Competition health: two years on

Professor Allan Fels, ACCC Chairman
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Introduction

Good afternoon. It is a pleasure to be here today to give the Australian Competition and Consumer Commission's perspective on competition in the health sector, two years after the extension of the Trade Practices Act to all participants in that sector. At the end of my speech I will ask Commissioner Sitesh Bhojani to join me. Many of you will know that Sitesh is the Commissioner with responsibility for the professions and the health sector. Together we will be pleased to answer any questions that you may have about my presentation or the Commission's work generally.

In May 1996, I addressed the AMA's first Competition in Health Conference. I outlined many issues that the health care industry may need to address in order to ensure that its obligations under the national competition policy are met. In my presentation today, I will revisit many of those issues and provide you with an insight into how the ACCC is addressing them.

But first, I would like to reiterate that the purpose of the Australian competition laws (including the Trade Practices Act (TPA)), and of the ACCC's enforcement of those laws in the health sector, is to ensure that competitive forces will be allowed to stimulate the development of products and services desired by consumers. Generally speaking, competition policy is based on the premise that consumer choice, rather then the collective judgement of sellers, should determine the range and prices of goods and services that are available. Or in other words that competitive suppliers should not pre-empt the working of the market by deciding themselves what their customers need, rather than allowing the market to respond to what consumers demand.

Moreover, competition tends to encourage efficiency on the supply side. When a competitor finds a new, more cost effective way of making a good or delivering a service this puts pressure on other competitors to match and/or improve their own performance.

The role of the Commission

The Australian Competition and Consumer Commission's role in all of this is to perform the functions conferred upon it by the TPA and Prices Surveillance Act. Among other things, the TPA provides the Commission with the duty to enforce compliance with some of its provisions.

Enforcement takes place in the Australian court system. The Commission has no law-making role - this belongs to federal, State and Territory legislatures. The Commission cannot fine those who breach the Act - that is the role of the courts. It is

important for you all to realise or remember that the Commission shares its right to take legal action under the TPA with the private sector.

The Commission's role as an enforcer depends upon what is and isn't prohibited by the Act. Broadly speaking Part IV of the Act aims to prevent anti-competitive conduct, thereby encouraging competition and efficiency in business with the result of greater choice for consumers in price, quality and service. In the health sector, this can mean looking at health professionals' conduct to determine whether it promotes or hinders patients' interests in being able to choose among a variety of service and price options according to their needs.

My speech today will tend to focus primarily on the way in which the Commission is seeking to ensure that the health sector complies with its obligations under part IV of the TPA as that is the part of the legislation to which it is newly exposed. However, it is important to remember that all health professionals also have ongoing rights and responsibilities under the other sections of the TPA that deal with consumer protection.

I also intend to discuss briefly some new provisions of the TPA that may have an impact on the way in which health professionals go about the business aspects of their professional practice.

Overall object of the TPA

It is important to appreciate what Parliament has set out as the object of the TPA. Namely, to enhance the welfare of Australians through the promotion of competition and fair trading and provision for consumer protection. The Act has various parts which ensure that there are checks and balances in the legislation. Those other parts could easily be the subject of separate presentations.

Part IV of the TPA

As Commissioner Bhojani, Commission staff and I have been saying publicly for well over 2 years now (even before the formal lead up to the extension of Part IV of the TPA to all businesses in July 1996), it is essential that all professionals at least develop a working knowledge of the requirements of Part IV of the TPA. Those provisions do have an impact on the business aspects of their professional practices. For some professions the impact may be greater than for other professions because of the way those professions have historically conducted themselves. For example, Barristers regularly tend to negotiate individually the fees they will charge on a case by case basis whereas historically many medical/health professionals have often relied on charging fees determined on a collective basis.

Just to refresh your memory I will very quickly run through the list of anti-competitive practices that are prohibited by Part IV:

- Agreements that have the purpose or effect or likely effect of substantially lessening competition in a market (section 45).
- Agreements that contain an exclusionary provision. (sections 45, 4D). These sections are known as the primary boycott provisions.

