Draft Determination

Application for revocation of authorisation A91334 and the substitution of authorisation A91599

lodged by

Australian Medical Association (AMA)

in respect of

intra-practice price setting by general practitioners and collective bargaining by single practices

Date: 6 December 2017

Authorisation number: A91599

Commissioners:

Sims
Rickard
Schaper
Court
Featherston

Summary

The ACCC proposes to re-authorise general practitioners that practise in defined business structures to set intra-practice fees and to collectively bargain as a single practice in relation to the provision of Visiting Medical Officer services and with Primary Health Networks (formerly Medicare Locals). The ACCC proposes to re-authorise this conduct for a further 10 years.

The ACCC originally authorised this conduct in 2013. The conduct has not changed since the original authorisation, except for a minor variation in 2016 to reflect the establishment of Primary Health Networks.

The ACCC will seek submissions in relation to this draft determination before making its final decision.

The application for authorisation

1. On 1 September 2017 the Australian Medical Association Limited **(AMA)** lodged an application with the Australian Competition and Consumer Commission (**ACCC**) under section 91C(1) of the *Competition and Consumer Act (2010*) (**the Act**) to revoke authorisation (A91334) and to substitute a new authorisation (A91599) (referred to as **re-authorisation**). The original authorisation (A91334) is due to expire on 15 March 2018.

2. Authorisation is a transparent process where the ACCC may grant protection from legal action for conduct that might otherwise breach the Act. In this case, the AMA has sought re-authorisation for conduct between GPs in a practice, who are technically competitors, because the conduct might be a cartel provision or might have the purpose or effect of substantially lessening competition within the meaning of section 45 of the Act.

3. The ACCC may 'authorise' businesses to engage in anti-competitive conduct where it is satisfied that the public benefit from the conduct outweighs any public detriment. The ACCC conducts a public consultation process when it receives an application for authorisation, inviting interested parties to lodge submissions outlining whether they support the application or not. Before making its final decision on an application for authorisation the ACCC must first issue a draft determination.[1]

4. The AMA is seeking re-authorisation to permit general practitioners (**GPs**) (that practise in defined business structures immediately below) to continue to engage in:[2]

    - intra-practice price setting

    - collective bargaining as single practices in relation to the provision of Visiting Medical Officer (**VMO**) services to public hospitals with '**VMO Service Purchasers**' which includes health departments, local area networks and hospitals as relevant and

[1] Detailed information about the authorisation process is contained in the ACCC's Guide to Authorisation available on the ACCC's website **www.accc.gov.au**.

[2] AMA application for re-authorisation A91599, 1 September 2017, p 3.

- collective bargaining as single practices with Primary Health Networks in relation to the provision of medical services including after-hours services (collectively referred to as the **Conduct**).

5. The AMA seeks re-authorisation to cover GPs who practise in a single general practice where those GPs:[3]

    i. Operate within the following business structures:

        - a partnership of two or more GPs where not all partners are natural persons (that is, where at least one is a body corporate or other separate legal entity)
        - an associateship of two or more GPs
        - any other business structure which involves two or more separate legal persons, whether natural persons, partnerships and/or bodies corporate, or
        - any of the above which, from time to time, employs GPs on a locum basis and

    ii. Share three or more of the following:

        - patient records
        - common facilities
        - a common trading name and/or
        - common policies and procedures.

6. The parties potentially involved in the Conduct are GPs and locums throughout Australia (including non-AMA members)[4], public hospitals that contract with GPs for VMO services and Primary Health Networks which use the services of GPs.

7. The AMA (including its State and Territory affiliates) is not directly involved in the Conduct. The AMA advises that any collective bargaining and intra-practice price setting occurs at the local level by GPs and the relevant negotiating party. The AMA advises that collective negotiations are typically handled by one or more of the practice owners.[5]

8. The AMA does not seek authorisation for collective boycott activity.[6] No parties are compelled to participate in the Conduct and GPs may withdraw from collective bargaining negotiations with VMO Service Purchasers or Primary Health Networks.[7]

9. The AMA has sought re-authorisation of the Conduct for a further 10 years.[8] The Conduct is the same as that previously authorised by the ACCC.

