Our Ref: 280204
Your Ref: A91360

Kelly&Co.
LAWYERS

3 June 2013

BY EMAIL: David.Hatfield@accc.gov.au

Australian Competition & Consumer Commission
23 Marcus Clarke Street
CANBERRA ACT 2601

ATTENTION: Mr David Hatfield

Dear Sir

Australian Society of Ophthalmologists Inc Application for Authorisation - A91360

As you know, we act for the Australian Society of Ophthalmologists Inc (**ASO**).

We refer to your email to this office of 17 May 2013, requesting further information from the ASO in connection with the abovementioned Application for Authorisation (**Application**).

Thank you for the opportunity to provide the ACCC with further information in connection with this matter. Our client's responses to your enquiries are set out below, with reference to the questions you have raised.

Terms defined in the Application and presented as defined terms in this correspondence bear the meaning ascribed to them in the Application.

Question 1: How the proposed benefits are likely to arise from the proposed conduct in the context of ophthalmology practices and evidence as to the significance of these benefits in that context. How the proposed benefits arise from ophthalmologists agreeing to set fees within a shared practice, as opposed to any benefits that might arise from the operation of a shared practice per se.

1. The ASO recognises that the cost of ophthalmological services and treatment are high, as they are with medical services (particularly specialised services) generally. The cost of ophthalmological services is driven, to a significant degree, by the cost of practising ophthalmology, which is one of the most expensive medical specialisations to practice. According to a report to the Medicare Schedule Review Board, as at December 2000, the cost of practising ophthalmology was the second highest of all types of medical practice (second only to radiation oncology). [1]

[1] Refer PricewaterhouseCoopers Report to the Medicare Schedule Review Board, volume 1, accessible via http://www.health.gov.au/internet/main/publishing.nsf/Content/health-rvs-overview.htm which formed part of a

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2. The Australian Medical Association (**AMA**) defines "informed financial consent" (**IFC**) as *"the dialogue undertaken between a doctor or his/her representative and a patient so that the patient understands:*

   2.1 the potential fee for the medical procedure,

   2.2 the potential fee associated with other medical providers involved in the procedure, including anaesthetists and assistant surgeons, and

   2.3 the potential rebate for the services from Medicare and / or the patient's private health insurer. As a consequence of this dialogue, the patient would be expected to have an estimate in writing of what his or her out of pocket costs might be, subject to variations in fee estimates due to unforeseen circumstances."[2]

3. The AMA strongly encourages practitioners to adhere to certain IFC principles and, as a minimum, provide patients with written information about fees and charges and obtain a signed acknowledgment and consent to those fees and charges.[3] The AMA strongly encourages practitioners to provide such costs disclosure in respect of each practitioner who may be involved in treating a patient. Hence, when a patient visits a shared practice from which he or she may receive treatment from a number of different practitioners, the shared practice ought to provide IFC in respect of various practitioners.

4. IFC occurs on two levels:

   4.1 At the referral stage. The majority of patients are referred to ophthalmologists by general medical practitioners (**GPs**) or optometrists. We are instructed that it is customary for the patient referrer to make enquiries as to the fees charged by the ophthalmologist to whom a patient is being referred. As things stand, the fees charged by ophthalmologists practising in shared practice tend to vary from one practitioner to the next. Furthermore, where practitioners set their fees individually, the referrer will not necessarily know when fee increases/variations occur from one practitioner to the next. Accordingly, shared practices tend to receive a large number of fee-related enquiries. As a matter of course, a referrer will generally make a fresh fee-enquiry for each new patient referral.

   4.2 At the shared practice itself. As already noted, the AMA encourages ophthalmologists to provide upfront cost disclosure and obtain each patient's formal written consent, as part of the IFC process.

5. At present, ophthalmologists are not subject to mandatory IFC obligations. However, threats have been made to impose mandatory requirements if the AMA's efforts to encourage IFC to be obtained as a matter of course are not effective enough. [4] We are instructed that IFC is obtained as a matter of course by the vast majority of ophthalmologists and that it is rare for it not to be obtained – for example, in emergency

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Relative Value Study designed by the Australian Medical Association and the Commonwealth Department of Health and Ageing.

[2] AMA Position Statement – Informed Financial Consent, 2006. Available at: https://ama.com.au/position-statement/informed-financial-consent-2006

[3] AMA Position Statement – Informed Financial Consent, 2006 [3.1.1].

[4] Refer, for example to speech notes of the then Minister for Health and Ageing, Tony Abbott MHR, accessible here: http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2006-ta-abbsp160506.htm?OpenDocument&yr=2006&mth=05.

situations. Our client is unaware of any ophthalmologists practising in shared practice who choose not to obtain IFC as a matter of course. Any such practitioners would therefore be in a very small minority (to the extent they may exist at all).

6. The Proposed Conduct seeks to promote efficiency and reduce the cost associated with practising ophthalmology in shared practice in various ways.

7. Presently, a patient attending at a shared practice will be presented with a range of practitioners, who will tend to charge different fees. In other words, patients tend to only know what their treating practitioner charges.