- Agreements that have the purpose, effect or likely effect of fixing, controlling or maintaining prices (section 45A).
- Secondary boycotts - that is, action by two or more people which hinders or prevents a third person from supplying goods or services to a business, acquiring goods or services from a business or engaging in interstate trade or commerce where this substantially lessens competition (section 45D).
- Misuse of market power - that is, taking advantage of a substantial degree of power in a market for the purpose of eliminating or substantially damaging a competitor, preventing the entry of a person into any market or deterring or preventing a person from engaging in competitive conduct in any market (section 46).
- Exclusive dealing - that is, one person who trades with another imposing restrictions on the other's freedom to choose with whom, or in what, to deal (section 47). I will say some more about the Commission's activities in relation to third and full line forcing, which is a form of exclusive dealing, later on in my speech.
- Resale price maintenance - that is, suppliers specifying the minimum price to a reseller (section 48, 96-100).
- Mergers which have the effect, or likely effect, of substantially lessening competition in a substantial market for goods or services (section 50).

The Commission and the health sector

I would now like to turn to the involvement that the Commission has had, and is having, with the health sector. Since the current Act was proclaimed in 1974, the Commission has been involved in numerous investigations and litigation relating to health service providers to the extent that the law has covered anti-competitive health services. For example, following Commission action, on 25 August 1993, four Tasmanian health funds and their relevant senior managers gave undertakings in the Federal Court not to enter any arrangement that could prevent or hinder Tasmania's private hospitals from setting their own fees for the supply of services to the Department of Veterans' Affairs. The funds also undertook to inform the hospitals that they would not seek to unlawfully influence the hospitals' fee scales. The Commission has also been involved with potentially anti-competitive mergers within the pharmaceutical, pathology and radiology sectors for many years.

Now that coverage of the TPA has been extended, it is very important that all involved in the health care industry understand their obligations, rights and responsibilities under the Act. However, participants should not be uneasy about the effects of the extension of the Act to the health care industry. The Act is not designed to harm business or prevent fair and fierce competition - in fact it protects both consumers and business from unlawful anti-competitive conduct and unfair market practices.

In the past two years the Commission has been active in pursuing conduct that breaches the TPA.

Third line forcing

You may be aware that in December of last year, Health Partners Incorporated was found by the Court to have engaged in exclusive dealing conduct in breach of section 47(7) of the Act (third line forcing). The Court held that the conduct established by the ACCC against Health Partners Inc. was serious and that it was in the public interest that it should be marked with the Court's disapproval.

Pharmacies affiliated with Health Partners offer its members retail discounts and prescription benefits. The Court found that the insurer had cancelled a contract with an Adelaide suburban chemist shop to service its members for the reason that the pharmacy had, for its own commercial reasons, left the Chem-mart pharmacy chain.

The ACCC is aware of other types of conduct that are likely to be per se technical breaches of the third line forcing provisions of the TPA. Such conduct can be notified to the Commission to provide immunity from legal proceedings. Third line forcing may also be authorised by the Commission on public benefit grounds.

Practitioners who engage in conduct that is likely to be a technical breach of the TPA are probably concerned with knowing if the ACCC is likely to take action against such third line forcing conduct if it hasn't been notified?

An example of a potential technical breach that is often brought to our attention is a surgeon who operates with one or two anaesthetists. Practically, the surgeon's patients must acquire services from the surgeon's preferred anaesthetist if the patients are to be supplied with the surgeon's services. I assume that most patients are perfectly happy to use whichever anaesthetist the surgeon chooses. Surgeons should be aware, however, that this practice is likely to breach the third line forcing provisions of the TPA if the surgeon will only provide his services to a patient on the condition that the patient obtain anaesthetic services from a particular anaesthetist. However, even in those circumstances, the ACCC is unlikely to take action unless there is a strong anti-competitive effect arising from the conduct.

If a patient requests that a particular anaesthetist provides anaesthetic services to that patient I would hope that most surgeons would accommodate such requests even if the anaesthetist is not normally one that the surgeon works with; provided of course that the anaesthetist has the credentials to perform the services at the particular hospital.

If, however, the third line forcing conduct is aimed at preventing any medical practitioner from gaining accreditation or practising in general, the ACCC is likely to take action to prevent the conduct. More information on the Commission's views on third line forcing can be obtained from its Guide issued in February 1998 (*Guide to authorisation and notification for third line forcing conduct*), which is available from ACCC offices or the ACCC's website.

Anaesthetists - alleged price fixing and boycotts

I would like to briefly mention another matter in the health sector that is currently before the Courts. The Commission instituted proceedings late last year in the Federal Court against five Sydney anaesthetists and the Australian Society of Anaesthetists.

