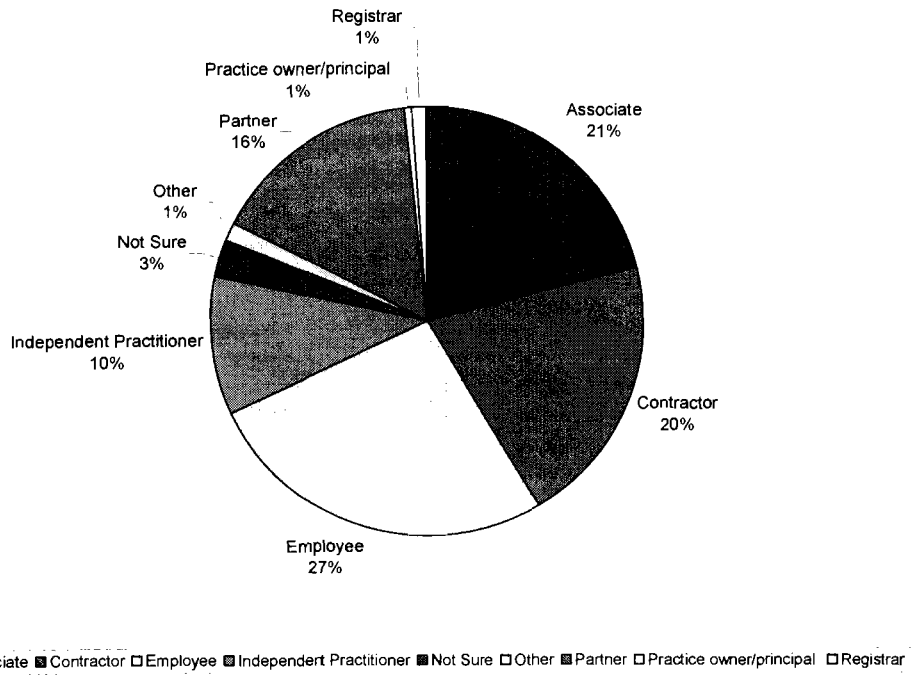

Figure 3: Current Price Setting – GPs views regarding possible link with fee rise

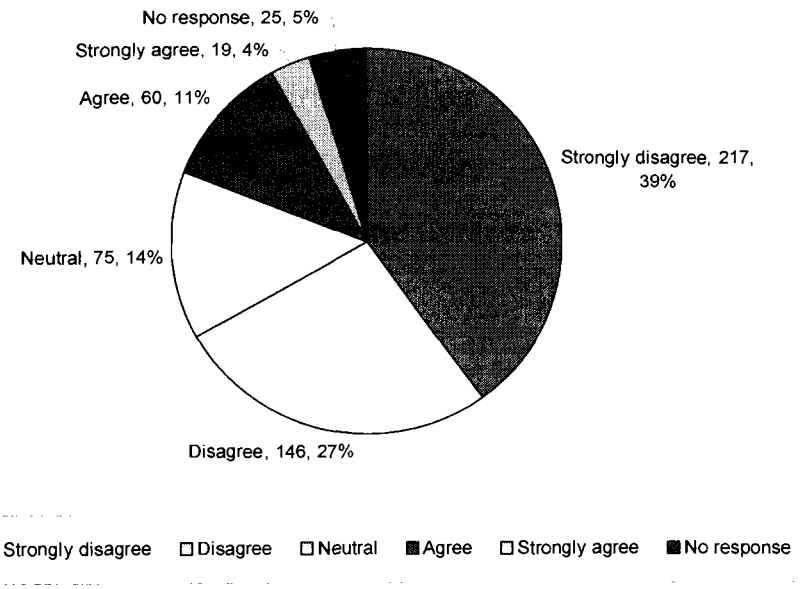

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Figure 4: Perceived influences of price setting on GPs patient access to care and fees

