The AMA has not demonstrated how the collective negotiation process has resulted in an increase in patient choice. Nor do the arrangements appear to reduce hospital costs. The Commission agrees that servicing private patients augments hospital budgets (by payments from private health funds) but it does not reduce overall costs. As argued previously, the collective negotiation of fees is likely in many instances to raise hospital costs. It is also likely to raise the SAHC's total expenditure on medical services provided by private medical practitioners to public patients in rural hospitals.

(d) The arrangements reduce the cost of medical services by reducing the transaction costs associated with individual negotiations between hospitals and medical practitioners. If medical practitioners had to negotiate individually they would incur significantly increased legal and related costs and this would be reflected in their fees. Hospitals would also incur additional costs through the increased transaction costs and the need to engage legal counsel. These transaction costs would ultimately impose additional costs on the public through increased demands on the general taxation and Medicare levy revenues that are utilised to fund the public hospital system.

The Commission's draft assessment of this claimed public benefit has been criticised by the AMA. The AMA claims, *inter alia*, that the Commission is 'blithely dismissive' of the AMA's position, and 'seeks to belittle the issue of transactions costs'. The AMA considers that the Commission's comments reflect some misunderstanding on the Commission's part.[44]

The Commission regrets that the AMA feels it has acted in the above manner. At all times, the Commission has considered each claim on its merit and on the basis of the available evidence. The Commission also reiterates its view that a reduction in transaction costs associated with collective negotiation is a public benefit if it delivers the same outcome at lower cost.

The AMA has pointed out to the Commission that its processes with its members are multi-faceted and work on collective negotiations is often combined with other tasks and other issues. As such the marginal cost of collective negotiation is considerably smaller than would be the case with individual negotiations.

The Commission agrees with the AMA that there is a compelling need for transaction costs to be accurately measured and properly assessed.[45] Until data are available, it is virtually impossible to evaluate claims made in relation to the impact of various forms of negotiation on transaction costs. The Commission reiterates that the onus is on the applicant to demonstrate the claimed public benefits. Given the absence of conclusive data on the issue of transaction costs the Commission is unable to place much weight on any public benefits that might be derived from this source.

Many medical practitioners can, and do, negotiate additional benefits above that contained in the standard agreement which indicates that some already have the necessary negotiation skills. The Commission acknowledges, however, that some medical practitioners will need

[44] AMA submission, June 1998, pp. 5-6.
[45] AMA submission, June 1998, p. 8.

to acquire new skills if collective negotiation is abandoned. The cost of acquiring those skills is, however, once-off. Such costs are usually incurred by industries that are undergoing restructuring. The size of the costs and the manner in which they are funded varies from industry to industry. It is not possible to say definitively whether medical practitioners would raise their fees to finance these costs.

The Commission also acknowledges that the SAHC may incur short run costs in training staff in new procedures and adjusting to new methods of negotiating.

The Victorian Department of Human Services submitted that when it changed to its present system there were some difficulties associated with the transition. The Department stated that initially, many hospital and medical staff found negotiations difficult and time consuming and some continue to experience difficulty in renegotiating contracts.

(e) Medical practitioners do not have the necessary resources or expertise to negotiate with the SAHC and its hospitals. The nature of the relationship between medical practitioners and the hospital administration in each of the small rural and urban fringe towns would also be adversely affected in the absence of the current arrangements. In these small communities members of the hospital board and administration will often be patients of the contracted medical practitioner. Tensions and conflict between individual medical practitioners and hospital officials over public hospital medical services and fees could adversely affect the standing of individual medical practitioners in the community and their relationship with patients. The arrangements remove such tension and conflict from interpersonal relationships in these communities. This leads to more harmony and equity while reducing costs.

The Commission accepts that some medical practitioners may not currently have the necessary skills to conduct negotiations with the SAHC. Consequently they may incur costs in acquiring those skills. However, many doctors do already negotiate for other items, such as access to private hospitals (if in the area) and accommodation for their general surgeries. The AMA has not explained why medical practitioners would have greater difficulty in acquiring such skills than any other private contractor.