The Commission has alleged that the parties to this action engaged in two separate forms of anti-competitive conduct in breach of Part IV of the Act.

The allegation from the Commission is that three of the anaesthetists, through their medical practice companies, each arrived at agreements with other anaesthetists to charge a $25 per hour on call services fee. The two other anaesthetists are alleged to have been knowingly concerned in, or a party to, one or more of the agreements. The Commission has alleged that this conduct amounts to an illegal price fix in relation to after hours anaesthetic services at the three Sydney metropolitan hospitals that were effected by the agreements.

The Australian Society of Anaesthetists (NSW Section) circulated a report to its members in late 1995. The Commission alleges the report recommended that the Society's members set an appropriate recommended on call fee to be paid by private hospitals to anaesthetists. The Commission alleges that the anaesthetists involved in this matter agreed to illegally fix the price for this service.

The Commission has also alleged that the anaesthetists at one of the 3 hospitals who were involved in an agreement at that hospital threatened to boycott that hospital unless the fixed on call payment was paid. The Commission has alleged that such a boycott would be anti-competitive and in breach of Part IV of the Act. As I mentioned, this matter is presently before the Court and is likely to go to trial later this year. It should be noted that the Commission has not sought penalties against any of the individual anaesthetists or the ASA.

However, I would like to stress that the Commission takes the type of conduct that is alleged in this matter very seriously. Price fixing is *per se* illegal under the Act and the Commission will investigate any allegations of this type of conduct very rigorously. The same applies to any form of boycott conduct. The penalties that are now in operation for any breach of Part IV are very severe - up to $10 million per breach for companies and $500,000 for individuals. The conduct proscribed by Part IV of the TPA should not be ignored or treated dismissively by those in the professions or in the health sector more generally.

The Commission has also been investigating a number of claims that general practitioners in some areas have been engaging in collusive arrangements to cease bulk billing. If true, these arrangements would be a breach of the price fixing provisions of the Trade Practices Act. One of the complaints was forwarded to the Commission by Minister Wooldridge. I would like to announce today that the Commission has finished investigating this complaint and has not found any evidence of collusive arrangements. We are, however, still investigating some of the other similar complaints of alleged collusive arrangements.

Accreditation

A further matter currently being investigated by the Commission is the accreditation process at Private and Public Hospitals. The Commission is aware that certain hospitals will only accredit doctors who are Australian Fellows - and in some cases, also belong to the specialist society or association. Both criteria may involve a *per se* breach of the TPA (third line forcing).

It is common practice for applications for accreditation to be given to the relevant 'hospital department' for advice and recommendation. This 'department' often consists of the applicant's competitors. The Commission has noted that these competitors often, and in many cases without reason, reject the proposed accreditation. Some rejections are based on the earlier mentioned reasons, ie. the applicant is not an Australian Fellow and not a member of the relevant society.

I understand that the department, ie. the group of competitors at the hospital, often enforce their rejection by threatening a boycott of the hospital. The message the Commission would want to convey here is:

- Competitors should not have control over who practices at any hospital.
- Third line forcing and threats of boycotts are serious anti-competitive conduct.
- Specialists of the same craft group must see themselves as competitors and the 'club' spirit attaching to competition issues has to be eliminated.

Any hospital which acquiesces with the specialist department and refuses accreditation for non-clinical reasons such as those identified above (Australian Fellowship or membership of a nominated society) is itself in breach of s.47(6), the third line forcing provision.

The Commission is also concerned that practitioners who are not members of the Australian College may be treated differently to College members when seeking accreditation. This may occur even though both sets of practitioners are recognised as specialists by the Health Insurance Commission. It is the ACCC's understanding that Australian Fellows are automatically recognised by the Health Insurance Commission whereas applicants who do not hold Australian Fellowship are considered on their individual merit and only recognised by the Health Insurance Commission after individual assessment of the person's ability. The Commission would want to investigate and properly understand the basis for any alleged refusal by a hospital to accredit a specialist where the specialist has been recognised by the HIC. This type of conduct clearly affects competition and is of particular concern because it is also the Commission's understanding that many Colleges, including the Royal College of Physicians, will not accept any applicant with overseas qualifications without a period of further training, regardless of the applicant's eminence. I understand that there may be sound reasons for requiring some applicants to undergo further training. However, I would like to stress that unless there are sound reasons the Commission is likely to examine this kind of behaviour very closely to ensure compliance with the TPA.