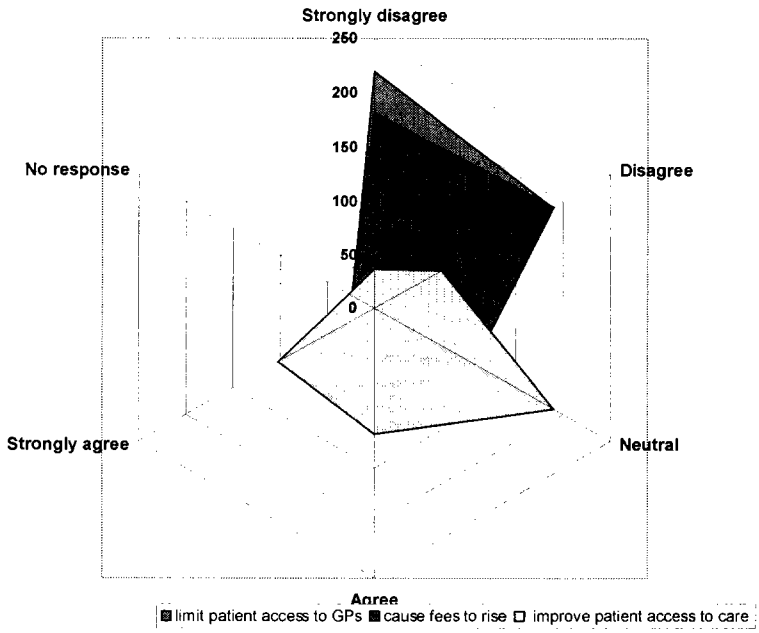


Figure 5: Perceived influences of price setting on the quality and safety of care

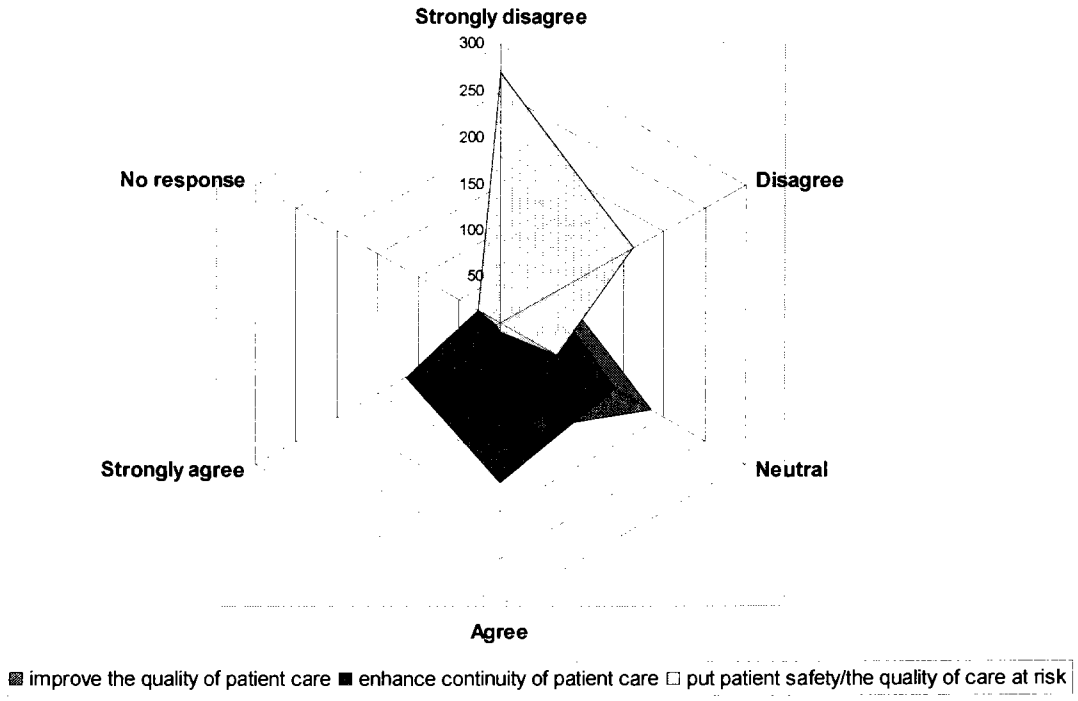
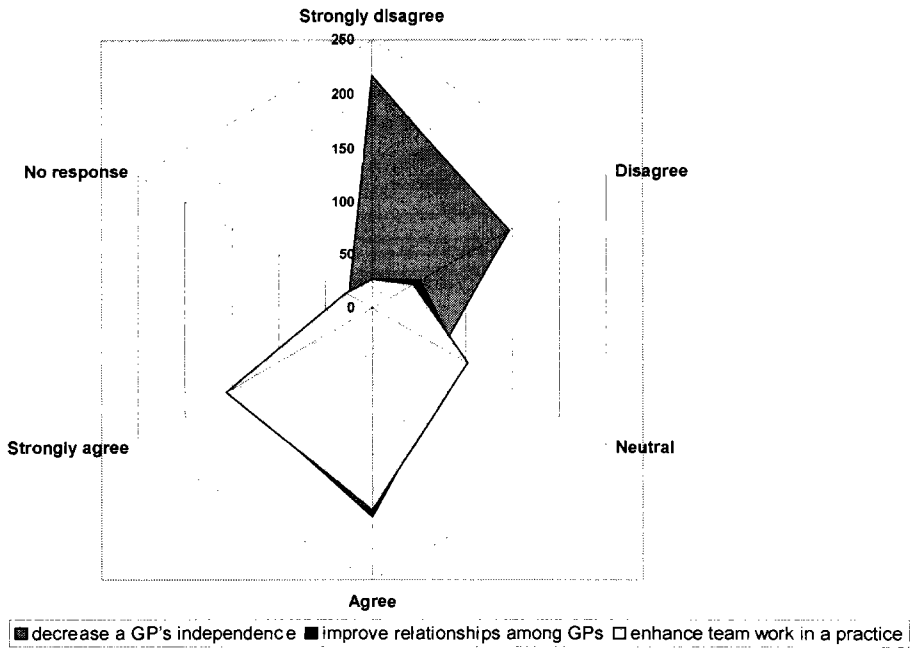


