Australian Competition and Consumer Commission

Second submission to the Inquiry into the impact of Part IV of the *Trade Practices Act 1974* on the retention and recruitment of medical practitioners in rural and regional Australia.

1 February 2002

EXECUTIVE SUMMARY

The Commission lodged its first submission containing background factual material to the Review Committee on 29 November 2001. This second submission addresses issues raised in submissions made to the Review Committee and after further information was requested by the Review Committee.

The Trade Practices Act does not contribute to the shortage of rural doctors

Recent literature shows that the desperate shortages in rural health can be attributed to a multitude of reasons, such as lifestyle, remuneration, lack of services, family issues, education for children, indemnity insurance, leaving social networks. In various submissions made to the Review Committee these issues are expanded upon in great detail. Submissions from the Rural Doctors Association of Australia (RDAA), the Rural Workforce Agency (RWAV) of Victoria, the Australian Medical Association (AMA) and the Australian Orthopaedic Association (AOA) are but a few. It appears that even these organisations, which claim to be concerned about the impact of the *Trade Practices Act 1974* (the Act) on rural and regional doctors, consider the primary reasons for the lack of rural doctors lie elsewhere.

In any event, the Commission considers that these groups have failed to make a case that the Act or application of the Act even marginally hinders the recruitment and retention of medical practitioners in rural and regional Australia.

In particular, the Commission is concerned that the AMA has, over an extended period, provided incorrect information to the medical community about the operation of the Act and particularly its impact on rural and regional doctors. Specifically, the AMA is continuing to assert that genuine rosters are a breach of the Act. As the Commission has stated repeatedly and publicly through press releases, public speeches, media comments and its draft GP guide to the Act, the purpose of a genuine roster is to ensure the availability of medical services from general practitioners after hours and on weekends. This is not a breach of the Act.

- The Trade Practices Act does not prevent country doctors taking a deserved and much-needed break from work while reaching an agreement with their colleagues to ensure that medical services continue to be available to their patients.

An exemption from the Trade Practices is not warranted

The AMA and other interest groups have called for an exemption from the Act because they believe the medical profession is different to other sectors in the community because doctors need to work collaboratively to ensure that the community receives the quality of service it expects.

Groups such as the AMA and the RDAA have failed to make the case for rural doctors to receive special treatment by being granted an exemption from the Act.

The Commission considers that if it is necessary for rural and regional doctors to engage in collaborative conduct which is also anti-competitive, then they may apply for "authorisation" in the same way as providers of any other good or service (e.g. pharmacists, dentists, physiotherapists, lawyers, accountants, etc) who wish to act together may do so to avoid the risk of breaching the Act.

- Authorisation is a process which enables persons who wish to engage in anti-competitive conduct to seek immunity from the Trade Practices Act where they can demonstrate to the Commission that the conduct is likely to be in the wider public interest.

Indeed, the Commission is currently considering a national application for authorisation from the Royal Australian College of General Practitioners (RACGP) to allow general practitioners to agree on fees where they operate within specified practice structures. Interim immunity has been granted to doctors while the Commission considers the merits of the RACGP's application.

Similarly, the Commission is considering an application for authorisation from the Royal Australasian College of Surgeons (RACS) for its processes for selecting, training and examining surgical trainees, accrediting surgical training posts and assessing overseas-trained surgeons. Again, interim immunity has been granted.

Moreover, if a broad statutory exemption were granted to rural and regional doctors, this would enable them to engage in anti-competitive conduct such as price-fixing and boycotts. For example, it would give them the ability to collectively agree to boycott bulk-billing; or to be in a position for all the different medical practices in a town to agree collectively on the fee to be charged by rural GPs in that town; or to agree to a collective boycott that would prevent no gap arrangements by private health insurers. Any conduct of this type has the potential to harm regional and rural patients who already have restricted access to other medical practitioners.

The authorisation process is effective

The AMA, RDAA and others have also criticised the authorisation process. Given that authorisation provides immunity from the law, the authorisation process is necessarily a thorough and rigorous one. Authorisation should not be a formality. Even the AMA's submission states that the authorisation process involves 'difficult assessments by the ACCC' and that 'the ACCC has a duty to consider applications in a detailed way'.

In particular, consultation with interested parties - which necessarily takes time - is important. Public consultation must be, by definition, an integral part of any process which aims to determine whether particular conduct is in the public interest. In addition, consultation is necessary to test applicants' arguments, as well as to allow detrimentally-affected parties to put their views to the Commission.

The AMA also claims that the test for obtaining authorisation places an impossible barrier on applicants. Yet, in the last three years the Commission has considered 39 applications for authorisation (excluding gas and electricity matters), granting 35 (89%) and denying 4 (11%).

Contrary to other claims by interested parties, the Commission has a long track record of accepting social public benefits in addition to economic public benefits; authorisations do provide certainty to applicants - they cannot be easily revoked; national authorisations are possible (e.g. the RACGP and RACS examples above); authorisation can be granted for conduct that has already commenced, although immunity only applies prospectively; and urgent requests for immunity can be accommodated by granting interim immunity (as granted to the RACGP and RACS).

The authorisation process remains a valuable and unique part of the Act. It has ensured that the Act is not a blunt instrument against anti-competitive conduct by making the public interest the paramount concern. Further, the Commission is always open to constructive input about how it conducts the process.

The Commission does not commence legal proceedings without due cause

The Commission does not decide to take action against an individual or a business without due regard to the facts, evidence, in some cases expert advice and of course, legal advice. In launching legal proceedings the Commission bears the onus of satisfying a Federal Court judge through admissible evidence that there has in fact been a breach of the law.

The Commission is ready to work with medical practitioners in rural and regional areas

The Commission is happy to work with medical practitioners and their representative associations in developing further open lines of communication to facilitate ongoing information flows. In order to accommodate the increasing need for information to reach rural and regional areas, the Commission has established a Rural and Regional Program. The Program's primary strategy is the development of communication and education outreach in rural and regional areas throughout Australia.

1. INTRODUCTION

The Australian Competition and Consumer Commission (the Commission) lodged its first submission to the Review Committee on 29 November 2001. That first submission contained background factual material outlining the role of the Commission, the application of the *Trade Practices Act 1974* (the Act) and the Commission's past and current work in the medical sector.

This second submission addresses the relevant issues raised in relation to the recruitment and retention of medical practitioners in rural and regional areas in response to submissions made to the Review Committee and after further information was requested by the Review Committee.

The Commission is concerned that there is a perception that the Act and the Commission's administration of that Act is having an adverse impact on the retention and recruitment of medical practitioners in rural and regional areas. The reality is that, in the past five years[1] the Commission has taken court action against medical practitioners and their associations in only **two** instances: the Australian Society of Anaesthetists (ASA) for price fixing and anti-competitive agreements; and the Australian Medical Association of Western Australia (AMA(WA)) and Mayne Nickless for price fixing and other anti-competitive conduct. To date, there has been no evidence forthcoming that the Act is having an adverse impact in rural and regional areas.

The Commission is concerned that some information being promulgated by the Australian Medical Association (AMA) is incorrect and misleading. In media releases, radio and television interviews with AMA representatives, information such as that rosters are a breach of the Act is disseminated to medical practitioners. This is not correct. **The Commission has no (and never had any) concerns about genuine rosters, which do not constitute a breach of the Act.**[2] There has been a misinformation campaign conducted by bodies such as the AMA and more recently the Rural Doctors Association of Queensland (RDAQ)[3] promoting this type of information.

The criticism of the Act has also involved allegations that the authorisation process is not effective and does not provide an adequate mechanism to account for authorisation of conduct that is potentially anti-competitive but has public benefits. The Commission disputes this criticism. The authorisation process is an extremely effective mechanism that allows certain

---

[1] Since the Act was extended in 1996 to cover all unincorporated businesses. From 1974 until 1996, the Act applied in part to the medical profession, that is, to practitioners in the Australian Capital Territory and the Northern Territory (for at least much of the period) and it also applied to incorporated medical practitioners. Under legislation introduced as part of National Competition Policy, the application of Part IV of the Act was extended in 1996 to non-incorporated businesses including medical practitioners operating under such arrangements.