Specialist entry

This conference is an appropriate forum to clarify the ACCC's interest in the specialist colleges and to chronicle the work that the ACCC has already done in this area. As with all sectors that are newly exposed to the TPA, the ACCC has placed a high priority on providing information and assistance to the health professions to assist them in complying with their trade practices obligations.

Many of the restrictions on competition in the health professions are legislative in nature. Such restrictions are beyond the jurisdiction of the ACCC but will be subject to review by the relevant government as part of the legislative review process

currently being undertaken by each of the governments. In addition to these legislated restrictions, many professional associations also impose restrictions on professional conduct. Some of those restrictions may have an anti-competitive effect even if that is not the purpose of the restriction.

One of the ACCC's first activities in the health sector after the acceptance of the Hilmer recommendation to extend the coverage of the TPA was to offer to provide assistance to those professional associations who were concerned that their various rules and regulations were in compliance with the TPA. In February 1996, the Commission wrote to 46 specialist Colleges, Associations and Societies. Among other things, the letter offered assistance to the organisation by proposing a consideration of the Memorandum and Articles of Association, Rules, by-laws etc if forwarded to the Commission.

The response to this initial request was not high with the Commission receiving 18 replies. Follow up letters to the 28 organisations that did not reply were sent in July 1997. Commission staff examined the documentation that had been forwarded to the ACCC. I am pleased to say that none of these contained provisions that directly breached the TPA. However, a number of provisions did have the potential to have an anti-competitive effect. The Commission has informed the relevant organisations over its concerns and extended a further invitation to discuss those concerns.

You will all be aware of public perceptions that the specialist colleges are 'closed shops' and of persistent allegations that entry to the relevant specialty is tightly controlled by incumbents so that they can maintain their workloads and income. The Commission has made no secret of the fact that it intends to place a high priority on investigating the activities of certain specialist colleges who:

- limit training places, and
- engage in trainee selection processes

with such conduct having anti-competitive purpose or effect. Nevertheless, it appears that some Colleges are uncertain of the impact of the TPA on their trainee selection processes especially if those processes are in line with recommendations made by the Australian Medical Workforce Advisory Committee (AMWAC). I am somewhat surprised, however, that none of the Colleges have approached the ACCC directly to clarify any uncertainty that they have given our earlier offer of assistance.

The Commission has been advised by senior counsel that if a college makes decisions about entry in order to protect the privileged position of its members then such colleges may be engaging in conduct in breach of sections 45 and 46 of the TPA (Agreements that have the purpose or effect or likely effect of substantially lessening competition in a market, and misuse of market power.).

I am aware, however, that the issue of quotas on trainees is complicated by government funding constraints, the availability of suitable training positions and government workforce planning policies. AMWAC is systematically reviewing the medical specialties where there is likely to be a future shortage of supply. AMWAC is making recommendations as to the number of trainees that will be required in those specialties in order to reduce existing shortages and/or to cope with expected

increases in demand. I understand that all of AMWAC's recommendations to date have been accepted by the Australian Health Ministers' Advisory Committee (AHMAC).

It is also my understanding that most of the Colleges that have been reviewed by AMWAC have taken steps to increase the number of trainee positions by at least that recommended by AMWAC.

On the basis of our legal advice, and the various complex issues associated with entry to specialist medical training, the Commission is considering its options on how to deal with the allegations that have been made.

In general, the Commission is opposed to the imposition of quotas. However, I recognise that there may be public benefits associated with these quotas. If this is the case, I would urge Colleges to make use of the authorisation provisions of the TPA. These provisions would enable any public benefit arguments to be aired in a public forum and may put to rest the long lingering concerns about anticompetitive practices in the limitation of specialist numbers. At the very least, I would urge any College which is concerned that its conduct may breach the TPA to discuss these matters with the Commission.

I would like to stress once again that the Commission intends to give the enforcement of the TPA in the health sector the highest priority and will be seeking to prosecute blatant breaches of the Act.

Contracts between health funds, doctors and private hospitals

There is ongoing publicity about contracting between private health insurance funds and private hospitals (hospital purchaser provider arrangements), private health insurance funds and doctors (medical purchaser provider arrangements, and private hospitals and doctors (practitioner arrangements). The Government policy underlying the support of such contracts is to eliminate 'out of pocket' expenses for private patients. Such expenses are often cited as one of the main reasons for the decline in the percentage of the population covered by private health insurance.

