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To:	Isabelle Arnaud	From:	VHIA
Company:	ACCC	Pages:	8
Fax No:	02 6243 1199	Date:	26/02/08
Re:	RDAA		

Message

Submission Attached

Ignace [signature]

AUST. COMPETITION & CONSUMER COMMISSION CANBERRA
27 FEB 2008

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26 February 2008

Ms. Isabelle Arnaud
Director
Adjudication Branch
Australian Competition &
Consumer Commission
GPO Box 3131
Canberra ACT 2601

Fax: (02) 6243 1199

Dear Ms. Arnaud

Re: <u>Application for authorization A91078</u>

The VHIA is disappointed that the process the ACCC has adopted in this case appears to rely on the parties to ensure that they are kept informed.

It seems that there is reliance by the ACCC that placing submissions on the public record is sufficient to ensure that the relevant parties are informed kept up to date. The effectiveness of this approach depends on a number of issues which include promptness by the ACCC to place submissions on the public record, and the parties checking the public record frequently.

The RDAA's submission in reply to submissions dated 14 February was not brought to our attention until we revisited your Website on 22 February 2008.

Response to RDAA submissions:

1. The response by the RDAA to the submissions indicates the lack of substance in the original application for authorisation by the RDAA. As stated in our submission, not only did the application lack detail in all relevant areas, but this response to submissions made is being used as the primary submission. The RDAA is only now addressing issues which it should have addressed in the submission in chief. It has used various submissions from other parties to try and make its case.

2. The RDAA appears to be confused about the status of VMO GPs. In its response to the ACCC, it talks about "employed doctors". In Victoria, the majority of VMO GPs are not employees but contractors. In addition, the RDAA does not require the ACCC's authority to negotiate on behalf of employed GPs. It appears that the RDAA is not aware of this fundamental difference. Further, the GPs have a union to negotiate on their behalf which is ASMOF. The RDAA would not be the appropriate vehicle in relation to employed VMO GPs.

3. The RDAA fails to understand the role of Hospitals and the Department in Victoria. The Hospitals are the Principals and are the Employer of staff. DHS does not employ or engage VMO GPs, nor would they have a role in this regard except relating to funding and labour force issues across the sector. This approach would create real issues around the governance of health services and would contribute to a break down in responsibilities and accountabilities of health services.

4. As stated above, the Health Services are incorporated entities pursuant to the Health Services Act. The suggestion by the RDAA to compel health services to purchase particular goods and services akin to HPV is a complete nonsense. HPV role and function is not related to medical or allied health services. It has no role in this area, nor would it want to bypass the current governance structures in place by assuming a much wider role and function. It is a matter for the public record that Victorian has the most efficient health services in the Commonwealth. In large part this is because of its governance structures. The RDAA's attempt to dismantle these systems, albeit in part, is totally counter productive. For the record, there is but one Health Service that supports the RDAA's application.

5. The RDAA admits that the result of a common schedule will mean higher and some lower fees for medical services in Victoria. The VHIA submits that the result will be a substantial increase in the cost of services across the board, and this has been detailed in our initial submission. The assertion by the RDAA that such cost increases will be insignificant indicates that the RDAA is simply not across the facts. Moreover, it has not established that an increase in costs will aid and abet the recruitment and retention of staff. Again, this is simply an assertion. The current flexibility where rural health services purchase their medical services from GP VMOs by striking their own agreement on fees is precisely the most flexible method and responds to market needs. A common schedule of fees fails to account for differences in the market.

6. The "Lochtenberg" arrangements of sessional or fractional VMOs are well known to be more cost effective then fee for service arrangements. In fact, as stated in the VHIA's prior submission, the AMA's application in the case of Latrobe Regional Hospital and the Mercy Hospital Werribee clearly stated that fee for service arrangements were on the average three times more costly than payments made on fractional arrangements. That is, VMO's prefer the "fee for service" arrangement in most cases as it results in greater income. The RDAA simply asserts that the FFS arrangement is the most appropriate method for the payment of services that may be

provided on an ad hoc basis. This again, shows a lack of understanding of the primary work of VMO GPs. Most of the services supplied are not ad-hoc. In fact, most of the services will be consultations, obstetric, minor surgery and anaesthetic services. These are no more ad-hoc then any other medical services supplied to rural health services.

7. It is difficult to understand the assertion by the RDAA that "many negotiations in Victoria have worsened" the relationship between doctors and the Hospital. The RDAA further asserts that they are aware of many instances of such a break down in relationships. The RDA (Vic.) is a minor party in the negotiations between health services and GPs. The main player is the AMA (Vic.). The RDA (Vic.) is unable to support a major effort in this area as is indicated by their use of fellow GPs and committee members of the RDA (Vic.) in such negotiations. The VHIA would probably negotiate the vast majority of agreements on behalf of various health services. It is only aware of one instance of a break down in the relationship and one other instance where a partial service was supplied by the VMO GPs to the health service. The animosity – if any – is not a result of negotiations in any event, but of past history and an unwillingness to deliver or provide after hour services by GP VMOs.

8. The RDAA's contention that "State markets are essentially the same i.e. a GP VMO provides a medical service to public patients in a public hospital" is naïve in the extreme. The notion that the delivery of a service is the same as a "market" is incomprehensible. This type of assertion is such that it taints the whole submission of the RDAA as fundamentally misconstrued.