[2] This issue is dealt with in more detail in the Commission's publication, *General practitioners: A guide to the Trade Practices Act*, March 2001, p.11.

[3] Kevin Meade, *Fee Ruling 'Will Deter Rural GPs'*, The Australian, Tuesday 29 January 2002, p.3.

anti-competitive conduct to occur if it can be demonstrated that there is net public benefit in doing so.

2. RECRUITMENT AND RETENTION IN RURAL AND REGIONAL AUSTRALIA

Recent literature shows that the desperate shortages in rural health can be attributed to a multitude of reasons, such as lifestyle, remuneration, lack of services, family issues, education for children, indemnity insurance, leaving social networks. In various submissions made to the Review Committee these issues are expanded upon in great detail. Submissions from the Rural Doctors Association of Australia (RDAA), the Rural Workforce Agency of Victoria (RWAV), the AMA and the Australian Orthopaedic Association (AOA), are but a few[4].

In fact, even in the AMA's own Policy Statement on Rural and Remote Health[5], which is currently available on the AMA's website, the AMA recognises the myriad issues that are facing rural and regional areas. The four core issues proposed by the AMA are the need for improved education and training, greater local community support, increased incentives and better work conditions (clinical and financial). In this policy statement, the Commission is mentioned once in the context of a need for scrutiny and the current inquiry into the impact of the Act and two examples were given. Firstly, the AMA cites the example 'where it [the Commission] deems collaboration on service delivery matters, such as rostering, to be illegal' and, secondly, where 'There is also the requirement to settle the law in regard to the treatment of private patients in a public hospital'.

The AMA then goes on to say in its Policy Statement that other government policies (besides the Commission), information and communication technology and funds-pooling/budget-holding are all important issues that need to be addressed in order to attract and retain doctors (both GPs and specialists) in rural and regional areas. The AMA's Policy Statement is at **Attachment A**. The Commission agrees with the AMA that there are a multitude of issues to be addressed and therefore the Commission finds it curious, in light of the call for the inquiry into the Act by the AMA and the media surrounding the AMA's statements, that the AMA's reference to the Commission in its Policy Statement on Rural and Remote Health is minor and still uses the example of rosters which do not constitute a breach.

The Commission believes that the Act exists to protect consumers and practitioners from anti-competitive conduct. It does not hinder the recruitment and retention of medical practitioners in rural and regional Australia.

2.1 Submissions to the inquiry

[4] It should be noted that the Commission has had access to only some of the submissions made to the Review Committee due to the confidentiality requirement. Those that it has had access to and that are mentioned in this submission are those that were released publicly as at 18 January 2001.

[5] AMA, *Position Statement on Rural and Remote Health*, Prue Power, Director General Practice and eHealth., available at www.ama.com.au.

The Commission has perused those submissions made to the inquiry that have been publicly available. It is the Commission's view that most of the points made by the various interested parties, while very pertinent and important points, do not provide evidence that the Act or the administration of the Act by the Commission is hindering the recruitment and retention of medical practitioners in rural and regional Australia. Despite repeated calls for such evidence, the response has been simply further unsubstantiated assertions.

3. APPLICATION OF TRADE PRACTICES ACT TO DOCTORS

As foreshadowed in the Commission's first submission to the Review Committee, the Act exists to protect the rights of consumers as well as businesses such as medical practitioners.

The Act protects medical practitioners from having their ability to practise restricted, prevented or damaged by other practitioners for anti-competitive reasons. It allows medical practitioners to make their own choices about their practice without fear of boycott from colleagues. The Act also protects a medical practitioner's right to have access to facilities on their own merit, such as access to hospitals. Independent practitioners are also protected by the Act in their dealing with stronger parties. If anti-competitive conduct is not being engaged in and the market is working effectively, this has flow-on benefits for the communities generally. The Act also benefits doctors if a competitive environment is fostered in other areas.

3.1 Claims about the Act and the Commission

The AMA on several occasions has made claims about the ineffectiveness of Act and the Commission.

Claim

On several occasions, Dr Kerryn Phelps, President of the AMA, has referred to the Act and the Commission as not being in line with common sense. For example, Dr Phelps stated that:

> Australians are a common sense people. In 21st century Australia, the Trade Practices Act 1974 leads to a range of unintended consequences for the health sector that are not common sense[6].

and the only example she gave was a hypothetical scenario put to the Commission and reported in its *General practitioners: A guide to the Trade Practices Act* (GP Guide) in relation to obstetrics:

> say that there were a group of three GPs who perform obstetrics in a local country hospital, and they decide that they can't afford to continue to all continue to provide obstetric services. And so they say 'well, one of us will continue to pay our medical indemnity insurance and continue to deliver babies at the local hospital'. Now, the ACCC said that that is a primary boycott and those doctors would be facing massive fines if they came to that arrangement between them. Now, that's the sort of thing that

[6] Dr Kerryn Phelps, *Speech to the AMA(WA) Health Symposium 2001 – Competition Laws and Principles*, Perth, 14 May 2001.

> is pushing obstetrics out of the country, and we cannot tolerate that continuing, because the Australian public are missing out on services[7].

Response

In its analysis of this example the Commission stated in its GP Guide that:

> …the Commission can authorise such an agreement if it can be shown that the conduct results in a benefit to the public such that the conduct should be allowed to occur. On the facts provided, the public benefit of such an agreement would ensure obstetric services would remain in an area where they would otherwise be withdrawn. There is obviously great public benefit in ensuring obstetric services are provided in country areas[8]

The Commission was approached by the Australian Division of General Practice (ADGP) about this issue and the possibility of lodging an application for authorisation. The Commission had numerous discussions with the ADGP in that regard. The ADGP eventually did not proceed with the application for authorisation. The Commission understands that in fact doctors were not intending to engage in the conduct and therefore there was no need to apply for authorisation.

Should doctors still wish to enter into such arrangements, the Commission has stated publicly as indicated above that it could recognise that ensuring the provision of obstetric services in rural areas would constitute public benefit.

Claim

Dr Kerryn Phelps was reported as saying that:

> people worked under constant fear that they will be persecuted and prosecuted for doing what is necessary to provide vital services

and that,

> Faced with Australian Competition and Consumer Commission investigation and huge fines for looking after their patients, country doctors have no choice but to consider leaving town or leaving the profession[9].

Response

If Dr Phelps is quoted accurately, the Commission reiterates that it has not to date, seen any evidence that medical practitioners are working "under constant fear" due to anything the Commission has done. The Commission appreciates that there is now a perception that the Act and the Commission is impacting on rural doctors. This is due to the misleading campaign from the AMA and does not reflect the reality of the Commission's action, in

[7] Dr Kerryn Phelps, Doorstop, AMA President, Parliament House, Canberra, 8 March 2001.
[8] ACCC, *General practitioners: A guide to the Trade Practices Act*, March 2001, p.15.
[9] Katharine Murphy, *Doctors fear persecution, AMA claims*, Australian Financial Review, Wednesday 12 December 2001, p.5

particular, the AMA continues to raise, wrongly, the issue of rosters. It may be true that medical practitioners are leaving town and/or the profession but this is not because of actual action by the Commission. If medical practitioners fear the Commission it is because there is a perception of fear generated by the AMA.

Again, the Commission extends to the AMA the invitation to provide such evidence.

3.2 Concerns of medical practitioners

It appears that medical practitioners believe the Act prevents them from engaging in conduct that they believe would benefit their practice. The types of arrangements that have been put to the Commission are after-hours fee setting, collective negotiations and boycotts.

After-hours fee setting

Under the Act, medical practitioners who participate in a roster system to offer after-hours care cannot agree on the fee they charge for their services unless they are operating under the one corporate structure, or as non-individually incorporated members of a partnership.

The AMA has raised this issue in its submission to the Review Committee stating that:

> the Commission has previously stated that it will take a robust view of enforcement of the boycott provisions of the TPA in the health industry...This is demonstrated by the Commission's approach to a group of anaesthetists who, in 1995, sought to put in place a roster to provide on-call cover for emergency obstetrics in a number of private hospitals [10].