The Commission accepts that the maintenance of harmony within small towns is desirable and that it may be unpleasant for doctors to have to negotiate with Board members who are their patients. However, these difficulties will not necessarily arise if collective negotiation is abandoned. Negotiations might, for example, take place between the doctor and the SAHC or area health service, rather than the hospital. If it transpires that the hospital is responsible for negotiating and that conflict arises, it can not be presumed that the scenario envisaged by the AMA will eventuate. There is also no reason to expect that parties behaving professionally would allow such private problems to spill over into the general community. Therefore any public benefit that arises from the potential maintenance of harmony must be heavily discounted.

(f) The SAHC and its hospitals are able to implement standard administrative procedures through collective contracts, for example, in relation to medical records, admissions, discharges, invoices, the use of facilities, on-call and emergency after hours

cover, operating sessions, clinical coding, pre admission testing, teaching, research and various other standard obligations. Evidence indicates that reduced average length of hospital stay is related to co-operative efforts between doctors with hospitals on admission and discharge procedures.

It is evident that a reduction in the average length of hospital stay is a public benefit if it is associated with improved health outcomes. However, as noted above, agreement on administrative issues can be achieved independently of collective negotiation of fees. The Commission accepts that it may well be convenient to 'piggyback' the remuneration negotiations for agreeing on such matters. However, the standard agreement as submitted to the Commission does not include many of the matters listed by the AMA under this item. Hence the nexus between the collective negotiation process and the claimed benefits would appear to be lacking.

As to the claim that cooperative efforts between doctors and hospitals on administrative matters have resulted in reduced average length of hospital stays, the Commission notes that many other factors are also involved. For example, Hirsch & Hailey (1992) found:

> The reductions in length of stay are attributable to many factors including: fewer patients who need only nursing home care being cared for in acute hospitals; better anaesthetics and antibiotics; and the use of less invasive surgical techniques. The increasing use of same-day treatments, both those which have long been performed on a same-day basis and those which until recently have required two or three days in hospital, has influenced the decline in length of stay. The continued development and increasing application of these techniques is likely to extend the decline in length of stay.

The Commission also notes that cooperative efforts between doctors and hospitals on administrative matters can be achieved in many ways and are not dependent on fees being negotiated collectively.

(g) The arrangements facilitate the collective acquisition by the SAHC and its hospitals of the full cross section of medical skills and specialities to cover state obligations to the community under the Medicare agreements and to undertake coordinated public health initiatives. In the absence of the broad range of medical skills and specialties being simultaneously available many medical procedures cannot be performed.

The Commission considers that the agreement is only one of several ways in which the SAHC and its hospitals can acquire medical skills. Any public benefits arising from the provision of such skills to the public can not be attributed solely to the agreement.

(h) The price impact on the consumer of medical services, ie the patient, is zero as the Medicare principles provide service free of charge in public hospitals. The arrangements serve to ensure medical services are available to public and private hospital patients.

Under the Medicare system the price impact on public patients is zero regardless of the way in which fees are set between medical practitioners and hospitals.

The critical issue is the price impact on the direct purchaser, ie the State government. The Commission accepts that some medical practitioners may be able to negotiate fees above those currently set collectively. However, in areas where competition is stronger, individually negotiated fees will probably be lower than those determined collectively.

In its draft determination the Commission noted that hospitals closer to Melbourne appeared to be able to negotiate lower fees than hospitals further away from Melbourne. The AMA's examination of this proposition has convinced the Commission that there is not necessarily a relationship between fees and geographic proximity to Melbourne.[46]

The Commission considers that there are many other ways of ensuring medical services are available to public hospital patients. Therefore the public benefits of such availability are not unique to the agreement. Furthermore, the AMA has not demonstrated the link between the collective negotiation of fees for medical services provided to public patients and the availability of medical services to private patients.

(i) Medical costs are only a small component of total hospital costs. Evidence indicates that total hospital costs are related to length of stay in hospital, which is affected by a large number of variables including medical technology and the nature of medical care. The arrangements ensure quality medical care is available to public patients in hospitals within their communities. This serves to reduce disruption to individuals and families of hospital care episodes and reduce the cost to the public of patient transfer to and treatment in metropolitan teaching hospitals.

The Commission accepts that the local availability of quality medical and hospital care is a public benefit. However, this is not reliant on the collective negotiation process or standard agreements. It can be achieved by other means and is one of the fundamental Medicare principles as specified in each Medicare Agreement.