Many hospital purchaser provider arrangements have been entered into. However, I understand that few medical purchaser provider arrangements have been signed. I know that some in the medical profession oppose such contracts. In particular they fear that the use of such contracts is the first step towards US-style managed care which the profession claims leads to the loss of effective control over the clinical management of their patients.

The Commission's role is not to determine the system of health care delivery in Australia. And of course, we respect the right of medical practitioners to choose whether or not to enter into such contracts and to oppose particular systems of health care delivery. I am informed, however, that the contracts that are currently in use endeavour to maintain the medical practitioner's control over clinical care. The Commission's concern is that the delivery of health care be in compliance with the TPA. To this end, there should not be any *collective* action to prevent the use of such contracts or to penalise those who individually chose to enter into them.

Unconscionable conduct

On a different note, the new section 51AC of the TPA came into effect on 1 July 1998. This section applies to unconscionable conduct in relation to business transactions although there is a cap of $1million per transaction to which the section can apply.

Whether conduct is unconscionable will be determined by examining all of the circumstances. However, section 51AC lists a number of factors that the Courts may have regard to in determining whether there has been a breach of the section. These factors include the matters already listed in s.51AB which prohibits unconscionable conduct by corporations against consumers. In addition, the new section includes six other matters to which the Courts may have regard.

The Commission is currently investigating a matter involving a contract between a large private health insurance fund and a small private hospital. The concern is that some of the provisions of the contract may impair the hospital's ability to compete with other service providers and may not be reasonably necessary to protect the legitimate business interests of the private health fund. It may be that in seeking to have the hospital agree to such provisions, the private health insurance fund is acting unconscionably.

The aim of section 51AC is to ensure that business conduct is fair. Thus, it may be able to assist individual medical practitioners who feel that their business is being adversely affected by any unconscionable behaviour of a larger organisation with whom they deal. I would like to invite any of you who feel that you may have been adversely affected by unconscionable conduct to discuss the matter with me, the other Commissioners or my staff.

Associateships

Medical practitioners who choose to organise their practice by entering into associateships with competitors must be aware of their ongoing obligation to comply with the TPA. In this regard, the Commission has received a number of complaints about alleged price fixing among members of associateships. If the business arrangement is such that, for example, medical practitioners share facilities and administrative staff, but otherwise remain in independent practices from one another, then each member of the associateship must determine their fees independently of other independent members of the associateship (or any other competitor for that matter). Such a business arrangement is similar to arrangements often adopted by barristers for the delivery of their professional services, in barristers chambers. If prices are fixed in cooperation with other members of the associateship then that conduct will breach the price fixing provisions of the TPA.

The Commission has put the AMA on notice that this conduct would be in breach of the TPA. We are therefore concerned that complaints continue to be received, suggesting that the message has not yet been fully disseminated or understood. To date, the Commission has not acted in relation to price fixing by associateships. However, if the level of apparent non-compliance continues and anti-competitive detriment can be demonstrated, the Commission will be forced to move against the

practice. As with any other law (such as the corporations law or tax laws) the obligation is on the professional to ensure that he or she is complying with the rights and responsibilities of the particular business structure a professional chooses to use for the delivery of his or her professional services.

Authorisation

While the premise of the Trade Practices Act is the promotion of competition, it is not about the 'blind pursuit' of such competition. The Act and the Commission recognise that in some circumstances there are over-riding public benefits that justify the anti-competitive conduct. Consequently, the Commission is able to authorise anti-competitive conduct that would otherwise be prohibited with the exception of the misuse of market power.

Authorisation is available where the conduct in question can be shown to result in a public benefit that outweighs its anti-competitive effect (benefits must be public not private). That is, the authorisation process is a balancing exercise - between public benefits and anti-competitive detriment. Decisions of the ACCC, in relation to authorisation applications, can be reviewed on the merits by the Australian Competition Tribunal. So Parliament has in no way set up the ACCC as the final determinator of net public benefit for authorisation purposes.

The AMA authorisation

The Commission has just released its final determination of an authorisation application made by the Federal and South Australian AMA. The application deals with a common service agreement for the remuneration of doctors practising in South Australian rural public hospitals.