The AMA failed to add that the Commission did not take action because there was a roster in place but rather took action under the price-fixing provision (the anaesthetists fixed a $25 per hour on call fee amongst themselves) and boycott provision of the Act (certain anaesthetists agreed collectively to withdraw their services from a private hospital unless the hospital agreed to pay that price for the supply of on call services). The Commission does not believe that price-fixing and boycotting are necessary elements of a medical practitioner's delivery of after hours medical services. Further, conduct such as price-fixing and boycotting are detrimental to patients and the community.

The AMA also stated that

> It is the AMA's view that it is completely unrealistic to expect doctors to establish a roster without some discussion of fees. The need to provide patients with up front advice on fees and to obtain informed financial consent actually requires that this be the case[11].

Doctors can provide information on their fees to patients without having to agree on that fee. The Commission is aware of instances where medical practitioners have set up after-hours

[10] AMA, *Submission to the Commonwealth Review of the Impact of the Trade Practices Act (1974) on the recruitment and retention of rural doctors*, December 2001, p.22.
[11] ibid., p.25.

services and patients are clearly informed, without any problems, that costs may differ between doctors and patients should check with the doctor before the consultation.

Should doctors wish to set common fees, they can do so lawfully by setting up an after-hours trading or management company or if they seek and are granted authorisation to do so. To obtain authorisation, doctors would have to demonstrate that there is a net public benefit in having a common fee for patients.

Not all interested parties agree with the AMA's position on this issue. The National Rural Health Alliance (NRHA) stated in its submission to the Review Committee that

> The Alliance is aware that entering into arrangements for co-operative provision of after-hours services is acceptable under the Trade Practices Act. It has seen no persuasive arguments that agreements on fee setting should be authorised as part of these inter-practice arrangements[12].

The AMA stated in its submission to the Review Committee that:

> In practical terms, rural and regional doctors need each other to physically provide these types of services, but a disparity in charges will mean that a roster will not hold together because of embarrassment with patients and other difficulties, despite initial goodwill between the participants. The AMA may be forced to advise doctors not to form rosters with other doctors who charge on a different fee basis. Under current application of the TPA the Commission objects to persons discontinuing rosters because of a falling out (say) over price[13].

This view is of great concern to the Commission. It is inaccurate to say that the Act prohibits doctors discontinuing rosters. If doctors discontinue a roster it is not in itself a breach of the Act, as doctors would simply decide individually whether and/or how each will supply after hours or weekend services. However, the Commission would be concerned if doctors collectively agreed to withdraw after-hours services. This would amount to a boycott. The Commission would also be very concerned if a group of doctors collectively agree to exclude another doctor from a roster because that doctor is charging less.

Collective negotiation

Competing practitioners cannot get together and agree on the price they will charge hospitals for their services. Negotiations regarding fees or allowances by groups of competing practitioners and/or their representative organisations with hospitals would be at risk of breaching the Act.

A hospital can consult or hold discussions with groups of practitioners and their representative organisations, and then choose to make its own independent decision about the terms and conditions for contracting practitioners. However, the group of practitioners with whom the hospital is consulting or holding discussions must ensure that they do not reach a

[12] National Rural Health Alliance (NRHA), *Submission to the Review of the Impact of the Trade Practices Act on the Recruitment and Retention of Doctors in Regional and Rural Australia*, December 2001, p.8.
[13] AMA Submission, op.cit., p.18.

collective agreement with each other on matters which may be anti-competitive such as the fees for the services they provide.

In its submission to the Review Committee, the NRHA represented both sides of the argument surrounding collective bargaining on medical contracts for public hospital services. Those of its members who oppose collective bargaining by doctors make the point that:

> Collective agreements will usually increase the price paid by health authorities for the services of doctors, and thus the cost to taxpayers[14].

The NRHA also stated that resolution of this issue should be made on the basis of the public interest as it relates to the consumers of health services[15]. This can be done within the Commission's authorisation process upon application by the parties if it can be shown the public benefit outweighs the detriment caused by the anti-competitive conduct. Representative organisations may also apply for authorisation on behalf of their members to enable negotiations to occur.

In the last 3 years the Commission has authorised six applications for authorisation to engage in collective negotiations and denied one application. Of the six authorised, one application was for rural hospitals to collectively negotiate with private health funds.

Boycotts

The Act prohibits two types of boycott: primary and secondary. Generally, any joint conduct by independent medical practitioners that has the purpose of excluding or limiting dealings with purchasers or patients may breach the Act. The Act prohibits collective boycotts but not individual boycotts. Any medical practitioner is free to individually decide whether or not to supply or withdraw his/her services. As stated by the AMA, the Commission takes a robust view of collective boycotts as such conduct is very detrimental to the patient.

The AMA stated in its submission to the Review Committee that:

> The AMA's position is that the application of the boycott provisions of the TPA to doctors' rosters in many circumstances, is a serious disincentive for doctors to work in country towns. This conduct should be the subject of an exemption for rural and regional doctors.[16]

Genuine rosters do not constitute a boycott therefore an exemption for this conduct is unnecessary. However, other conduct would constitute a boycott. That is, the AMA believes doctors should be allowed to boycott hospitals and other providers, for example, if a new doctor arrives in town the existing medical practitioners may threaten to collectively boycott the hospital if the new doctor is given admitting rights. The Commission believes this would reduce services which is very detrimental to patients.

[14]NRHA, op.cit., p.6.
[15]NRHA, op.cit., p.7.
[16]AMA Submission, op.cit., p.23.

The boycott provisions would cover the situation where medical practitioners agree on which specialist to refer patients to. In its submission to the Review Committee, the AMA stated that:

> doctors agree to refer all their patients to one specialist in order to provide the critical mass needed to induce that particular specialist to visit their area and service their patients…This conduct has no real anti-competitive effect…However, such an arrangement by the doctors not to deal with other specialists may constitute an unlawful primary boycott[17].

However, the Commission notes that others disagree. The NRHA stated that

> It is clear that doctors do from time to time make individual discretionary decisions about referral. The Alliance would be most concerned if such sensible and informal decisions were to be the subject of formal agreements because this is not the best way to ensure quality practice[18].

The Commission agrees with this statement by the NRHA that engaging in anti-competitive agreements is not the best way of addressing quality issues. An agreement to refer all patients to a particular specialist would affect the ability of other specialists to compete. If this agreement leads to a substantial lessening, preventing or hindering of competition between the specialists then it would be a breach of the Act. Referral of specialists can also be a breach of the third line forcing provisions of the Act. However, should there be public benefit in particular conduct, there is an authorisation process available.

4. FAIRNESS AND ACCOUNTABILITY

In its submission to the Review Committee, the AMA states that

> the AMA considers that most doctors would find an ACCC investigation extremely intimidating and threatening and many country doctors would seek work elsewhere rather than risk being subject to such a costly, damaging and one sided process. Similarly, any doctor considering moving to a rural community would be much less inclined to do so if he or she knew that the ACCC could take such heavy handed and costly action if he or she could be perceived to take a collective decision with other doctors that had some commercial aspect[19].

This is not an accurate description of how the Commission conducts its investigations.

Wider responsibilities, and growing public expectations of the Commission's ability to deliver, have underscored the importance of securing speedy resolution of matters – where possible without resort to litigation. The available "tools" in addition to litigation are varied – administrative settlement, adjudication, promotion of self-regulation, compliance programs, information and liaison.

Frequently the most appropriate response to a particular market problem is a combination of these tools in an integrated strategy.

[17]AMA Submission, op.cit., p.25.
[18]NRHA, op.cit., p.7.
[19]AMA Submission, op.cit., p.29.

In forming a view as to whether the Act has been breached, the Commission has a series of internal processes for decision making. The Commission does not decide to take action against an individual or a business without due regard to the facts, evidence, in some cases expert advice and of course, legal advice. It must be remembered that in launching legal proceedings the Commission bears the onus of satisfying a Federal Court judge through admissible evidence that there has in fact been a breach of the law.