Figure 6: Perceived influences of price setting on a GP's independence, working relationships and the teamwork in a practice.



8. Conclusion

8.1 The findings of the 2007 PSS support the RACGP application to the ACCC for revocation and substitution of the 2002 ACCC authorisation. The authorisation provides coverage to a significant proportion of GPs. Thus, 81% of GPs (N=409) in the sample currently agree on a single set of fees with other GPs in their practices, further 2% of GPs wanting to be able to (2%) or planning to (1%) agree on a single set of fees.

8.2 One of the characteristics of general practice is the diversity of business models being used around Australia. These include incorporated companies with more than one shareholder or director, corporate GP services, unit trusts, partnerships, associateships, and business models combining two or more of the above practice structures with a range of working and contractual arrangements among practice owners and other GPs.

The findings of the 2007 PSS indicate, that

- both the diversity and complexity of business models used by GPs continue to grow
- the associateships continue to be one of the most commonly used medical business structures in Australia

While revocation and substitution of the ACCC authorisation is important for GPs (and OMPs) working under various business arrangements, it is particularly crucial for those in associateships that represent a substantial number of medical workforce. Possible inability of GPs in one practice to agree on a single set of fees would be detrimental to a significant proportion of Australian general practice workforce.

8.3 The findings of the 2007 PSS indicate, that GPs believe that the proposed arrangements to enable GPs in one practice to agree on a single set of fees would be beneficial to good teamwork. The trend toward team-based models of general practice has continued since 2002, when the RACGP was granted its first authorisation. This trend is supported by many initiatives introduced by the Australian Government. Teamwork is central to developing the culture of open communication in general practice which, in turn, brings about enhanced patient safety, increased morale, job satisfaction and efficiency among GPs[2].

8.4 In the 2007 PSS, GPs tend to believe that the proposed arrangements brings benefits to patients through enhanced quality and safety of patient care and improved 'continuity' of care. This is important in the context of encouraging all Australians to have 'their' GP[3].

8.5 In the 2007 PSS a significant proportion of GPs expressed an opinion that ability of GPs to agree on a single set of fees in a practice does not case fees to rise. This demonstrates, that there is no detriment to patient access to GPs due to price setting activities in general practice.

The RACGP concludes that from GPs (and OMPs) perspective public benefits the public and/or GPs (and OMPs) that occurs as a result of agreeing to set control or maintain fees within a practice exceed possible detriments. The RACGP concludes that in the context of existing business models in general practice the authorisation that it requests brings benefits for both patients and GPs by promoting a culture of safety, quality and teamwork while preventing the costs and risks of further fragmentation of care.

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[1] Australian Bureau of Statistics, Private Medical Practices, Australia, 2001-02 (8685.0) <http://www.abs.gov.au/AUSSTATS/abs@.nsf/ProductsbyCatalogue/1220099A83B33568CA2568A90013933D?OpenDocument

[2] Sexton JB, Thomas EJ, Helmreich RL. Error, stress, and teamwork in medicine and aviation: cross sectional surveys. BMJ, 2000:320:745-9.

[3] Robers, R; Snape, P and Burke, K, (2004), "Task Force Report 5. Report of the Task Force on Family Medicine's Role in Shaping the Future Health Care Delivery System", *Annals of Family Medicine*, volume 2; supplement 1, March/April: s88 – s99.