(j) The arrangements redress the unequal bargaining power between individual medical practitioners and the SAHC. In past authorisation cases the ACCC has suggested that where bargaining power is unequal in an industry the industry is likely to operate less efficiently. Medical practitioners depend totally on the public hospital in their locality to treat public in-patients. Public hospital visiting rights and clinical privileges are also necessary for medical practitioners to treat their private patients in these hospitals. The lack of private hospital facilities in the areas covered by the application accentuates the impact of this dependency. Public hospitals, however, have a much larger number of medical practitioners upon which to draw to provide services. Notwithstanding this, the shortage of medical practitioners in some rural communities also affects relative bargaining power. The arrangements covered by this application serve to assist the SAHC recruit scarce medical practitioner resources in these areas and prevents doctors in some localities and hospitals in others from the extraction of monopoly rents.

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[46] see AMA submission, June 1998, p. 6.

The balance of negotiating power does not appear to be clear cut. The Commission considers that there is a high level of mutual dependency between rural medical practitioners and public hospitals.

The Commission accepts that the arrangements assist the SAHC recruit scarce medical resources in rural areas and has already acknowledged that the availability of such resources is a public benefit. However, the Commission is not convinced that other, less anti-competitive, arrangements would not also achieve those benefits.

The AMA has raised the possibility that doctors and/or hospitals may extract monopoly rents if collective negotiations are abandoned. Monopoly rents can only be extracted and maintained if there are barriers to market entry (regulatory, economies of scale, etc.). If there are no barriers to entry, new resources will be attracted to the market by the monopoly rents and compete those rents away. The Commission considers that barriers to entry to rural medical practice are low, notwithstanding the shortage of rural doctors. A distinction needs to be drawn between high prices arising from monopoly rents and high prices in areas where there are shortages. The former reduces economic efficiency whereas the latter improves economic efficiency by acting as a signal for more resources to enter a region.

The Commission acknowledges the likelihood that private practitioners will be able to negotiate higher fees in some locations than in others. This is in keeping with competitive market outcomes provided that the outcomes do not result from collective actions such as boycotts.

The Commission considers it unlikely that public hospitals would be able to extract monopsony rents. In markets where there is only one hospital the Commission considers that the bargaining power is likely to reside with the general practitioner. In other markets, hospitals will be in competition for scarce medical resources and will need to pay competitive prices to attract those resources.

(k) Industrial harmony, trust, goodwill and certainty in contract terms decrease the need for recourse by individuals to the courts to settle contract disputes. Continuity in the delivery of medical services is enhanced by the arrangements.

The Commission is not convinced, on the information supplied by the AMA, that the current arrangements provide any greater industrial harmony or continuity of service than other arrangements.

(l) Contract stability also encourages the full cross section of medical specialists to set up private practices in the larger centres such as Whyalla, Mt Gambier and Port Augusta, based in part on predicted and available public hospital work. This contract stability and the continuing medical education provisions of the arrangements also encourage general practitioners to obtain and maintain the procedural skills necessary to undertake public hospital work. This ensures that the range of skills necessary to undertake complex medical procedures for both public and private patients in both public and private hospitals is available to the community.

The Commission agrees that there is a public benefit from having the range of skills necessary to undertake complex medical procedures available to the community. However, contract stability can be achieved in a number of ways and does not depend on collective negotiations. For example, a medical practitioner may be able to secure even greater stability by negotiating a longer term agreement on an individual basis. Similarly, the continuing medical education provisions could be contained in other forms of arrangement.

(m) The arrangements enable integrated, multi specialty, 24 hour emergency cover to be collectively organised and available for public hospital patients.

It is unclear from the AMA's submission how the collective negotiation process and standard agreement achieve this claimed benefit. Similar claims could be made about the systems in place in other States that do not involve collective negotiation of fees.

(n) The arrangements provide a cheaper option for securing medical services in South Australia's rural public hospitals where full time salaried medical staff in specific disciplines would not be fully utilised.

The Commission agrees that the use of contracted private practitioners is probably cheaper than the employment of full time salaried medical officers in rural SA public hospitals. However, the matter is irrelevant to this application. It is the manner in which private practitioners are contracted that is the relevant issue.

(o) The arrangements provide for the focus of individual competition between medical practitioners for public hospital appointments to be on quality of services and clinical skills through the clinical privileging process rather than price. In circumstances of an excess of medical practitioners over available appointments, selection is based on demonstrated clinical skills and experience and not the lowest price. This ensures public benefits accrue from the provision of quality medical services.