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3 Ibid, pp 3,4.
4 Submission from the AMA, 20 October 2017, p. 1.
5 Submission from the AMA, 20 October 2017, p. 3.
6 AMA application for re-authorisation A91599, 1 September 2017, pp 3,4..
7 Submission from the AMA, 20 October p. 1.
8 AMA application for re-authorisation A91599, 1 September 2017, p 4.

10. The AMA seeks to maintain the immunity for GPs that choose to take part in the Conduct. The AMA submits that a team-based approached to the provision of healthcare within single practices is likely to improve patient outcomes. It advises that it seeks re-authorisation to provide GPs and practices with legal protection from certain action under the Act for relatively straightforward conduct, without having to seek third party advice or representation.[9]

Background

The parties

11. The **AMA** is a national health advocacy organisation in Australia, representing more than 29 000 medical practitioners across Australia, including 7356 GP members.[10] AMA membership includes doctors employed in the public sector and in private practice, and covers a range of special interest groups – namely, salaried doctors, general practitioners, other specialists, academics, researchers and trainee doctors. Medical students are also eligible for membership.[11]

12. The AMA has affiliated organisations in each State and Territory. When doctors join the relevant State or Territory organisation, they are granted membership of the federal AMA.

13. The AMA advises that its aims and objectives are to:[12]

- promote and advance ethical behaviour by the medical profession and protect the integrity of independence of the doctor-patient relationship
- promote and advice public health
- protect the academic, professional and economic independence and the well-being of medical practitioners and
- preserve and protect the political, legal and industrial interest of the medical practitioners.

14. In 2015, there were 27 754 GPs across Australia, which represents 111.6 full time equivalent (FTE) GPs per 100 000 population.[13] There are approximately 7000 general practices nationwide.[14]

15. GPs are free to decide how much to charge for their services, taking into account a range of factors including competition and their particular costs in delivering services. The Australian Government sets a Medicare Benefits Schedule (MBS) fee for most medical services. However, GPs may charge their patients more than the MBS fee if they choose. Medicare pays a benefit of 75 per cent of the MBS fee

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9 Submission from the AMA, 20 October 2017, p. 1.
10 Australian Medical Association, *Annual Report 2016,* p 51.
11 Ibid, p 1.
12 Ibid.
13 AIHW, *Medical practitioners overview data tables, Table 4: Employed medical practitioners (main field of medicine, selected characteristics, 2012 and 2015)* viewed at **https://www.aihw.gov.au/reports/workforce/medical-practitioners-workforce-2015/data** on 20.10.17.
14 Submission from the AMA, 20 October 2017, p. 5.

for in-hospital treatment (as a private patient) and 85 per cent of the MBS fee for out of hospital services. GPs may 'bulk bill' patients. This means the GP bills Medicare directly and a patient pays nothing for treatment. If the GP does not bulk bill, the patient pays the difference between what Medicare pays and the GP's fee.[15]

16. Established on 1 July 2015, there are 31 **Primary Health Networks**[16] across Australia. Primary Health Networks are independent organisations which were selected by the Australian Government with the objectives of:

    - increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes and

    - improving coordination of patient care.

17. Primary Health Networks work directly with local GPs, other primary health care providers, secondary care providers and hospitals.

18. **VMO Service Purchasers** include health departments, local area networks and public hospitals. A VMO is a doctor who is contracted to provide specialist services in a public hospital. GPs often have a role as VMOs in rural and regional public hospitals (except in the Northern Territory).

[15] Private Health Insurance Ombudsman, *A guide to consumers about doctors' fees,* pp. 1, 2.

[16] 10 in NSW, 6 in Vic, 7 in Qld, 2 in SA, 3 in WA, 1 in Tasmania, 1 in Northern Territory and 1 in the ACT.