9. It is simply incorrect for the RDAA to assert that the VMO Specialists in the case of Latrobe and the Mercy Hospitals are of the "fly in, fly out models", and that they are not residents. There will be some specialists that may travel to either of the Hospitals, but there are also many specialists that are resident in the general area of the Hospital. This is particularly the case in the Mercy – Werribee which in a real sense is part of greater Melbourne. In addition, there are little or no similarities between this application and that of the Royal Australian College of General Practice as asserted by the RDAA. That application by the College for authorisation was related to the circumstances when GPs may agree on patient fees.

10. The fact that there is a form of centralised contracting in other states is basically irrelevant to the application. The RDAA fails to understand and ignores the fact that there are multiple entities in Victoria all of whom enter into direct agreements with VMO GPs. In the other states, there is only

one entity that contracts with VMO GPs. Further, there is competition in the Victorian rural market, particularly where there is more than one provider. The major impact however in negotiating centrally and having one schedule of fees is that the fees will rise as opposed to there being different fees in different localities which is the result of past history that includes competition in the market. The effect of one common schedule must perforce mean that the highest common denominator will apply, which will have the effect of nullifying all contracts which pay less. The only flexibility available would be to pay more. This would further drive up prices.

11. The VHIA is in a direct position to assess the capacity of the RDAA state branches to perform this new function. The VHIA has direct experience with the RDA, as it is a player in this area, albeit insignificant. The experience or otherwise of the CEO of the RDAA is not a factor. It is presumed that he will not be engaged in negotiations, and hence his experience is not relevant.

12. The facts are that bulk-billing in accident and emergency patients in rural hospitals is not common. What happens is that some GPs bulk bill whereas others charge private fees. This is the case because in the majority of rural hospitals, the A&E patients are private patients and treated as such. They are not public patients for which the Hospital has responsibility. The billing of such A&E patients depends on the billing policy of the private practitioners or practice providing the service. A common fee schedule which is intended to include after hour services, will of necessity also move towards the highest common denominator and hence eliminate any bulk billing practices. The only exception to this will be those health services that might have a large itinerant patient through put in A&E which may result "bad debts". In that case, bulk billing would be an obvious, but not preferred response.

13. The RDAA by its assertion that the common schedule of fees will not flow on to Specialists totally disregards the facts. It indicates on the part of the RDAA an ignorance and a certain amount of naivety of the market for GP VMO services. It facts are that Specialist VMOs are often paid the same rates in terms of the percentage of the CMBS as are the GPs. Moreover, in most cases, VMO GPs are always paid at the Specialist rate for similar services they deliver. This would be the case for anaesthetic, obstetric and surgery services. The common fee schedule, which will no doubt be based on CMBS rates and ASA rates will perforce flow onto Specialist VMOs' contracts as a result of the relationship between the rates for GPs and Specialist VMOs.

14. The reference by the RDAA to the metropolitan market for specialists is totally and utterly irrelevant as Specialists in metropolitan health services are employed as sessional or fractional staff on "Lochtenberg" rates. In those cases where FFS applies, the flow on of the "common schedule" is inevitable.

15. The whole concept, as proposed by the RDAA, of DHS giving directions in matters such as fee structures and remuneration is unrealistic and an unwitting proposal to undermine effective governance structures in Victorian health services. As argued before, the system in place in Victoria is a delicate balance which maximises flexibility and autonomy as well as accountability, and a measure of community control together with central control. This system maybe at risk should the application by the RDAA be granted. It is also apparent that the RDAA intends for the common schedule to be "enforced" by central direction and control. This is apparent when they state that they have no intention to negotiate an "opt in, opt out" system. This is of serious concern and will remove all flexibility at the cost of services to the public.

16. The VHIA has dealt with the "evidence" in regard to the flow on effect of a common schedule to VMO Specialists. The evidence is straight forward in that the fees payable to both the VMO GP and the VMO Specialist are based on the same percentages of the CMBS in most cases and at most rural health services. The item numbers are clearly different, but the percentages are the same. A common fee schedule therefore will flow on to Specialists because of the connection that currently exists.

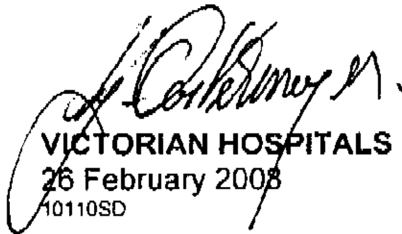
In conclusion therefore, this application should be refused. It lacks merit, it is full of assertions, it fails to deal with the issues of concerns and displays a fundamental lack of understanding of the market for medical services.

The submissions by the RDAA also lack significant detail. Even if the concept of a common fee schedule is a desirable outcome, the submissions in support by the RDAA have failed to make out a case. On that basis alone the ACCC should reject this application.

At the end of the day however, a common fee schedule is at odds with the manner in which the health services are governed in Victoria, particularly if this can only be achieved by central direction. The current governance structure in the health sector in Victoria is its major strength. To undermine this strength is to place the governance structure and hence productivity at risk.

The ACCC's task is to judge the RDAA's submission on the merits and in light of its legal obligations under the Trade Practices Act 1974. Its obligations relate to being satisfied that the public benefit from the arrangements proposed by the RDAA outweighs any public detriment.

It is submitted by the VHIA that in this case the "authorisation" should not be granted by the ACCC as the public detriment far outweighs any public benefit that may result. It will essentially permit or allow independent practitioners to get together and collectively agree on prices with the result that bulk billing will altogether disappear; cost of medical services to consumers will rise; and a flow to VMO Specialist medical services will result.



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26 February 2008
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