8. It is common for situations to arise in which patients will benefit from being able to see a practitioner other than their usual practitioner/the practitioner to whom they have been referred. For instance:

   8.1 the practitioner may be unable to see the patient for some time because their appointments are booked out;

   8.2 the situation may be an emergency and the usual treating practitioner may be unavailable;

   8.3 the practitioner may be unwell;

   8.4 the practitioner may be on leave;

   8.5 the practitioner may have other personal or professional commitments, such that they are unable to see the patient as quickly as the patient requires, or would like.

9. In these situations, the patient will benefit from being able to see an alternate practitioner, in a streamlined and efficient way. The Proposed Conduct promotes efficiency because:

   9.1 It simplifies the IFC process. For instance:

      9.1.1 it will eliminate the need for (or greatly reduce the frequency in which) patient referrers enquire about the fees charged by practitioners in a shared practice. This will be made possible because patient referrers will be able to obtain simple and consolidated cost information from a shared practice;

      9.1.2 the IFC provided at shared practices will be much more simplified.

   9.2 It will remove a cost-related barrier to cross-referral – this can be manifested by customer concern about seeing another practitioner because they do not know what cost that will involve.

10. The Proposed Conduct therefore seeks to:

   10.1 facilitate a greater degree of cross-referral of patients between ophthalmologists practising in "shared practice". In our submission, a greater degree of cross-referrals would reflect a stronger "teamwork culture" and a greater degree of collaboration between practitioners;

10.2 generate administrative efficiencies – administrative staff will not have to spend time addressing issues associated with price differences.

11. As indicated in paragraph 14 of Schedule 1 to the Application, shared practice is an increasingly common means for practising ophthalmology. It is trite to note that, shared practice offers certain distinct advantages – for instance, as practitioner numbers grow, the pool of expertise available to patients grows, as does the range of services. Hence, steps that are taken to provide shared practice will, in our submission, facilitate the availability of a greater range of ophthalmology services to meet demand.

12. The Proposed Conduct allows ophthalmologists practising in shared practice to agree to fix fees. It is self-evident that this will facilitate certainty, consistency and predictability of price of ophthalmic care in those shared practices.

Trend toward sub-specialisation

13. As has already been indicated, ophthalmologists are increasingly opting to practice in shared practice. There is also a trend towards sub-specialisation within shared practices. Examples of sub-specialisations include:

13.1 Corneal surgery.

13.2 Vitreoretinal surgery ophthalmology.

13.3 Medical retinal specialist.

13.4 Glaucoma.

13.5 Neuro-ophthalmology.

13.6 Ocular oncology.

13.7 Ophthalmic pathology.

13.8 Pediatric ophthalmology/Strabismus (mis-alignment of the eyes).

13.9 Ocular inflammatory disease.

13.10 Oculo Plastic surgery.

14. The trend towards sub-specialisation in shared practice is attributable to:

14.1 The significant increase in detailed knowledge of very specific sub speciality areas. This means that now because of this level of information on treatments/conditions available a specialist, can only give this level of treatment if he/she concentrates on a very small area of the total scope of eye diseases and treatments.

14.2 The cost of sub-specialised practice. The burden of such costs can be shared in shared practice.

14.3 The increasing compliance burden of specialisation tends to encourage practitioners to narrow their professional focus.

14.4 The ability for ophthalmologists to refer patients to sub-specialists within the same shared practice.

15. The Proposed Conduct will facilitate the sorts of benefits that have been identified in connection with shared practice generally, in connection with sub-specialists practising in shared practice as well.

16. We trust that the further information set out above assists your understanding of how the Proposed Conduct will result in:

16.1 Improved quality of ophthalmology services through a promotion of teamwork culture and collaboration between specialists.

16.2 Continuity and availability of patient services - Cross referral allows continuity of care – ie, if a treating practitioner is not available, a customer may be more likely to use the services of another practitioner if they know they will be charged the same price for the service. Further, the co-operative arrangement will encourage shared responsibility for ensuing the quality of patient care is maintained.

16.3 Range of ophthalmology services to meet demand.

16.4 Certainty and predictability of price of ophthalmic care.

16.5 Efficiency in providing ophthalmology services.

Further Benefits - New Technology

17. There are a number of treatment processes and systems that have been and are continuing to be developed to facilitate ophthalmological treatment via new electronic/telephonic means. For example, the ASO is presently involved with an initiative which aims to deliver eye health services to people living in remote parts of Australia. This is being pursued by the ASO through its Indigenous and Remote Eye Health Service (**IRIS**), which is a leading agency in providing many Australians with access to high quality eye services. The IRIS is presently providing ophthalmological services to people living on Torres Strait Island and remote parts of Western Australia through an initiative with the CSIRO, which allows for treatment to be provided remotely through the use of new technology. Such technology requires a seamless approach to fee setting, regardless of the number of different practitioners involved.

18. If practitioners were available to provide treatment via such means on some sort of a roster basis, then patients would find themselves faced with the prospect of paying a variety of fees, depending on who was rostered to work on a particular shift.