The AMA stated in its submission that 'in the event that the ACCC decides to interrogate the doctor, he or she has very little legal protection'[20]. In her very own article in The Australian, Dr Phelps states that:

> Doctors have been brought in for interrogation by the ACCC and threatened with fines of up to $500,000 if they do not co-operate, yet they are not allowed to have their lawyers present. This is a denial of natural justice[21]

This is not correct. The Commission may decide during an investigation to use its s.155 power[22] to seek information if it has a reason to believe that there is a breach. As stated in the Commission's guide to s.155 of the Act, as a matter of procedural fairness, the Commission will permit an examinee the assistance of a legal adviser[23] (the Commission's guide to s.155 of the Act is at **Attachment B)**. It should also be noted that throughout any investigation, businesses are free to seek their own legal advice at any time.

Justice French stated in his judgment of the *Kotan Holdings* case that:

> The examination process undertaken when the Commission exercises its powers under s.155(1)(c) involves no determination by the Commission and beyond the exercise of the coercive power to require answers to questions does not affect the right of the examinee…The process is inquisitorial, not adversarial.[24]

While the Commission does not normally seek publicity during an investigation, the media are often interested and sometimes report on investigations they feel are of concern or interest to the public. However, the Commission usually issues a press release when the Commission institutes proceedings in court, when a court decision is made, or when the Commission obtains a court-enforceable undertaking. The Commission does not raise the issue in the press before it has talked to the business concerned.

5. AUTHORISATION

[20] ibid.
[21] Dr Kerryn Phelps, *Unhealthy approach to doctors*, The Australian, 29 December 2000, p.15.
[22] Section 155 of the Act gives the Commission the power to require a person to provide information, documents and/or give evidence under oath or by way of affirmation, and limited powers to enter premises and inspect and/or copy documents.
[23] Australian Competition and Consumer Commission, *Section 155 of the Trade Practices Act*, October 2000, p.16.
[24] *Kotan Holdings Pty Ltd and Big Rock Pty Ltd & Anor v Trade Practices Commission (1991) ATPR 41-123.*

A number of submissions to the Review Committee have argued that the authorisation process is not an appropriate mechanism to address possible breaches of the Act that may be in the public interest.

The Commission notes that the terms of reference of this review state that:

> In undertaking this Review the Review Committee should consider that competition policy recognises that there can be circumstances in which restrictions on competition may be justified where there are offsetting public benefits.

While a key objective of the Act is to prevent anti-competitive conduct, the Act also recognises that the public interest may not always be met by the operation of competitive markets. The authorisation processes in the Act address this eventuality by allowing the Commission to grant immunity from the application of almost all of the restrictive trade practices provisions of the Act in certain circumstances.

5.1 Authorisation Process

The authorisation process allows an independent body with expertise in competition and public benefit issues and with a mission to enhance the welfare of Australians (s. 2 of the Act) to assess in an informed, objective and transparent manner claims that anti-competitive conduct provides offsetting public benefits such as to justify granting immunity from the Act. The authorisation process is outlined in detail in the Commission's first submission to the Review Committee.

In order to grant immunity from the competitive conduct provisions of the Act the Commission must be satisfied that the conduct would, or would be likely to, result in a benefit to the public which outweighs the detriment to the public constituted by any lessening of competition resulting from the conduct.

The authorisation process is designed to establish whether or not this is the case. Given that authorisation provides immunity from the law – effectively a licence to engage in anti-competitive conduct – the authorisation process is necessarily a thorough and rigorous one, the onus being on the applicant to demonstrate that immunity is justified (as is required under the Act). The granting of immunity from the Act should not be a mere formality for those applying.

Consistent with this view, the AMA has stated in its submission to the Review Committee that the authorisation process involves:

> … difficult assessments by the ACCC in relation to the processing of each application. The applications must be assessed by the ACCC in each relevant market area. The competitive outcomes and relevant public benefits may vary quite considerably in different regions and towns. The ACCC has a duty to consider applications in a detailed way. Other persons and institutions affected by proposed conduct, particularly hospitals, are likely to comment and may oppose broad-brush applications.[25]

[25] AMA Submission, op.cit., p.31.

Further, authorisation decisions made by the Commission are reviewable by the Australian Competition Tribunal at the application of any interested party (including the applicant). A review by the Tribunal takes the form of a full reassessment of the merits of a matter. Authorisation decisions are also appealable to the Federal Court on administrative law grounds. It is therefore in the best interest of all parties that the Commission engages in a thorough consideration of applications in the first instance.

Given the different circumstances of each authorisation application – as recognised by the AMA – it is proper that the Commission consider applications on a case by case basis, assessing each one on its merits.

Further, applicants are expected to lodge a supporting submission with their application which, as well as providing details of the conduct, addresses the benefits to the public claimed to result or be likely to result from the conduct and how the public benefit might outweigh any anti-competitive detriment. This submission gives applicants an opportunity to put their case to the Commission, thereby ensuring them procedural fairness. Moreover, a thorough and comprehensive submission often allows the authorisation process to be expedited.

The Commission tests applicants' claims through an open, transparent, public consultation process which involves consulting with interested parties and those likely to be affected by the conduct including customers, competitors, suppliers, government bodies, consumer groups and trade organisations. It must be remembered that, while some anti-competitive conduct will be assessed to be, in all the circumstances, in the public benefit, there are invariably groups of consumers and small businesses that can be adversely affected by such conduct. It is again quite appropriate that the Commission be fully informed of the effects of anti competitive conduct where an applicant proposes that it be immune from legal action by any person, not only the Commission. Such consultation generally takes the form of inviting written submissions from interested parties in the first instance, and where necessary, supplementing this with further discussions.

Before determining an application for authorisation the Commission is required to issue a draft determination stating whether or not it proposes to grant authorisation to the conduct and summarising its reasons. The Commission aims to issue a draft determination within four months of receipt of an application, although the time period may be shortened / lengthened depending on the complexity of issues, the time taken for interested parties to respond to requests for information and the extent of opposition to the proposed conduct.

Once a draft determination is published the applicant and other interested parties are afforded the opportunity to meet with the Commission face to face to discuss the operation and effect of the draft determination at a pre-decision conference should the applicant or any interested party request a conference be held. Interested parties may also be afforded a further opportunity to provide submissions in response to the Commission's draft determination.

Following the conference, the Commission takes into account issues raised at the conference, and any related submissions, and issues a final determination. The Commission's final determination sets out its decision on whether to:

- Deny authorisation;
- Grant authorisation subject to conditions; or
- Grant authorisation unconditionally;

and states the reasons for its determination.

The Commission considers it in the best interest of all parties likely to be affected by any application for authorisation, and indeed the public generally, that the applicant's public benefit claims are thoroughly and transparently tested and the reasons for Commission's decisions publicly released.

The Commission would generally aim to issue a final determination within six months of receipt of an application. However, the timeframe may be longer or shorter than this depending on all the circumstances surrounding the application. The time the Commission takes is to a large extent dependent on information provided by the applicant and sought from interested parties. (The processes and timeframes for assessing applications along with examples of indicative applications considered are discussed in more detail in **Attachment C**). Given that both the issuing of a draft determination and the holding of a pre-decision conference (if requested) are required under the Act, the Commission is unable to avoid the time required to complete these steps. Having said that, seeking immunity to engage in conduct that is anti-competitive is a significant issue, and should not be engaged in without appropriate scrutiny and consultation.

In the last three years the Commission has considered 39 applications for authorisation, granting 35 (89%) and denying 4 (11%).[26] None of these decisions were appealed to the Tribunal.

The Commission also has the power to grant interim authorisation, at the time that an application is lodged or at a later stage, which provides immunity to parties to engage in the potentially anti-competitive arrangements while the Commission assesses the merits of the claims of public benefit. Before granting such immediate protection, the Commission generally requires an applicant to demonstrate that exceptional circumstances exist; for example, there is an urgent need for protection. In addition, the Commission usually requires that the market be able to return to its existing (ie. pre-interim authorisation) state if full authorisation was subsequently to be denied.