It is the Commission's understanding that the clinical privileging process ensures that private practitioners who practise in public hospitals have the necessary level of clinical skills and experience. It is this process which provides the public benefit of ensuring the provision of quality medical services. The clinical privileging process and the contracting of private medical practitioners to provide medical services to public hospitals are quite separate activities.

The collectively negotiated fee for service arrangement reduces the opportunity for hospitals to offer different fees to doctors with different levels of skills and experience but who nevertheless satisfy the requirements for gaining clinical privileges. For example, a less experienced doctor may warrant a lower fee than a very experienced doctor. Less experienced doctors may be dissuaded from offering to work at lower rates than those collectively agreed because of the notion that the negotiated rate is 'fair'.

(p) The arrangements provide for equitable access to essential public facilities by medical practitioners to treat public and private patients and for patients to be treated by their family medical practitioner in the local public hospital.

The Commission considers that achieving fair and equitable access by medical practitioners to public hospitals is not reliant on these particular arrangements and that the AMA has not demonstrated that this is the case. Furthermore, the agreement, as submitted to the Commission, only makes reference as to how private patients will be billed and is silent on the question of access by medical practitioners to treat private patients. Furthermore, this benefit appears to be a private, rather than a public benefit.

As to the claim that the arrangements enable patients to be treated by their family medical practitioner, the Commission does not consider this to be a result of the collective negotiation or the agreement as it stands. There is no reference in the agreement to such matters. In addition, the Medicare system does not enable a public patient to choose their doctor. The fact that in rural areas a public patient may be treated by their family doctor in a public hospital in more likely a function of the low number of doctors in the area.

(q) The arrangements provide for countervailing market power. Medical practitioners depend on public hospital appointments to secure access for both public and private patients to public hospital facilities and medical services. Such access facilitates capital investment in private medical practices in the locality of the hospital. However, there is little scope for using these private medical practices for purposes other than the provision of medical services. Furthermore, medical practitioners do not own the public hospital. These are owned by governments. The arrangements provide a level of stability that facilitates private medical investment in these communities.

These claims are similar to those made in point (j) above. The Commission agrees that investment in private medical facilities is a public benefit. However, it is not convinced, on the evidence currently before it, that there is a nexus between the arrangements subject to this application and the investment in private medical facilities.

Securing access to public hospitals is a separate issue to that covered by this application and can be achieved without the collective negotiation process.

(r) The arrangements facilitate greater coordination among medical practitioners in relation to specific community health initiatives and ensures the public hospital has the capability, expertise and stability of work force to plan for the health and medical needs of the community.

The agreement submitted to the Commission does not cover such coordination issues. Other States have demonstrated that such coordination can be achieved without the need for collective negotiation of fees and standard contracts.

(s) Market efficiency will decrease if a collective approach is not continued, ie transaction costs will increase and the lack of integration of the services across medical

disciplines, between medical practitioners and with the hospital has the potential to affect the range and quality of services provided to the community.

The Commission acknowledges that the Victorian experience suggests that a change from the collective approach is likely to result in some short term difficulties. However, there is insufficient data to evaluate the relative efficiency of current and alternative systems. Consequently, the Commission is not convinced, on the basis of information currently before it, that market efficiency would be improved in the longer term under a collective approach relative to some other arrangement. Nevertheless, the Commission considers that the current system is likely to reduce market efficiency by distorting the manner in which prices are determined in the market.

(t) The contract and medical work force stability arising from the arrangements enable the public hospitals to engage in formal quality assurance, medical, training and research programs and to provide the clinical supervision and expertise necessary to meet medical training and quality assurance program requirements.

As noted previously the Commission is not convinced that the collective arrangements lead to greater contract and medical work force stability than other arrangements.

(u) The arrangements provide for predicability for the SAHC in health and medical service costs, hence facilitating better planning of services.

Predicability of costs depends on price and volume. Under fee for service arrangements, medical practitioners are paid a known rate for every procedure they perform. The number of procedures is not known at the time of entering into the arrangements. Since volume cannot be controlled then there is little predicability under fee for service arrangements whether collectively or individually negotiated. In any event, other arrangements adopted by the SAHC may also provide for such predicability; it is not unique to a collective negotiation process.