Doctors in rural SA provide services on a fee for service basis - they are paid for each procedure that they perform while in the hospital. Rural hospitals find it more effective to hire private doctors on a 'piece' basis because the throughput is not sufficient to validate employing them on a full time basis. The AMA applied for authorisation because there are concerns that the collective negotiation for this fee for service agreement - negotiations between all rural doctors in South Australia - may amount to price fixing between these doctors who may otherwise be in competition with each other. The price fix would relate to the prices that doctors charge public hospitals for their services.

As I noted earlier, authorisation provides an immunity from the Trade Practices Act and the doctors would therefore be allowed to 'price fix'. The Commission can only grant authorisation if it is satisfied that the public benefits from the proposed conduct outweigh the anti-competitive effects from the conduct. It is up to the applicant to demonstrate the public benefits to the Commission.

The AMA claimed many public benefits in its application. The concept of public benefit isn't defined in the Act but there is quite a lot of previous Commission (and TPC) and Tribunal deliberation on the matter that sheds light on how the Commission might assess claims made by applicants about public benefits. Fundamentally, public benefits must:

- be public; and
- must derive purely from the proposed anti-competitive conduct (in this case, the collective negotiation of the fee for service agreement).

The Commission considers that the Fee for Service Agreement has a significant effect on competition because while the contract exists doctors are reluctant to negotiate or offer lower fees to SA rural public hospitals. On the other hand, hospitals are often put in the position where they have to offer terms over and above those in the Fee for Service Agreement. Although the contract is not compulsory, every practising doctor except one in rural SA has adopted the agreement. This indicates that it may have the effect of being an agreement or understanding as to price.

Following the release of the draft determination, the AMA amended its application so that authorisation is now sought only insofar as it relates to the current fee for service agreement that expires on 30 June 1999.

The AMA presented a submission to us at a pre-decision conference in Adelaide in June of this year. That submission commented on the ACCC's draft determination and made a number of new points. The ACCC has also received a number of new submissions from interested parties. We have considered all of this new information as part of our final determination.

The Commission has affirmed its draft determination and granted authorisation for the AMA's amended application until 30 June 1999.

I must say that the AMA's response to our draft determination was quite strong and I consider it appropriate to deal briefly with two criticisms made of the ACCC in that response. Perhaps the most surprising criticism was that the ACCC had failed to tell the AMA that it had concerns with its claimed public benefits *prior to* releasing the draft determination. There are two things I would like to say in relation to this. The first is that the criticism shows a misunderstanding of the authorisation process. The release of the draft determination gives all interested parties the opportunity to see the Commission's views based on the information and argument that has been provided. There is then a period of review where interested parties can present new information and argument to the Commission if they think that the Commission got the draft determination wrong. In this case, the AMA clearly thought that the Commission got it wrong but it had the opportunity in the pre-decision conference and subsequent submissions to present new information and argument to convince the Commission of this, as did anyone else who held a similar view.

You can see that it is this public process of issuing a draft determination followed by a period of review that provides a feedback mechanism to applicants as to how the Commission considers the applicants' claims. The Commission is not obliged to tell applicants prior to the release of the draft determination that their application is unlikely to be granted authorisation at that time. In fact, if the Commission did this you can imagine that the process could be dragged out indefinitely.

Nevertheless, the Commission did attempt to provide assistance to the AMA prior to the lodging of the application for authorisation, and it offers this service to anyone else who proposes to lodge an application. This is because we recognise that the

applicant is probably unfamiliar with the Commission and the authorisation process. Staff of the Commission met with the AMA in June 1997 when the application was in draft form and provided feedback on areas where they thought that the application could be amended to strengthen the application. This included advice as to the need for further evidence in support of claimed public benefits. Surprisingly, further evidence to establish the claimed public benefits was not incorporated into the actual application lodged with the Commission.

The other criticism, or perhaps it's better described as a claim, is that the ACCC does not have the jurisdiction to consider the application for authorisation; that is, that the Trade Practices Act doesn't apply to the conduct anyway. The AMA apparently shares this view with the South Australian Health Commission. The reasons for the view are quite complicated and I don't intend to go into them in detail. But suffice it to say that the issue is not one for the ACCC to decide - questions of jurisdiction are matters for the Courts to decide. Our position is that the AMA lodged a valid application for authorisation with the Commission. That is, the conduct for which authorisation was sought by the AMA was not conduct clearly outside the reach of the TPA. The AMA was aware of the South Australian Health Commission view on jurisdiction. Not only was the application for authorisation not withdrawn by the AMA but rather, the AMA (after various discussions with the Commission) pursued its formally amended application for authorisation. That is, the application that was formally amended by the AMA at the pre-decision conference in Adelaide in June 1998. It is somewhat curious that the AMA as applicant pursued its amended application for authorisation from the ACCC on the one hand but were apparently submitting there was a lack of jurisdiction on the other.