Interim authorisation has recently been granted in respect of the applications for authorisation by the Royal Australian College of General Practitioners (RACGP) and the Royal Australasian College of Surgeons (RACS). The granting of interim authorisation by the Commission has allowed the RACGP and RACS to continue to engage in the subject conduct as if they had

[26] These figures exclude authorisation applications relating specifically to the regulation of the gas and electricity industries.

authorisation, with full certainty that they are protected from legal action under the Act, not only from the Commission but also from third parties, while the substance of their applications are considered by the Commission.

The authorisation process is necessarily a thorough, rigorous process, given that what is being contemplated is immunity from the law. The most time consuming element of the process is consultation with interested parties. However, consultation is vital to the Commission gaining a full understanding of the nature of the conduct, the environment in which the conduct will occur and the likely consequences of the conduct on the markets in which it will occur. This process is also important in testing the veracity of the applicant's claims about the public benefits of arrangements. In the Commission's experience, applicants generally tend to emphasise the public benefits of their proposed conduct over any associated public detriment.

A significant amount of time in the Commission's assessment process is also taken up with following up details of the arrangements with applicants, and with providing the applicant with the opportunity to respond to issues raised by interested parties in the course of the Commission's consultation process.

5.2 Costs

The Commission notes that a number of submissions to this review have raised concerns about the cost of authorisation applications. Applications for authorisation carry a fee of $7,500 for an initial application ($15,000 for a mergers application) and $1,500 for additional related applications. These fees are prescribed in the Trade Practices Regulations and the Commission has no discretion to waive or vary them. However, the Commission has adopted a flexible practice by accepting a single application and fee where authorisation is sought for an industry wide set of similar arrangements. For example, the Commission is currently considering an application from the Australian Dairy Farmers Federation (ADFF) for dairy farmers throughout Australia to collectively negotiate with dairy processing companies. The Commission recently released a draft determination proposing to authorise these arrangements.[27]

The Commission also notes that between 1974 and 1977, when parties were able to apply to the Commission for clearance for certain conduct without a fee applying, the Commission received nearly 15,000 applications, the vast majority of which were for conduct which raised only marginal, if any, concerns under the Act (the clearance procedures are discussed in more detail in section 6.2).

Applicants may also incur expenses in preparing applications and submissions in support of applications. While some applicants choose to employ legal advisers, others lodge applications without legal assistance. Further, the Commission also makes itself available to assist applicants in formulating applications and identifying the sort of information the Commission would expect to be provided in supporting submissions. For example, the Commission understands that the ADFF application and supporting submission (as discussed

[27] *Australian Dairy Farmers Federation Limited*, draft determination, 2 October 2001.

above) were drafted by the ADFF without legal counsel, following consultation and guidance provided by the Commission. Similarly, the Commission recently assisted the RACGP in formulating its application for authorisation and provided assistance regarding the sort of information that would be expected in a supporting submission. Indeed, the RACGP recently wrote to the Commission expressing its

> gratitude to the Commission staff who have assisted the College with this activity by explaining the requirements of the Commission.[28]

The Commission is also proposing to undertake to update its November 1995 Guide to Authorisations and Notifications to make it more user friendly, provide more useful information on what the authorisation process entails, including a step by step check list of what to include in an application and supporting submission. The Commission proposes to consult broadly on the proposed new guide.

The RDAA has stated in its submission to the Review Committee that there should be modifications to the adversarial nature of the authorisation process. As stated above, the Act puts the onus on applicants for authorisation to satisfy the Commission that the public benefits of their proposed conduct outweigh any associated public detriment. Further, given that immunity from the Act is at stake, the Commission assesses applications for authorisation rigorously and thoroughly.

However, having said this, the Commission also endeavours to ensure that authorisations are progressed within a co-operative framework with applicants and all interested parties. As noted above, it is common for the Commission to meet with applicants in order to assist them in framing their applications and to provide details of the sorts of information required to assist the Commission in making its assessment. Commission staff will often meet with applicants a number of times during the course of an application. Where the Commission considers that an application is likely to be rejected, where possible it will include advice in its draft determination on how the applicant might amend the application to improve its chances of success. More generally, the Commission has adopted the practice of informing applicants, once an application is made, of a contact officer within the Commission who can provide advice on the progress of the application, answer particular queries and so on. Naturally, the Commission requires its staff to act professionally, courteously and fairly when dealing with applicants.

The RACGP recently stated that its experience in applying for interim authorisation:

> shows there are areas where you can deal with the ACCC if you take a reasonable approach and don't go in with all guns blazing. [29]

5.3 Misconceptions and inaccuracies

[28] Letter from the Royal Australian College of General Practitioners to the Commission dated 17 January 2002.
[29] Fred Brenchley, *In the Line of Fire*, The Bulletin, 29 January 2002, p.18

The Commission notes that a number of submissions to the Review Committee contain general misconceptions and factual inaccuracies in relation to the authorisation process. These are addressed below.

Misunderstanding: the authorisation process should consider broader (non-economic) public benefits

The RDAA submits that the authorisation process should consider the broader public interest rather the 'rigidly applied tenets of competition and strictly economic paradigms'[30].

While public benefit is not specifically defined under the Act, in *Queensland Co-operative Milling Association; Re Defiance Holdings Ltd (1976) ATRP 40-012* the Australian Competition Tribunal discussed it in the following terms:

> 'anything of value to the community generally, any contribution to the aims pursued by the society including as one of its principal elements (in the context of trade practices legislation) the achievement of the economic goals of efficiency and progress.'

Consistent with this approach, the Commission and Tribunal have in the past recognised a wide range of public benefits both economic and social. The Commission continues to apply this broad approach to the definition of public benefit. Any conduct which produces direct or indirect benefit to the Australian public constitutes a public benefit. Over the years, the Commission has granted authorisations taking into account a wide range of non-economic public benefits. As stated in the Commission's first submission to the Review Committee, examples of such non-economic public benefits taken into account in past authorisations include:

- environmental benefits such as the likely reduction in carbon, nitrous oxide and greenhouse gas emissions flowing from a joint venture's upgrading of a sodium cyanide plant in Gladstone, Queensland;[31]
- benefits from the provision of information on public health, namely encouraging the provision of information on formula feeding from public health professionals that is accurate and balanced and not undermining the decision of women to breastfeed (these public benefits were found to outweigh the detriment from restricting advertising and other promotional activities in relation to infant formula);[32]
- promoting public safety by:
    - ensuring the safe use of farm chemicals and national uniformity in the storage of farm chemicals;[33]
    - only allowing scuba gear to be hired to certified divers;[34]

[30] Rural Doctors Association of Australia, Submission to the Review of the Impact of the TPA on the recruitment and retention of the rural medical workforce, December 2001, p.55.
[31] *DuPont (Australia) & Ors* (1996) ATPR 50-231.
[32] *Abbott Australia* (1992) ATPR (Com) 50-123.
[33] *Agsafe* (1994) ATPR (Com) 50-150.

- requiring tyre retreaders to adhere to certain operational practices, including a code of practice;[35]

- fostering fitness and recreation (this public benefit was found to outweigh the anti-competitive detriment from a sponsorship agreement which required certain divers to wear the sponsor's gear when competing and prevented the sponsor's competitors from advertising at diving events);[36]

- reducing the risk of conflicts of interest (this public benefit was found to outweigh any anti-competitive detriment from prohibiting solicitors from acting for both vendor and purchaser in matters concerning the sale of land);[37]

- facilitating the transition to deregulation:

  - the dairy industry was deregulated on 1 July 2001. On 12 December 2001, the Commission released a determination authorising dairy farmers in Queensland to negotiate collectively with a milk processor;[38] and

  - similarly, on 27 June 2001, the Commission authorised Victorian chicken farmers to negotiate collectively with chicken processors. The authorisation was granted in anticipation of full deregulation of the industry following an NCP legislation review;[39]

- maintaining the viability of efficient firms. For example, the Commission recognised in a recent determination that efficient private hospitals can provide benefits to the communities in which they operate including: the choice and convenience provided to local patients; employment opportunities for medical, nursing and support staff; the provision of infrastructure necessary to attract specialists; and other wider regional benefits such as the positive effect that purchasing local services can have on employment in the local community.[40]

This list is not exhaustive. The Commission is willing to consider any public benefit claimed by applicants.