(v) The arrangements provide for an orderly and structured system for the resolution of disagreements and disputes over medical service provision to public hospital patients. These arrangements facilitate liaison between senior SAHC and AMA officials and medical practitioners, provide an infrastructure to negotiate difficult issues and to raise them with the Minister for Health when necessary and provides a mechanism for independent arbitration to resolve disputes. This gives rise to public benefits by minimising the impact on public hospital medical services of disputes over contract provisions.

It would appear to the Commission that the mechanisms for resolution of disputes is independent of the agreement as no reference is made to such dispute resolution in the agreement submitted to the Commission. In such circumstances the claimed public benefit cannot be attributed to the behaviour which is subject to this application.

(w) The granting of an authorisation will remove any uncertainty that may arise from the extension of the Trade Practices Act to the industry over the legality of continuing the

orderly process of medical services acquisition and delivery in South Australian public hospitals.

Conversely, refusing the authorisation may also remove any uncertainty. The Commission does not consider this to be a public benefit arising from the collective negotiation process or standard contract.

South Australian Health Commission's public benefit claims

5.3.13.The South Australian Health Commission also submitted that there were several public benefits arising from the Fee for Service Agreement in rural South Australia. These are addressed below (the SAHC's claims are in italics).

The agreement provides 'an efficient and effective medical service to small populations at an economical cost'.

The Commission agrees that the provision of an efficient and effective medical service is a public benefit and acknowledges that the SAHC supports the current system of collective negotiation. The Commission understands that it is difficult to compare the hypothetical costs of alternative systems of providing medical services to small populations with the known costs of the current system. The AMA criticised the Commission for using the Victorian experience with individual negotiation to question, in the draft determination, the nexus between collective negotiation and the provision of an efficient and effective medical service to small populations. The Commission accepts that there are insufficient data to compare the costs of the various systems whereby medical services are provided in rural Australia. As such, the Commission is unable to fully evaluate this claimed public benefit.

The agreement provides 'protection from exploitation for vulnerable populations where doctors are hard (to) recruit'.

The Commission has not seen any evidence that the agreement serves as a price cap for costs to vulnerable populations in their attempt to attract doctors to remote areas. This is because remote towns and small rural locations are often forced to resort to offering incentives to doctors over and above those listed in the Fee for Service Agreement. For example, doctors negotiate the provision of accommodation, guaranteed salary amounts and payment of their professional insurance levies.

The agreement provides 'a common schedule of fees which can be centrally produced and distributed to all rural hospitals, eliminating a multiplicity of regional or local schedules'.

In so far as the SAHC wants to centrally produce and distribute a common schedule of fees it can still do this without a collective negotiation process.

The agreement provides 'an ability to budget for the annual expenditure on FFS, again eliminating a multiplicity of administrative effort throughout the State'.

This issue was covered in point (u) above.

The agreement provides a cost effective means of negotiating.

The SAHC has not verified this statement. As the doctors and hospitals spend time negotiating individual packages in addition to the agreement, any lower transaction costs from centralised negotiation would appear to be minimal or normal.

Conclusion on public benefit

7.5.14. In considering the public benefits, the Commission considered the AMA claims in its June 1998 submission that the hospital contract with medical practitioners often has a covert social and political objective. This occurs if medical practitioners' private practices in rural areas are not profitable. In such cases the State government may choose to cross-subsidise medical practices.[47] The Commission has received no other comment on this issue from State governments. Whether such cross-subsidies are paid is a matter for State governments to decide and the payment does not require collective negotiation. The Commission notes, however, that the South Australian system of collective negotiation would seem to impede, rather than facilitate, any social policy objectives associated with hospital contracting. This is because the visiting medical practitioners are generally paid at the same rate regardless of location. This suggests that any cross-subsidy, if it exists, is poorly targeted and not necessarily paid only to those practitioners who are unable to sustain private practices in areas where there is considered to be a need for such a service. As noted in section 7.5.2. above, the onus is on the AMA to demonstrate that the public benefits arising from the arrangements outweigh any anti-competitive effects and that the public benefits are a result of the arrangements (and not other factors).

7.5.15.The Commission is not convinced that in all the circumstances the public benefits identified by the AMA and SAHC outweigh the anti-competitive effect of the conduct.