Previous ACCC authorisations

The original AMA authorisation (A91334) – 2013

19. On 21 February 2013 that ACCC granted authorisation to the AMA for the Conduct for five years until 15 March 2018. Among other things, the original authorisation involved GPs within single practices collectively negotiating with Medicare Locals, which were replaced by Primary Health Networks in 2015. All other aspects of the Conduct have been unchanged since the original authorisation.

20. Further information about the ACCC's original assessment of the likely public benefits and public detriments from the Conduct is contained in the **2013 AMA final determination.**

AMA application for minor variation of authorisation A91334 – 2016

21. Following the Australian Government's replacement of Medicare Locals with Primary Health Networks in 2015, on 16 February 2016 the AMA applied to the ACCC for a minor variation to authorisation A91334. The ACCC was satisfied that the variation did not result in any reduction to the net public benefits resulting from the Conduct originally authorised. The ACCC granted the variation to allow GPs to collectively bargain with Primary Health Networks on 8 April 2016.

Other previous authorisations

22. Over the years, the ACCC has granted other authorisations to permit GPs in a general practice to engage in intra-practice price setting and to collectively negotiate VMO contracts. These matters are summarised below:

Organisation	Year	Authorised conduct	Expired
Royal Australian College of General Practitioners (**RACGP**)	2002 (A90795) and 2007 re-authorisation (A91024).	These two authorisations permitted GPs and other medical practitioners in general practice to engage in intra-practice price setting and collective bargaining (as single practices) of VMO services to public hospitals.	Authorisation (A91024) was granted for 4 years. Expired on 14 June 2011.
Rural Doctors Association of Australia (**RDAA**)	2008 (A91078)	This authorisation permitted the RDAA and its state associations to collectively negotiate, on behalf of RDAA members who were rural generalists and GPs, with state and territory health departments regarding the provision of VMO services.	Authorisation granted for 5 years and expired on 30 June 2013.

AMA (NSW)	2013 (A91383)	Re-authorisation for AMA (NSW) to collectively bargain with the NSW Ministry of Health and public health organisations regarding the terms and conditions of employment of VMOs within the NSW public health system.	Re-authorisation granted for 10 years and will expire on 30 December 2023.
AMA (NSW)	2017 (A91590)	Granted on 24 November 2017, this authorisation permits the AMA (NSW) to negotiate on behalf of VMOs the terms and conditions (including remuneration) of VMO contracts with Healthscope Operations Pty Ltd at the Northern Beaches Hospital. The conduct effectively extends the scope of AMA's (NSW) existing collective bargaining arrangement (A91383) with the NSW public health system to those VMOs employed by Healthscope.	Authorisation granted for 5 years until 2022.

What has happened under the current AMA authorisation (A91334)?

23. The AMA submits that during the life of the current authorisation it has not received any negative feedback about the Conduct from GPs, health consumers or any other stakeholder. Regarding participation in the Conduct, the AMA advises that:

- **Intra-practice price setting** – is widely engaged in by GPs, with a history of ACCC authorisation dating back until 2002.[17]

- **Collective negotiation of VMO contracts** – this has mainly been used in rural areas. The AMA submits that this conduct supports rural GPs/practices and rural hospitals to engage in local discussions about services provided, including on call rosters, after-hours coverage, procedural services and emergency care. It submits that the current authorisation provides reassurance to those GPs and practices that wish to negotiate directly with their local hospital.[18]

- **Collective negotiations with Primary Health Networks (formerly Medicare Locals)** – there has been participation in this aspect of the Conduct in both metropolitan and rural areas. For example:

[17] AMA application for re-authorisation (A91599), 1 September 2017, p. 5.
[18] AMA submission, 20 October 2017, p. 5.