19. The Proposed Conduct will help shared practices take advantage of such technology as efficiently as possible, by simplifying the IFC process and providing certainty as to price to patients. If a common fee is charged for services/treatment provided by remote means, there will be no need for multiple cost disclosures to be made, depending on who the treating practitioner is. This may be of particular value in emergency situations.

20. The sorts of new technologies we have described create the opportunity for patients to be able to access the most competent or most expert doctor without delay, regardless of time, place or the circumstances of the illness or injury. The Proposed Conduct will help to facilitate this because it will streamline the IFC process/steps required to obtain IFC.

Question 2: During the same conversation, ACCC staff raised concerns regarding the definition of shared practices set out in the application. For the ACCC to consider granting authorisation for fee setting in shared practices, the definition of what constitutes a shared practice would need to be clear. The current definition is not sufficiently objective to provide clarity as to whether any particular practice is a shared practice or not. As noted above, while the ACCC has previously considered other authorisation applications relating to shared practices, it is necessary for each application to clearly define the meaning of this term as relevant to the particular industry/medical area in question. Please consider providing a refined definition which clarifies precisely what is to be considered a shared practice for the purposes of the application.

21. To clarify, for the purposes of the Application, shared practices cover the following business structures:

21.1 a partnership of two or more ophthalmologists; or

21.2 an associateship of two or more ophthalmologists:

21.2.1 who are co-located or operate as a branch practice; and

21.2.2 which has a common service entity, in which each of the ophthalmologists must either have an interest; have contracted with the service entity; or be employed or otherwise engaged by the service entity to provide ophthalmology services on the service entity's behalf; and

21.2.3 the service entity is responsible for managing and/or maintaining a common reception, common fee collection, common bank account, common trading name, common medical records and, except for branch practices, common policy and procedures.

Question 3: Further, the ACCC would appreciate clarification around the kind of agreements any authorisation, if granted, would apply to. Specifically, are ophthalmologists in shared practices expected to agree on a single, common price for particular services, or is a common fee schedule expected to be agreed upon in which the expertise and experience of each practitioner may be recognised by different fee levels for the same services?

22. Ophthalmologists in shared practices are expected to implement uniform consultation fees for the most commonly utilised item numbers covered by the Medicare Benefits Schedule (**MBS**) - Items 104 (Initial Consultation) and 105 (Follow Up Consultation). It is expected that the same fees will be charged for such items, regardless of the practitioners' age and experience.

23. However, it is expected that exceptions will be made for fees charged by certain sub-specialists, such as those associated with neuro ophthalmic consultations or paediatric consultations, which would be expected to be set at a higher professional fee.

24. Furthermore, it is expected that there will be discounts applicable to pensioners, who will enjoy uniformly discounted fees.

Question 4: Information regarding the number of ophthalmology practices in Australia, specifically:

(a) the number of ophthalmology practices in each regional and metropolitan area;

(b) the number of shared practices, in each regional and metropolitan area;

(c) the number of ophthalmology practitioners in each sub-speciality in each regional and metropolitan area; and

(d) how many practices are likely to be affected by the proposed conduct.

The number of ophthalmology practices in each regional and metropolitan area

25. We are instructed that, overall, 42% of ophthalmologists practice in rural and regional Australia. We are unfortunately unable to break down numbers on a state by state basis.

The number of shared practices, in each regional and metropolitan area

26. Approximately 50% of ophthalmologists practice within a group setting, overwhelmingly as associates, rather than as true partners (with an equity stake in the practice).

The number of ophthalmology practitioners in each sub-speciality in each regional and metropolitan area

27. Approximately 85 – 90% of ophthalmologists practice as general ophthalmologists, with the remaining 10 – 15% practising exclusively in a sub-specialty.

28. We are unable to provide a break-down of this data by metropolitan and regional areas. However, we are instructed that the vast majority of sub-specialty practice only exists within major CBD precincts. This is because sub-specialty practices are only able to enjoy a sufficiently large referral base to remain economically viable in major CBD precincts.

How many practices are likely to be affected by the proposed conduct

29. The ASO estimates that 50% of ophthalmologists practise in shared practice.

30. As the Proposed Conduct is voluntary, the ASO is unable to predict how many of those shared practices would adopt uniform fees.

Question 5: Finally, I note at para 36.4.2 of Schedule 1 to the application, the ASO states that ophthalmologists in shared practices may practice in conjunction with other ophthalmologists "charging separately in accordance with agreed fee schedule". Can you please explain the nature of the fee schedule referred to here and how it is used in the setting of fees by ophthalmologists. Can you please provide a copy of the fee schedule referred to.

31. By way of clarification, the reference to an "agreed fee schedule" was not intended to refer to a practice of fixing fees within a practice in the manner sought by the Proposed

Conduct. Rather, it was a reference to the practice of shared practices to provide cost disclosure to their clients for each practitioner working in the shared practice. The word "agreed" was not intended to refer to an agreement between practitioners to charge certain fees. Rather, it refers to the practice of recording the fees charged by the various practitioners in shared practice and disclosing those fees to patients, who may, in due course, agree to obtain services for the fees specified.

Yours faithfully
KELLY & CO.

per:

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