Misunderstanding: national authorisation is not possible

The RDAA submits that the authorisation process appears unable to provide for national authorisations and the ongoing stable environment which national authorisations would provide. The RDAA therefore recommends that the authorisation process be modified to give

---

[34] *Federation of Australian Underwater Instructors* (1983) ATPR (Com) 50-055.
[35] *Australian Tyre Dealers' and Retreaders Association* (1994) ATPR (Com) 50-162.
[36] *Speedo Knitting Mills* (1981) ATPR (Com) 50-016.
[37] *ACT Law Society* (1977) ATPR (Com) p16, 615.
[38] *Premium Milk Supply Pty Ltd,* final determination, 12 December 2001.
[39] *Marven Poultry Pty Ltd for itself and on behalf of Victorian Chicken Growers and Chicken Meat Processors*, final determination, 27 June 2001.
[40] *NSW Inter-Hospital Agreement,* ACCC Final Determination, 15 August 2001 (although in this case, insufficient information was provided by applicants to sustain this particular public benefit argument. However, the Commission granted authorisation based on other public benefit arguments).

the Commission the authority to grant national authorisations to address nation-wide problems. The AMA also submits that while many of the issues it considers need addressing require the protection for all doctors, were it to apply for authorisation, only its members would be covered.

The Act *does* allow an organisation to seek a national authorisation covering all parties within an industry engaging or proposing to engage in a set of similar arrangements. Provided an application for authorisation is so expressed, authorisation can have the effect of authorising the applicant and any other party on whose behalf the application is made to engage in the arrangements for which authorisation is sought. Parties or proposed parties to arrangements need not be named individually before the authorisation can be granted.

Authorisation can be granted to a class of persons to engage in arrangements for which authorisation is sought. Furthermore, the Act is flexible enough to allow the Commission to extend the protection of authorisation to those who become parties to the authorised conduct at a later stage.

For example, as noted above, the Commission recently granted interim authorisation to an application from the RACGP for all current and future recognised general practitioners operating in Australia within specified business structures to agree on the fees they charge patients. This in effect provides immunity from the Act to any recognised general practitioner operating within the specified business structures to engage in the subject conduct while the Commission considers the merits of the application.

Misunderstanding: authorisation does not offer ongoing certainty as the subject conduct may change

The AMA has expressed concerns that types of conduct may be authorised but then change slightly resulting in the Commission revoking the authorisation.

There are strict, specific criteria that have to be met before the Commission can revoke an authorisation. As noted in the Commission's first submission to the Review Committee, the Commission may only commence the revocation process if it is satisfied that:

- the authorisation was granted on the basis of evidence or information that was false or misleading in a material particular;
- a condition applying to the authorisation has not been complied with; or
- there has been a material change of circumstances since the authorisation was granted.

Before revoking an authorisation, the Commission must seek submissions from interested parties. The Commission may only revoke the authorisation if it is satisfied that the public detriment from the conduct given immunity by the authorisation outweighs the public benefit. Again, any final decision by the Commission to revoke an authorisation is reviewable by the Tribunal.

The Commission rarely has cause to consider revoking authorisations once granted. Of the 35 authorisations granted in the past 3 years none have been subsequently revoked.

The Act also enables minor variations to be made to authorisations through the process outlined in s 91A. This process can provide confidence to parties that even minor changes to arrangements do not alter the protection granted to the original arrangements.

Applications may also be expressed to apply to parties who become involved at a later stage in the conduct for which authorisation is granted – that is, authorisation can apply to current and future parties to an arrangement, meaning that the addition of new parties would not result in a loss of immunity for the arrangement.

Misunderstanding: authorisation does not provide ongoing immunity

The AMA and RDAA have also submitted that the authorisation process is unable to offer long-term security because of the timeframe for which authorisation is granted.

The Act allows authorisation to be granted for a specific period of time. The Commission's practice is to make use of this provision so as to provide it with an opportunity to review authorisations in the light of any changed circumstances. The average period of authorisation for authorisations granted over the last 3 years is 3.5 years. However, many of these authorisations have involved arrangements designed to facilitate the smooth transition to deregulation in particular industries and are, by definition, not intended to remain in place in the longer term. It should be noted that the average period of authorisation does not include the additional period of immunity in those cases where interim authorisation has been granted while the Commission evaluates applications.

The period for which the Commission grants authorisation depends on the specific circumstances of each case, and where the applicant seeks longer-term authorisation the Commission's assessment is based on the merits of the arguments put before it.

In its submission to the Review Committee, the RDAA states that the Commission's preference is for two-year authorisations. This is incorrect. Of the 35 authorisations granted by the Commission in the past three years, 31 have been for periods significantly greater than two years, 30 being for periods of three years or more.

It should also be noted that many authorisations which are time limited are rolled over by the Commission on further review. For example in 1992 the Commission granted authorisation for an agricultural and veterinary chemical industry self-regulation compliance program overseen by Agsafe Limited. These arrangements are currently the subject of an application from Agsafe for re-authorisation. The Commission recently released a draft determination proposing to roll these arrangements over for a further 5 years.

Generally speaking, where applications for re-authorisation are lodged these are able to be dealt with by the Commission far more expeditiously than initial applications, particularly where the conduct and market conditions have not changed significantly.

Misunderstanding: authorisation can only be granted before the conduct commences

The AMA has submitted that the provisions of the Act are directed at striking down collaborative decisions unless authorisation is granted before the conduct commences. While it is correct the Commission cannot grant authorisation retrospectively, it can authorise parties to give effect to the provisions of an existing contract or arrangement. That is, authorisation can be sought, and granted, for conduct that is already being engaged in. For example, the Commission is currently assessing an application for authorisation from the RACS for its selection and training processes which have been in place in various forms for several decades. Therefore, to the extent that rural and regional doctors have concerns about the trade practices implications of conduct already being engaged in, these can be addressed through the authorisation process. However, immunity from the anti-competitive provisions of the Act only apply from the time that authorisation (or interim authorisation) is granted.

Misunderstanding: the authorisation process cannot accommodate urgent requests for immunity

The AMA has submitted that the types of collaboration between doctors have a sense of urgency which does not sit well with the requirements of the authorisation process.

Parties applying for authorisation may, at the time of lodging an application, apply for interim authorisation. Section 91 of the Act allows the Commission to grant interim authorisation (which has the same effect in providing immunity from the Act as full authorisation) without making a decision on the merits of the application. Interim authorisation allows the applicant to engage in the subject conduct as if it had authorisation, while the substance of the merits of the application is considered by the Commission.

As interim authorisation may be granted without the Commission considering the merits of the application, it is generally only granted where the applicant is able to demonstrate exceptional circumstances (e.g. an urgent need for protection from the Act), and where the Commission is satisfied that the market would be able to return to its pre-interim authorisation state if the Commission later denied full authorisation.

Where an applicant can meet these requirements, the granting of interim authorisation provides the applicant and other parties to the conduct for which authorisation is sought with certainty that by engaging in the conduct they will not be in breach of the Act, while the Commission considers the merits of the application. Parties requesting interim authorisation can generally expect a decision from the Commission within four to six weeks of making that request.

The Commission recently granted (within four weeks) interim authorisation to general practitioners operating within specified business structures to agree on the fees they charge patients while it assesses the merits of their substantive application (RACGP). The Commission also recently granted (within five weeks) interim authorisation to the RACS' training and selection processes.

The RWAV expressed concerns in its submission that interim authorisation does not necessarily protect rural GPs from adverse assessment findings under compliance requirements. In fact, this is the very point of interim authorisation. Where granted, interim authorisation provides the applicant and other parties to the arrangements with certainty that the conduct the subject of the application can be engaged in without risking breaching the Act while the application is being considered by the Commission.