- Under the former Medicare Locals After-Hours Program, Medicare Locals coordinated after-hours GP services which would have involved the negotiation of contracts for the provision of these services with an estimated 1500 general practices. The current authorisation helped to ensure that GPs in these practices could discuss the terms and conditions on which services could be supplied and the AMA understands that around 95 per cent of practices that were previously funded to provide after-hours GP services took up contracts with Medicare Locals.[19]

- More recently, the NSW Government has established a number of Integrated Care Pilots to improve the management of chronic conditions in primary care. This pilot program involves local Primary Health Networks negotiating with general practices, including about GP support payments participating in the pilot. The AMA expects more initiatives utilising the services of GPs like the Integrated Care Pilot will be developed in the future, given that health policy increasingly focuses on strengthening the delivery of primary care.[20]

24. Further, the AMA advises that since the original authorisation was granted in 2013 the rate of bulk billing for GP attendances increased from 82.4 per cent (March quarter of 2013) to 85.6 per cent (March quarter 2017).[21]

Consultation

25. The ACCC tests the claims made by an applicant in support of its application for authorisation through an open and transparent public consultation process.

26. The ACCC invited submissions from a range of potentially interested parties, including health departments, Primary Health Networks, relevant industry associations and peak bodies and consumer groups.[22]

27. The ACCC received two submissions from interested parties. These submissions generally supported AMA's application for re-authorisation of the Conduct. An overview of the public submissions received from the AMA and interested parties follows.

AMA

28. Overall, the AMA notes that no stakeholders have raised concerns with it since the ACCC originally authorised the Conduct. The AMA submits that the Conduct is likely to continue to result in a number of public benefits and the previous factors that mitigated the likely public detriment from the Conduct continue to apply.[23]

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19 AMA submission, 20 October 2017, p. 2.
20 Ibid.
21 AMA application for re-authorisation, 1 September 2017, p. 17.
22 A list of the parties consulted and the public submissions received is available from the ACCC's public register www.accc.gov.au/authorisationsregister.
23 AMA application for re-authorisation, 1 September 2017, pp. 15, 17.

Interested parties

29. The ACCC received a combined submission from the **Rural Doctors Association of Australia** and the **Australian College of Rural and Remote Medicine**. They support re-authorisation for ten years, noting the absence of evidence to indicate that the original authorisation had a detrimental impact on competition or patient access to services, and the widespread acceptance of the Conduct by all stakeholders.[24]

30. **Gippsland Primary Health Network** supports re-authorisation of the Conduct for ten years. Among other things, it submits that:[25]

> The renewal of AMA's authorisation aligns to Gippsland PHN [Primary Health Network's] purpose by ensuring people attending general practice are not disadvantaged by fee uncertainty and confusion but influenced by quality clinical care and efficient business practices.

31. Copies of public submissions may be obtained from the ACCC's website **www.accc.gov.au/public-registers.**

ACCC assessment

32. On 6 November 2017 a number of amendments to the Act came into effect, including changes to the authorisation provisions in Division 1 of Part VII of the Act. Pursuant to section 183(2), these changes apply to applications for authorisation under consideration by the ACCC on or after 6 November 2017. Accordingly, the Act, as amended, will apply to this application for re-authorisation, notwithstanding that it was lodged with the ACCC prior to the amendments coming into effect.

33. The ACCC's assessment of the Conduct is carried out in accordance with the relevant authorisation tests[26] contained in the Act. In broad terms, the ACCC may only grant an application for revocation and substitution if it is satisfied that the proposed substitute authorisation satisfies the relevant authorisation test.

34. In this case, pursuant to subsections 90(7) and 90(8) of the Act, the ACCC must not make a determination granting the substitute authorisation in relation to conduct unless it is satisfied that in all the circumstances that the conduct would result, or be likely to result, in a benefit to the public, and that benefit would outweigh the detriment to the public that would result, or be likely to result, from the conduct.[27]

35. To assist the ACCC's assessment of conduct against the authorisation test, the ACCC identifies the relevant **area(s) of competition** and compares the benefits and detriments likely to arise in the **future with the conduct** for which authorisation is sought against those in the **future if the conduct did not occur**.

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24 Combined submission from the Rural Doctors Association of Australia and the Australian College of Rural and Remote Medicine, received 22 September 2017, p. 1.

25 Submission from Gippsland Primary Health Network, 18 September 2017, p. 1.

26 Subsections 91C(7), 90(7) and 90(8) of the Act.

27 As a cartel provision applies to the Conduct, the alternative test under sub-section 90(7)(a) of the Act does not apply: section 90(8).