7.5.16. The factors influencing the Commission's reasoning fall into four categories. First, many of the claimed public benefits were not unique to the Fee for Service Agreement. That is, the benefits arise from the very provision of medical services in South Australia or the benefits can be duplicated by other systems that are less anti-competitive. Second, the Commission believes that some of the public benefits claimed would result in private benefits that would enhance the welfare or bargaining position of the applicants, but would not result in broader public benefits. Third, arrangements that do not change the status quo, but merely maintain the existing system will not generally be sufficient to be public benefits. Finally, the Commission is not convinced that there is a nexus between some of the benefits claimed and the Fee for Service Agreement.

7.5.17.The Commission considers that public benefits may arise from the reduction in transaction costs compared with other potential arrangements. However, there is insufficient data available to fully evaluate this possibility. Therefore, the weight of the AMA's argument with regard to transaction cost reductions must be discounted.

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[47] AMA submission, June 1998, p.9.

7.5.18.The Commission also considers that the availability of a skilled medical workforce and public hospital facilities to rural populations is a public benefit. However, neither the AMA nor SAHC have demonstrated the nexus between this public benefit and the collective arrangements. The Commission has also been influenced by the existence of alternative systems in other States which achieve similar public benefits without collective negotiation. The Commission is cognisant of the fact that unincorporated businesses (and therefore, doctors carrying on their professional businesses in SA without incorporating) have previously been exempt from the Trade Practices Act. In addition, collective negotiation systems have been used and developed over many years in South Australia and are supported by both sides to the negotiation. In similar circumstances, the Commission has acknowledged that there may be public benefit in allowing the industry to adjust gradually in reaching compliance with the Trade Practices Act (see South Australian chicken growers' contract, Australian Wool Exchange and Victorian Egg Industry Co-operative authorisations). In assessing these applications, the Commission accepted that in most cases there would be a public benefit in mechanisms that facilitate the transition from a regulated scheme to a deregulated regime. However, the industries were required to demonstrate a clear commitment to deregulation.

7.5.19.The Commission is of the opinion that there is some public benefit in facilitating the transition to full compliance with the Trade Practices Act in certain circumstances. This will help minimise the adjustment costs that could result from too precipitous a change from the previous exemption. A public benefit arises because a transition phase may help to allow industry participants to adjust to new negotiation systems.

7.5.20.The Trade Practices Act has already applied to doctors for over two years and therefore some adjustment should already have occurred. Furthermore, the AMA has consulted extensively with the Commission about the implications of exposure to the Act for the way in which doctors conduct their business and is well aware of the Commission's views. These factors dissuade the Commission from extending the adjustment period further.

7.5.21. The Commission recognises, however, that the SAHC is not currently in a position to switch immediately to a different system of negotiation. In Victoria, for example, there was a lead time and investigation into alternative methods which enabled the Victorian government sufficient time to develop the skills and processes necessary to implement a new system. The Commission notes that the current agreement expires on 30 June 1999. The Commission also places reliance on the SAHC submission to the effect that it is committed to examining closely its processes leading to the 'determination of payment arrangements for medical practitioners providing services to public patients in country hospitals' and its commitment and strong support for trade practices legislation.

7.5.22.The amended application requests authorisation until 30 June 1999. The Commission notes that the SAHC informed it at the pre-decision conferences that the arrangements that it intends to put in place after this time will be in keeping with trade practices requirements. The AMA also indicated that the new arrangements that it is developing are trade practices neutral and will not involve the Australian Competition and Consumer Commission.

7.6 Other issues

AMA's comments on competition policy

7.6.1. On pages 7 and 8 of its June 1998 submission the AMA makes a range of comments under the heading 'Concluding Comments on Competition Policy'. The Commission has considered these comments throughout the document except where they are of peripheral relevance to this authorisation application. The Commission's role is to administer the Trade Practices Act and competition policy is the role of the Federal and State Governments.

7.6.2. In a section headed 'The hazards of too narrow a view of the public interest' the AMA discusses the impact of competition policy on quality in the provision of health care. In doing so the AMA states that competition policy is about the 'blind pursuit of lower prices for health care' and that as a result of this pursuit 'quality is sacrificed'[48]. The Commission considers that it does not follow from the application that it is necessary for quality to be sacrificed merely because the form of negotiation of contracts is reformed. The overall quality of health services is a matter for governments, health departments, health boards and individual practitioners themselves.