Misunderstanding: the burden of proof required for authorisation is difficult to meet

The AMA has raised concerns that burden of proof required by the Commission before granting authorisation places an impossible barrier on applicants. In support of this contention, it claims that the Commission rejected an AMA application for authorisation in relation to fee for service agreements in rural South Australian public hospitals.

In fact, these arrangements were authorised by the Commission, the Commission concluding that the arrangements would be likely to result in a benefit to the public likely to outweigh any lessening of competition that would be likely to result from the arrangements. As noted, all authorisation decisions issued by the Commission are also reviewable by the Australian Competition Tribunal. The AMA chose not to exercise this option.

More generally, of the 39 applications for authorisation the Commission has considered in the past 3 years, 35 (89%) have been granted[41]. This strongly suggests that the burden of proof for applicants seeking authorisations is not insurmountable.

5.4 Conclusion

The public benefit test and the authorisation process remain a valuable and unique part of the Act. It has ensured that the Act is not a blunt instrument against anti-competitive conduct by making the public interest the paramount concern.

The Commission is always open to constructive input about how it applies the test. In this regard, as stated above, the Commission will be updating its Guide to Authorisations and Notifications published in November 1995 with the intention of providing a more comprehensive and user-friendly guide to the authorisation process. Amongst other things, the revised Guide will discuss the Commission's approach to the assessment of public benefits under the authorisation process, as well as the manner in which public detriment is considered. The Commission proposes to consult with relevant stakeholders as part of the process.

6. Proposals for change

6.1 Exemption from the Act

[41] Excludes applications for authorisation in the electricity and gas industries.

The RDAA proposes a blanket exemption for doctors resident and supplying services in rural and remote Australia within RRMAs 4-7 pending the success of strategies to effectively increase the number of doctors in country areas. This exemption would be subject to a sunset clause and indicators would be negotiated to measure progress. The sunset clause would appear to not take effect for at least ten years.[42]

The AMA proposes that the Act be amended to provide an express exemption for rural and regional doctors. Alternatively, it proposes to exempt specified conduct of these doctors from the Act. It states that such an exemption could cover conduct such as:

- price fixing between members of practices which have corporate partners, and price fixing between members of associate practices;
- collaborative arrangements, including rosters, between doctors in the provision of services to patients, hospitals and other third parties in rural and regional areas;
- collaborative arrangements for exit from the provision of services to patients, hospitals and other third parties in rural and regional areas;
- collaborative arrangements between rural and regional practices in relation to specialist referrals for the provision of services to patients, hospitals and other third parties in rural and regional areas.[43]

The Commission considers that this alternative exemption would be a very wide one. In particular, the second dot point is very broadly expressed, so much so that it could be construed as covering virtually any collective conduct by doctors which relates in any way to the provision of medical services to patients – that is, it could be interpreted as providing a blanket exemption for doctors from the competition provisions of the Act. Even if the AMA does not intend this to be read so widely, the list above includes much of the conduct that doctors would be likely to wish to engage in which the AMA considers breaches the Act. Moreover, the AMA is not proposing that the exemption be limited to this list.

The Commission is surprised by the AMA proposals. In an article in the *Age* on 7 December 2001, the President of the AMA, Dr Kerryn Phelps stated that the AMA:

> has never sought an exemption for doctors from the Trade Practices Act.

Yet this is just what it has done in its submission, lodged with the Review Committee four days later.

This aside, the Commission is of the view that a blanket or wide-ranging exemption would be very detrimental to patients in rural and regional areas. In particular, an exemption for *all* conduct by rural and regional doctors or *all* instances of specified types of conduct would result in much conduct that is not in the public interest. The AMA itself recognises this when it notes that authorisation applications:

[42] RDAA submission, p.53.
[43] AMA Submission, op.cit., p.32.

> must be assessed by the ACCC in each relevant market area. The competitive outcomes and relevant public benefits may vary quite considerably in different regions and towns.[44]

Case-by-case assessments – as provided by the authorisation process – clearly allow differences between regions and towns to be accounted for. National authorisations can also be tailored to account for these differences. A blanket exemption for rural and regional doctors overall (or for all instances of certain types of conduct) cannot.

Further, the AMA and the RDAA have failed to demonstrate why doctors alone should be given an exemption from the Act. The AMA stated in its submission that:

> Collaborative conduct is entrenched in the profession and it is in everyone's interest not to impede these processes, which are in general motivated simply by service factors. This situation does not sit well within the framework of the TPA…[45]

The Commission considers that, to the extent that this is true, then doctors may apply for authorisation in the same way as providers of any other good or service (e.g. pharmacists, dentists, physiotherapists, lawyers, accountants, etc) who wish to act together may do to avoid the risk of breaching the Act. The AMA and RDAA have not justified why a special exemption for doctors is warranted.

The Commission also notes that, even in the health sector where the Commission commenced assessing applications for authorisation only comparatively recently, the Commission has authorised 6 of the 8 applications (75%) considered to date.

In addition, it should be noted that the first type of conduct listed in the AMA's alternative proposal is currently the subject of an application for authorisation by the RACGP. Interim authorisation has been granted. The second and third types of conduct in practice would give doctors a licence to collectively fix prices and boycott patients, hospitals, health funds, other health providers and any other third party. The second type of conduct specifically refers to rosters which do not constitute a breach of the Act.

As regards the fourth dot point, as stated earlier, the Commission notes the submission of the NRHA:

> Other circumstances which have been mooted as justifying exemptions from the provisions of the Trade Practices Act to enable doctors to enter into work sharing arrangements with other doctors relate to the protection of specialised expertise or to the high and growing costs of medical indemnity for some services, notably obstetrics. Such practices have some benefits but they also serve to limit consumer choice. Longer term solutions such as increasing the supply of specific expertise through innovative service arrangements or the use of alternative suitable qualified practitioners are required to deal adequately with these problems. The Alliance as a whole is therefore not convinced that there are public interest reasons why exemptions from the Trade Practices Act should apply to enable doctors to collaborate in agreements to refer, or not to refer, to particular practitioners[46].

[44] AMA Submission, op.cit., p.31.
[45] AMA Submission, op. cit. p.17.
[46] NRHA, op.cit., pp. 7,8.

The AMA also claims that the National Competition Council (NCC), in its National Competition Policy review of the partnership exemption in section 51(2)(d) of the Act, concludes that 'competitive constraints are not currently operating' in rural and regional Australia. From this, the AMA claims that collective conduct by doctors in rural and regional Australia has no anti-competitive effect.[47]

The AMA has misunderstood the NCC report. The NCC was actually making the point that if all doctors in a country town form a partnership, then given that the partnership has no competitors, there are no competitive constraints on it as regards the setting of fees and other aspects of the services it provides. This is very different to suggesting that competitive constraints do not operate in rural and regional Australia.

The NCC did note the uncontested fact that there is a shortage of doctors in rural and regional Australia. This potentially reduces the level of competition in at least some parts of country Australia. However, this is, in fact, a strong argument for subjecting rural and regional doctors to the Act; that is, this is necessary to preserve the limited competition existing in some country areas and the benefits flowing from this for patients e.g. in relation to fees. Further, as has been stressed in this submission, the existence of the authorisation process allows anti-competitive conduct which is nevertheless in the public interest to occur. The actual level of competition in a rural area would be a key factor considered by the Commission in assessing the practical effect of an authorisation application by rural doctors.

6.2 Amended authorisation process

AMA proposal

The AMA has proposed that a 'streamlined' authorisation process be introduced. To support this proposition, it has highlighted the 1970s clearance process.

From 1974 until 1977 businesses were able to apply to the Commission for clearance of certain conduct.

Clearance did not provide immunity from the Act in the way that authorisation and notification does. To obtain clearance, businesses were required to lodge a written notice with the Commission detailing the particulars of the conduct. The Commission was then able to issue a notice stating that the relevant conduct did not have a significant effect on competition. If it did, the conduct was deemed not to be in restraint of trade for the purposes of the Act.