Areas of competition

36. Consistent with the original 2013 authorisation, the ACCC considers the relevant areas of competition likely to be affected by the Conduct are localised geographic areas of competition for the provision of:

    - primary medical services to the public
    - VMO services to public hospitals and
    - GP medical services to Primary Health Networks.

Future with and without the conduct

37. In assessing the likely impact of the Conduct, the ACCC considers that without the conduct:

    - **intra-practice price setting** – other than general practices that meet certain limited exceptions,[28] GPs within practices will set prices for patients on an individual basis
    - **collective bargaining over VMO services** – apart from any GPs in practices that meet certain limited exceptions,[29] GPs will negotiate individually with VMO Service Purchasers in relation to VMO services, and
    - **collective bargaining with Primary Health Networks** – apart from GPs in practices that meet certain limited exceptions,[30] GPs will contract on an individual basis with their local Primary Health Network.

38. In the future where the Conduct occurs, the ACCC considers that GPs who practise in a single general practice (as defined at paragraph 5) will continue to have the opportunity to collectively negotiate VMO contracts with public hospitals and health authorities, collectively negotiate with Primary Health Networks and agree on the fees charged to patients when visiting any doctor within the shared practice.

Public benefits

39. Public benefit is not defined in the Act. However, the Tribunal has stated that the term should be given its widest possible meaning. In particular, it includes

> …anything of value to the community generally, any contribution to the aims pursued by society including as one of its principal elements … the achievement of the economic goals of efficiency and progress.[31]

40. The **AMA** submits that the continued authorisation of both the collective bargaining aspects of the conduct and intra-practice price setting is likely to result in public benefits, which may be summarised as:[32]

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28 For example, practices that are partnerships of natural persons, practices that constitute single bodies corporate or related bodies corporate and certain joint ventures.

29 As above in footnote 28.

30 As above in footnote 28.

31 *Queensland Co-operative Milling Association Ltd* (1976) ATPR 40-012 at 17,242; cited with approval in *Re 7-Eleven Stores* (1994) ATPR 41-357 at 42,677.

- efficiencies for GPs and contracting parties
- greater input by GPs into terms and conditions of their contracts with VMO Service Purchasers and Primary Health Networks
- continuity and consistency of patient care, resulting from predictable pricing among GPs operating within a single practice
- fostering a team approach to patient care within a single practice and
- assisting with the attraction and retention of GPs, particularly in rural and remote communities.

41. **Gippsland Primary Health Network** submits that the AMA's application for re-authorisation delivers the following benefits to the community:[33]
    - team based care and continuity of care to patients
    - transparency and reduced confusion for patients attending various GPs within one practice, and
    - efficiencies for practices, which can translate into increased effectiveness and access to services for patients.
42. Further, Gippsland Primary Health Network considers that the Conduct:

> …enables our rural and the more remote general practitioners to negotiate on a practice by practice basis and that this is likely to provide certainty for employees when attracting and retaining potential general practitioners to the region and assist in the retention of rural doctors.[34]

ACCC view

43. In its original 2013 authorisation, the ACCC concluded that the Conduct was likely to result in a number of public benefits. The ACCC considered that the Conduct was likely to increase the attractiveness of and benefits of shared practice through:
    - administration efficiencies for single general practices which can reduce the number of different charging schedules each practice must administer and allocate costs against
    - a greater ability (at the margin) for single general practices in remote and regional areas to attract and retain locums and GPs (through greater certainty relating to remuneration packages), and
    - improved continuity and consistent patient care by providing a seamless integrated service across GPs in each practice.
44. The ACCC also concluded that the collective bargaining aspect of the Conduct was likely to result in public benefits, including:

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32 AMA application for re-authorisation, 1 September 2017, p. 15.
33 Submission from Gippsland Primary Health Network, 18 September 2017, p. 1.
34 Ibid.