Advertising

Many of the legislated restrictions on medical practitioners' advertising have been removed as part of the review of all legislation that contains anti-competitive provisions.

I understand that many of you may feel that it is unethical or unprofessional to advertise medical services. I don't plan to question those beliefs. However, I wonder if any of you would be concerned about a medical practitioner who advertises their name, qualifications, location, hours of operation and fees. I suspect not. This type of advertising provides useful information to patients to assist them in choosing a medical practitioner. It is this type of information that promotes competition to the benefit of patients and I can see few arguments for restricting advertising of this form.

If on the other hand, a medical practitioner advertises that he has qualifications that he does not hold, or that a certain procedure will provide results that are unproven, then I'm sure that most of you would be very concerned. I can assure you that the ACCC would share this concern. This type of information, which is false and misleading, does not promote competition and does not benefit patients. Instead, in the case of health, it has the potential to do great harm to a patient's well being.

The Trade Practices Act has strong consumer protection provisions that prohibit advertising that is false and misleading, or likely to mislead (section 52) as well as advertising that makes false representations (section 53). While the Commission is

keen to see factual information being provided to patients, we are equally keen to ensure that advertising of medical services complies with the Trade Practices Act. That is, the Commission's concern is to ensure honest and accurate information is provided to patients and the community at large.

We have, in fact, been quite active in ensuring that advertisements for medical services do not mislead consumers. Many of the complaints that we receive about potential breaches of the consumer protection provisions of the Act come from medical practitioners themselves. They are, of course, in the best position to assess whether technical medical information is likely to be false or misleading. An example of this is advertising for laser eye surgery. The Commission received a complaint that certain advertisements for this surgery contained statements that were false or likely to mislead consumers. The Commission investigated this complaint and as a result the advertisements were stopped. The advertisers also agreed not to place similar advertisements in future. The ACCC is currently investigating further complaints in this area. I think that this is a good example of how the Commission and the medical profession can work together for the benefit of patients. There is probably more scope for this to occur in the future.

In my address to the Conference on Competition Law and the Professions in Perth in April 1997 I raised the issue of professional associations providing annual directories of members from which the public and other members of the profession can obtain information about members' practices and perhaps even fees charged. I noted that many Bar Associations were doing this and that it helped solicitors in deciding which barrister to brief to meet their clients' needs.

I can see very clear parallels between the legal profession and the medical profession here. In particular, it seems that if the professional Colleges published an annual directory of their members that this would greatly assist general practitioners who wish to refer patients to a specialist. Patients do not have the right of direct access to specialists and often rely on a general practitioner's judgement as to the best specialist for the patient's needs. It seems to me that a directory of specialists would be a great help to general practitioners in making this judgement. It would also help patients become more actively involved in decisions that affect them by letting them see, for example, the fees that different specialists charge and the different level of experience between them. If consumers are better informed, and actively involved in the choice of specialist, then it is more likely that they will be referred to a specialist who best meets their needs in terms of both service and price. This could also make a significant contribution to enhancing patient understanding and satisfaction with the role of and treatment by medical specialists.

I would be interested to know if any of the Colleges have taken up this suggestion or propose to do so.

Future regulation of professionals in the health sector

A National Competition Council discussion document circulated earlier this year suggested that the ACCC should have a major role in regulating the professions. The NCC's suggestions included the development of ACCC guidelines, codes or deemed-to-comply standards under the Trade Practices Act, to incorporate provisions for the

reservation of title and competency standards for each profession. These would be enforced by the ACCC and would replace existing legislation (as well as other standards supported by legislation) applying to the professions.

The Commission's view is that it would not be appropriate for it to undertake such a central role in the regulation of the professions. The Commission is primarily an economy-wide enforcement agency although our regulatory role has been increased considerably. The Commission has neither the expertise nor the resources to play a direct role in setting and/or enforcing industry-specific standards for the professions. The Commission's understanding is that the issues involved in the future regulation of the professions have moved on since that discussion paper was prepared and those suggestions are not being pursued by the NCC.