Clearance was available for contracts, arrangements or understandings in restraint of trade or commerce, exclusive dealing and mergers. Further, clearance was only available for conduct which had not commenced.[48] Unlike authorisation, clearance was available for conduct

[47] AMA submission, op. cit. p.33.

[48] Except for the four month period following the commencement of the Act, when clearance applications for existing conduct were permitted.

which might not breach the Act. Clearance differed significantly from authorisation and authorisation was never viewed as a substitute for clearance.

In practice, it appears that clearance was generally sought for conduct that was unlikely to be illegal under the Act (because it was not significantly anti-competitive) and the function of the clearance procedure was to certify that the conduct did not raise concerns under the Act.

The Act gave the Commission the power to revoke a clearance if the Commission was satisfied that the clearance was granted on the basis of false or misleading information or if there had been a material change of circumstances since the clearance was granted.

Between 1974 and 1977 the Commission received 14,984 clearance applications.

Following a review of the Act in 1976 (known as the Swanson Review), major amendments to the Act came into operation on 1 July 1977, including the repeal of the clearance provisions in the Act.

The Swanson Review Committee noted that a significant number of the submissions from both business and legal groups urged that the clearance procedures should be abandoned. No submissions were received which suggested that the authorisation process should be abandoned.

The Committee reached the view that the clearance provisions of the Act should be repealed, except in relation to mergers, for a number of reasons, including:

- While the clearance provisions were in place, corporations were inclined to seek clearance of possible anti-competitive conduct, rather than rely on their own judgement as to whether the conduct was likely to be anti-competitive. The clearance provisions encouraged the practice of submitting for clearance by the Commission patterns of business conduct which were likely to be only very marginally anti-competitive. The Committee considered that the existence of the clearance opportunity in relation to section 45 and section 47 conduct had deprived the community of business self-reliance.
- Should businesses wish to seek immunity for conduct on the basis of the effect of the particular conduct on competition, this could be achieved by way of authorisation rather than clearance. The Committee proposed that the test for authorisation be changed in such a way that the effect on competition of particular conduct for which authorisation is sought will be taken into account and balanced against public benefits that the applicant can demonstrate. This is the test that is now in the Act.

While the AMA proposal for a ‘streamlined’ authorisation process lacks clarity, it appears the AMA is proposing that rural and regional doctors be able to obtain the immunity provided by authorisation through a process along the lines of the 1970s clearance process or the existing notification process.

If the former (ie a clearance-type process), it seems that the Commission would be required to grant immunity, presumably within a brief time period, unless it could satisfy an unstated test.

It is also not stated whether clearances would be time-limited or revocable. The Commission notes the AMA's view that authorisations fail to provide long-term security to doctors because they are revocable.

If the latter (ie a notification-type process), immunity would presumably attach to conduct until the Commission revoked it, which it would only be able to do if it could satisfy the unstated test.

This test would appear likely to relate either to whether conduct has a significant anti-competitive effect (ie as for clearances) or whether it provides some level of public benefit (ie. similar to notifications). Whichever, the AMA has stated that the test should favour the grant of immunity to doctors.

As mentioned previously, the underlying principle of the Act is that the promotion of competition will generally enhance the welfare of Australians, but supplemented with a process that enables restrictions on competition to be permitted where a person proposing to engage in such restrictions demonstrates to an independent body through an objective, rigorous and transparent process that it is in the public interest to do so.

Whatever the precise characteristics of the process the AMA has in mind, it is effectively proposing to allow rural and regional doctors to relatively easily obtain immunity from the Act. While the Commission, at least superficially, would oversee the process, its role would be constrained by the nature of the test it would need to satisfy to withhold immunity.

Further, if a clearance-type process is contemplated, and the Commission only had brief period to consider an application, it is unlikely to be able to accurately assess whether many clearances should be granted or not. In particular, it is unlikely to be able to obtain the views of detrimentally affected parties on how competition would be affected by the conduct. If notification-type process is contemplated, the conduct (e.g. collective bargaining) may have been completed before the Commission has had time to accurately and thoroughly assess whether e.g. the conduct provided the required level of public benefit.
Ultimately, the Commission considers that the AMA's clearance proposal would be the equivalent of a blanket exemption in practice. The Commission's concerns about blanket exemptions are expressed above.

The AMA has also proposed that if a clearance process is not introduced, authorisation fees should be removed and authorisation processes streamlined for doctors Australia-wide. In addition, a statutory direction should be included to favour the grant of authorisation to rural and regional doctors. Generally, this proposal appears similar to the one considered immediately above and the Commission would raise similar concerns. In addition, the existing authorisation costs and processes have been discussed in detail in Chapter 5.

Generally, it appears that underpinning the AMA's proposals is the view that collective conduct by rural and regional doctors is inherently unlikely to be significantly anti-competitive. The Commission does not agree. For example, all the doctors in a particular

area or town agreeing on a fee or that they will not bulk-bill could, depending on the particular circumstances, be significantly anti-competitive.

Moreover, one of the features of the Act which make it an effective contributor to the efficiency of the broad economy and welfare of Australian consumers and business, is its general application. Any special treatment to one group of businesses will undermine the effectiveness of the Act as a legislative instrument, and open the floodgate for claims of special treatment by other interest groups.

RDAA proposal

The RDAA proposes that the authorisation process be modified to:

- make it simpler and less expensive;
- reduce its adversarial nature;
- provide for long-term and ongoing authorisations; and
- provide for national authorisations.

These concerns have been addressed elsewhere in the submission.

6.3 Other proposals

The AMA also proposes an exemption from the Act for:

- members of partnerships which include a corporation; and
- associate practices.

The RACGP application for authorisation proposes to allow doctors operating in these structures to agree on fees. If the Commission is satisfied that public benefits flow from this conduct, immunity will be granted and the AMA's proposal for an exemption would be largely redundant.

The AMA also proposed that rural and regional doctors should be exempted from the penalty provisions of the Act. As stated previously in this submission, the Commission has seen no evidence of any case for rural doctors to be above the law and receive special treatment by being granted an exemption from the Act, including an exemption from the penalty provisions.

7. COMMUNICATION AND INFORMATION

7.1 GP Guide

As stated in the Commission's first submission to the Review Committee, the Commission has prepared a guide, *General Practitioners – A Guide to the Trade Practices Act*, to provide GPs with information and assistance to better understand the impact of the Act on their practices. In relation to the release of the final guide, the RDAA stated in its submission to the Review Committee, that:

> The continuing delay in publishing the final version of the Guidelines has not helped. The Professional Unit of the ACCC has explained the reason for this – a perceived need to await the final determination in the RACGP's application on behalf of doctors in associateship practices – but the continuing uncertainty is hardly helpful in the current environment, or in the preparation of submission to this Inquiry[49].

As stated in the Commission's first submission to the Review Committee, it would be prudent for the Commission to release the final GP Guide once the final determination of the RACGP's application for authorisation has been issued. This would provide GPs with more certainty than if the guide was released prior to the authorisation application being finalised.

The RACGP lodged its supporting submission on 18 January 2001. The Commission has now commenced its analysis of the RACGP's application. However, the delay in receiving the RACGP's submission has impeded the finalisation of the GP Guide. The RACGP's supporting submission is at **Attachment D**.

7.2 Information and Guidance

As stated in the Commission's first submission, in order to accommodate the increasing need for information to reach rural and regional areas, the Commission has established a Rural and Regional Program with additional resources announced in the May 2001 budget. The Program's primary strategy is the development of communication and education outreach in rural and regional areas throughout Australia. The program is managed by a newly created Rural and Regional Unit.

As outlined in the previous submission, the Commission did undertake an extensive information/education program when the Act changed in 1996. The Commission is happy to work with medical practitioners and their representative associations in developing further open lines of communication to facilitate ongoing information flows.

It should be noted that Commission staff are always prepared to discuss any issues of concern with medical practitioners. Although the Commission does not provide legal advice, the Commission can discuss whether particular proposed arrangements would be likely to raise issues under the Act. The Commission answers calls and letters on a daily basis.

[49]RDAA, op.cit., p.49.