- a greater ability for GPs within a practice to identify efficiencies in the way that the practice provides VMO and GP services to public hospitals and health authorities and Medicare Locals (now Primary Health Networks), following the information exchange inherent in collective bargaining

- efficiencies for GPs within a practice that can share negotiation expertise and costs

- efficiencies from transaction cost savings for any VMO Service Purchasers and Medicare Locals (now Primary Health Networks) that are able to reduce the number of negotiation processes that must be engaged in and contracts that must be monitored, and

- greater input by GPs within a practice into the terms and conditions under which services are provided by the GPs in that practice to VMO Service Purchasers and Medicare Locals (now Primary Health Networks), which is likely to lead to more efficient contracts and service provision.

45. The ACCC considers that the Conduct is likely to continue to result in the public benefits identified and accepted in 2013. The ACCC has recognised that there are transaction costs associated with contracting and these costs can be lower where a single negotiation process is employed, relative to a situation where there are multiple negotiation processes recurring. The Conduct will also continue to provide the opportunity for GPs (within a single practice), public hospitals and health authorities and Primary Health Networks to collectively negotiate mutually beneficial contracts.

46. In addition, the ACCC notes the general level of support from interested parties for GPs to continue to engage in the Conduct. The ACCC considers the continuation of the Conduct underpins long standing intra-practice price setting arrangements, which is likely to continue to facilitate a team-based approach within shared general practices and provide fee certainty to patients visiting these practices.

Public detriment

47. The Act does not define what constitutes a public detriment and the ACCC adopts a broad approach. This is consistent with the Tribunal which has defined it as:

> …any impairment to the community generally, any harm or damage to the aims pursued by the society including as one of its principal elements the achievement of the goal of economic efficiency.[35]

48. In the original authorisation decision, the ACCC concluded that the Conduct was likely to result in little, if any, public detriment in local markets since:

    a) The provision of primary medical services to the public is unlikely to be affected by reduced competition or services from intra-practice price setting since:

        - around 80 per cent of GP services in Australia are bulk-billed

        - prices are only being set within practices, and inter-practice competition (on price and non-price terms) would continue

[35] *Re 7-Eleven Stores* (1994) ATPR 41-357 at 42,683.

- existing intra-practice competition is likely to be limited in associateships and partnerships due to the sharing of patient records and an emphasis upon a team approach

b) VMO services to public hospitals and Medicare Locals (now Primary Health Networks) are unlikely to be affected by reduced competition or services from collective bargaining with GPs since:

- the Conduct covered any GP, including non-AMA members
- the collective bargaining is voluntary for VMO Service Purchasers and Medicare Locals (now Primary Health Networks)
- any collective bargaining would be conducted by small groups and
- public hospitals and Medicare Locals (now Primary Health Networks) operating within the constraints of health budgets, will provide a consistent and limited cost framework in which the negotiating parties will have to operate.

49. The **AMA** submits that the above mentioned factors continue to apply in the current re-authorisation application. In particular, it notes that under the current authorisation, the bulk billing rate for GP services has remained at high levels – and has increased from 82.4 per cent in March 2013 to 85.6 per cent in March 2017.[36] It also submits that the voluntary nature of collective bargaining (for GPs, VMO Service Purchasers and Primary Health Networks) minimises any likely public detriment from the collective bargaining aspect of the Conduct.

50. The **Rural Doctors Association of Australia** and the **Australian College of Rural and Remote Medicine** support re-authorisation of the Conduct given that it:[37]

> …continues to cover all general practitioners; together with the absence of any evidence indicating that the previous application has had a detrimental impact on competition or patient access to services; and its widespread acceptance by all stakeholders…

51. While supporting the AMA's application for re-authorisation, **Gippsland Primary Health Network** raised the following issues for consideration by the ACCC:[38]

- The authorisation must remain voluntary for all GPs within the practice
- GP discretion to discount fees for patients must be maintained
- The authorisation must be limited to intra-practice fee setting…

52. In response, the **AMA** confirmed that no parties are compelled to take part in the Conduct for which re-authorisation is sought, including the ability for GPs to refuse to participate in or withdraw from any collective negotiations with VMO Service Purchasers or Primary Health Networks. In addition, it submits that there is nothing