Competition and the health sector

Some commentators have questioned the appropriateness of applying the TPA to the health sector. Some have questioned the Commission's approach to enforcing the law in relation to health. These questions are on the basis that things like quality of service, ethical matters and the doctor/patient relationship are peculiarly important to the health sector. It has also been suggested that there may be possible economic distortions in the market for health services - caused by things like supplier induced demand (ie. doctors creating additional work for themselves by encouraging patients to seek additional treatment) and distortions caused by the existence of Medicare, private health insurance and public indemnity insurance. Implicit in the questions about the Commission's enforcement activities is a belief that the Commission does not understand these issues and is pursuing competition for competition's sake.

However, I would suggest that these things do not have a big impact on the matters looked at by the Commission. This is because the sorts of issues that the Commission deals with in relation to the health sector usually do not raise these high level considerations. The issues where the Commission usually becomes involved in relation to the health sector are similar to the issues that the Commission becomes involved in with other sectors - ie. generally the use of market power to increase income. In this context, I would point out that the Federal Trade Commission (the American antitrust enforcement agency) spends a high proportion of its time (maybe 25%) on health matters. Most of these cases do not raise the sort of high level issues alluded to earlier. For example, what is it about ethics, the doctor/patient relationship, or quality of care that warrants a boycott of a hospital so that operations can not be performed unless a supplier of medical services gets a pay rise?

Some individual people have also argued that increased competition in the health sector would be a bad thing as the focus would be on price competition which would be likely to lead to a decline in the quality of the service being provided. However, I would point out that a well functioning market will aim to provide consumers with what they want. In the medical services market, consumers are likely to want a quality service first and a good price second. As a consequence, increased competition in the health sector will manifest itself in competition over the quality of the service being provided.

Experience in other sectors of the economy would not support the claim that service quality would be likely to decline as competition has been shown to lead to an increase in quality. For example, many in the community would agree that in Telecommunications, the service provided by Telstra has improved since it was subjected to competition by Optus. And of course consumers now have a choice as to the supplier they want to deal with. In any event quality of care under any environment is a matter for governments, health departments and State and Territory health boards and individual practitioners themselves.

I would respond to concerns about the Commission's approach to enforcing the law by noting that, all things being equal, we have taken the same approach to the health sector as we do to any other sector. That is, we have used and are using both education and enforcement to secure compliance by the health sector with the requirements of the TPA. Accordingly, we will vigorously investigate any allegation of breaches of the Act that fall within our priorities. If we believe that a breach has occurred, we seek to remedy this in exactly the same manner as we would if a non-health related breach is identified. Of course, I should remind you that it is ultimately the Courts that decide if a breach has occurred.

Criticisms of the Commission's approach also overlook the fact that there are checks and balances built into the Act to ensure that competition is not pursued for its own sake and that the Commission's decisions are subject to independent review.

Conclusion

I would like to stress the point that the health sector really has to learn to live with the TPA in the same way that businesses in every other sector of the Australian economy do. The application of the Act to the health sector has strong political support - all major parties and States believe that the TPA should apply to the sector. Attempts by various bodies to lobby State Governments for exemptions to the TPA have failed. Thus, there is a need for all health sector participants to become familiar with their rights and obligations under the TPA. Understanding how to comply with the TPA should be a major focus for all in the health sector. At the same time, you should be aware that the Commission is learning how to deal with the health sector and its special characteristics.

I am confident that in a few years consumers will be much benefited from the extension of the TPA to the Health Sector. As well ethical health sector professionals will not be constrained by rules and regulations which inhibit their growth and success while protecting the inefficient.

In conclusion I would like to say that the Commission is firmly of the view that professional associations can do a lot to help their members understand their rights and responsibilities under the TPA, and ultimately to comply with its requirements. I also draw your attention to the generic Australian Standard on compliance systems (AS 3806 - 'Compliance Systems') issued by Standards Australia in February 1998.

The challenge for the professional associations is to adapt the compliance standard to suit the association's needs and their member's needs. The aim is to understand and comply with the law. To be effective, compliance activities need to go beyond the

issuing of manuals and/or videos to ensuring a change in the culture and conduct of the ‘business activities’ dimension of a professional person’s practice of a profession.