[36] AMA application for re-authorisation A91599, 1 September 2017, p. 17.
[37] Combined submission from the Rural Doctors Association of Australia and the Australian College of Rural and Remote Medicine, 22 September 2017, p. 1.
[38] Submission from Gippsland Primary health Network, 18 September 2017, p. 1.

in the Conduct that would prevent a GP from exercising discretion over the fees charged to patients and this already happens extensively now.[39]

ACCC view

53. The ACCC notes that the AMA's application for re-authorisation does not extend to inter-practice price setting, and therefore, any authorisation would not extend to such conduct. Given the conduct is voluntary for all parties, there have been no changes to the Conduct since the original authorisation, and the absence of any submissions from interested parties that the Conduct has had a detrimental impact on competition or access to medical services, the ACCC considers the above mitigating factors (at paragraph 48) continue to apply. Therefore the ACCC considers that the Conduct is likely to result in minimal, if any, public detriment in local markets for the provision of primary medical services to the public, VMO services to public hospitals and GP medical services to Primary Health Networks.

Balance of public benefit and detriment

54. Broadly, the ACCC must not grant re-authorisation unless it is satisfied, in all the circumstances, that the Conduct for which re-authorisation is sought is likely to result in a public benefit, and that public benefit will outweigh any likely public detriment.

55. The ACCC is satisfied that the Conduct is likely to result in public benefits. In particular, enabling GPs to continue to engage in the Conduct is likely to increase the attractiveness of and benefits of shared practice through:

- administration efficiencies for single general practices
- a greater ability (at the margin) for single general practices in remote and regional areas to attract and retain locums and GPs (through greater certainty relating to remuneration packages) and
- improved continuity and consistent patient care by providing a seamless integrated service across GPs in each practice.

56. The ACCC also considers that the collective bargaining aspect of the Conduct is likely to result in public benefits, including:

- a greater ability for GPs within a practice to identify efficiencies in the way that the practice provides services to VMO Service Purchasers and Primary Health Networks, following the information exchange inherent in collective bargaining
- efficiencies (including transaction cost savings) for GPs within a practice that can share negotiation expertise and costs
- efficiencies (including transaction cost savings) for any VMO Service Purchasers and Primary Health Networks that are able to reduce the number of negotiation processes that must be engaged in and contracts that must be monitored, and

[39] Submission from the AMA, 20 October 2017, pp. 1 and 6.

- greater input by GPs within a practice into the terms and conditions under which services are provided by the GPs in that practice to VMO Service Purchasers and Primary Health Networks, which is likely to lead to more efficient contracts and service provision.

57. The ACCC considers these significant public benefits outweigh the minimal, if any, detriment to the public, including any lessening of competition, likely to result from the Conduct.

58. Accordingly, the ACCC is satisfied that the authorisation test is met and proposes to grant authorisation.

Length of authorisation

59. The Act allows the ACCC to grant authorisation for a limited period of time.[40] This enables the ACCC to be in a position to be satisfied that the likely public benefits will outweigh the detriment for the period of authorisation. It also enables the ACCC to review the authorisation, and the public benefits and detriments that have resulted, after an appropriate period.

60. In this instance, the AMA is seeking re-authorisation for Conduct that has been operating since 2013. There have been no changes to the Conduct.

61. The AMA seeks re-authorisation for ten years, from the expiry date of the original authorisation (being 15 March 2018). In support of its request, the AMA submits that:[41]

> …given its [the original authorisation] success and demonstrated absence of any evidence that would suggest that it has had a detrimental impact on competition or patient access to services…a term of 10 years is appropriate for the current application.

62. All submissions received from interested parties support re-authorisation of the Conduct for 10 years.

63. Given the history of this Conduct, including an absence of submissions that the Conduct has resulted in any public detriment during the period of the current authorisation, the ACCC considers that the proposed period of authorisation is appropriate. Therefore, the ACCC proposes to grant authorisation for 10 years.

Draft determination

The application

64. On 1 September 2017, the AMA lodged an application to revoke authorisation A91334 and substitute authorisation A91599 (referred to as re-authorisation). The application for re-authorisation was made using Form FC, under section 91C(1) of the *Competition and Consumer Act 2010* (the Act).[42]

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40 Subsection 91(1).

41 AMA application for re-authorisation A91599, 1 September 2017, p. 4.

42 As noted at paragraph 32, changes to the authorisation provisions of the Act came into effect on 6 November 2017. A number of amendments to the Act came into effect, which apply to applications for authorisation under consideration at or after that date, including changes to the authorisation provisions in Division 1 of Part VII of the Act. Pursuant to

65. The AMA seeks re-authorisation to permit general practitioners (**GPs**) (that practise in defined business structures immediately below) to continue to engage in:[43]

- intra-practice price setting
- collective bargaining as single practices in relation to the provision of Visiting Medical Officer (**VMO**) services to public hospitals with '**VMO Service Purchasers**' which includes health departments, local area networks and hospitals as relevant, and
- collective bargaining as single practices with Primary Health Networks in relation to the provision of medical services including after-hours services (collectively referred to as the **Conduct**).

66. The AMA seeks re-authorisation to cover GPs who practise in a single general practice where those GPs:[44]

a) operate within the following business structures:

- a partnership of two or more GPs where not all partners are natural persons (that is, where at least one is a body corporate or other separate legal entity)
- an associateship of two or more GPs
- any other business structure which involves two or more separate legal persons, whether natural persons, partnerships and/or bodies corporate, or
- any of the above which, from time to time, employs GPs on a locum basis, and

b) share three or more of the following:

- patient records
- common facilities
- a common trading name and/or
- common policies and procedures.

67. Authorisation is sought as the Conduct may contain a cartel provision or may have the purpose or effect of substantially lessening competition within the meaning of section 45 of the Act.[45]

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section 183(2), these changes apply to applications for authorisation under consideration by the ACCC on or after 6 November 2017. Accordingly, the Act as amended, will apply to this application for re-authorisation, notwithstanding that it was lodged with the ACCC prior to the amendments coming into effect.

43 AMA application for re-authorisation A91599, 1 September 2017, p 3.

44 Ibid, pp 3,4.

45 The reference to 'within the meaning of section 45 of the Act' includes the making and/or giving effect to a provision of a contract, arrangement or understanding or to engage in a

68. Subsection 90A(1) of the Act requires that before determining an application for authorisation, the ACCC shall prepare a draft determination.[46]

The net public benefit test

69. For the reasons outlined in this draft determination, the ACCC is satisfied, pursuant to subsections 90(7) and 90(8) of the Act, that in all the circumstances the Conduct for which re-authorisation is sought would result or be likely to result in a public benefit that would outweigh any detriment to the public that would result or be likely to result from the Conduct.[47]

Conduct which the ACCC proposes to authorise

70. The ACCC proposes to revoke authorisation A91334 and grant substitute authorisation A91599 to the AMA. Authorisation A91599 proposes to allow GP's (that practise in defined business structures – see paragraph 66) to continue to engage in the Conduct.

71. The ACCC proposes to grant authorisation A91599 for 10 years, from the date the proposed authorisation comes into effect.

72. Under section 88(2) of the Act, the ACCC proposes to extend the authorisation to future parties to the proposed Conduct.

73. This **draft determination** is made on 6 December 2017.

74. The ACCC **now seeks submissions** in response to this draft determination. In addition, consistent with section 90A of the Act, the applicant or an interested party may request that the ACCC hold a conference to discuss the draft determination.

concerted practice, any or all of which may have the purpose or effect or likely effect of substantially lessening competition.

46 For applications for revocation and substitution of a new authorisation, section 91C(5) of the Act also requires the ACCC to comply with the requirements of section 90A prior to making a determination.

47 As a cartel provision applies to the Conduct, subsection 90(7)(a) of the Act does not apply section 90)8) of the Act. For applications for re-authorisation, section 91C(7) of the Act provides that the ACCC may only revoke an authorisation and grant a substitute authorisation if it is satisfied that the proposed substitute authorisation satisfies the relevant authorisation test.