Applicability to other states

7.6.3. Several submissions have expressed concern that the Commission's decision in relation to this authorisation may have implications for the manner in which other States provide medical services to public patients in rural public hospitals.

7.6.4. In any State where the AMA wishes to engage in collective negotiations, it will be necessary for an application for authorisation to be made. The Commission would then consider the anti-competitive effects of the conduct and the public benefits arising from it. Each application would be considered on its merits. It can not be assumed that an identical outcome would occur in each State because of potential differences in the types of arrangements, competitive conditions and associated public benefits.

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[48] AMA submission, June 1998, p7.

8. Conclusion

8.1.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 Commission has been informed that the contract is not compulsory, the fact that every practising doctor except one in rural SA has adopted the agreement indicates that it may have the effect of being an agreement or understanding as to price.

8.2.The Commission accepts that the provision of medical services in rural South Australia is necessary and services provided by rural doctors provide many related public benefits. However, the Commission is not convinced that these public benefits are unique to the Fee for Service Agreement or that they could not be provided by other methods that have a lesser effect on competition.

8.3.The Commission recognises that the SA medical profession has always conducted its negotiations jointly in a forum facilitated by the SA Rural Doctors' Association or the AMA. In addition, the SA Health Commission is also used to dealing with a united body and believes that the AMA endorsement of the agreement increases its acceptability among rural doctors. The SA Health Commission strongly supported the application. The Commission recognises that in light of the strong tradition built around the central negotiation system in South Australia and the entrenched process that it would be hard for both doctors and the SAHC to change this system immediately. The relevant parties have indicated that they are changing the system beyond June 1999 to arrangements that will be trade practices neutral. The Commission is therefore of the opinion that there is a public benefit in allowing a phased transition to deregulation. This will allow the SAHC, in particular, time to develop the skills and procedures necessary to implement new arrangements.

8.4.On balance the Commission considers that the public benefit from allowing the SAHC to have a period to develop new procedures will outweigh the anti-competitive effect of the agreement that fixes prices between all rural doctors providing services to SA rural public hospitals.

8.5.Of course it should be noted that the SAHC as the acquirer of medical services can choose to determine for itself the most efficient basis upon which it or the country hospitals will purchase medical services from private medical practitioners in rural South Australia. That process may or may not include consultation with the AMA, the RDASA, or other groups or individuals to assist the SAHC in determining an appropriate basis for the purchase of the requisite medical services. The appropriate basis may also vary in the different rural regions of South Australia, as the SAHC sees fit.

9. Determination

9.1. For the reasons outlined in section 7 of this determination the Commission concludes that in all the circumstances the proposed understanding and conduct for which the AMA has sought authorisation would be likely to result in a benefit to the public that would outweigh the detriment to the public constitute by any lessening of competition that would be likely to result.

9.2. On 3 April 1998 the Commission issued a draft determination proposing to grant authorisation for a period expiring on 30 June 1999 instead of the five years that the AMA had requested in its authorisation as the Commission considered that this reflected the transitory nature of the public benefit from the agreement. The draft determination was issued proposing to grant authorisation for this period subject to the condition that no party to the authorisation would engage in boycott conduct during the period of the authorisation. The AMA subsequently amended its application for authorisation — requesting authorisation until only 30 June 1999. The Commission therefore affirms the draft determination and grants authorisation for the conduct outlined in section 1.3 of this document relating to the collective negotiation of common Fee for Service Agreement for visiting medical officers in rural SA public hospitals and including necessary consultation with all doctors working in South Australian rural public hospitals.

9.3. This determination is made on 31 July 1998. If no application for a review of the determination is made to the Australian Competition Tribunal it will come into force on 21 August 1998. If an application for review is made to the Tribunal the determination will come into force:

- where the application is not withdrawn — on the day on which the tribunal makes a determination on the review; or

- where the application is withdrawn — on the day on which the application is withdrawn.

Appendix A: Hospitals covered by the application

(See map on page 5)

1. Angaston District Hospital
2. Balaklava and Riverton Districts Health Service
3. Barmera District Health Services
4. Booleroo Centre District Hospital
5. Bordertown Memorial Hospital
6. Burra Hospital
7. Ceduna Hospital
8. Central Yorke Peninsula Hospital
9. Clare District Hospital
10. Cleve District Hospital
11. Coober Pedy Hospital
12. Cowell and District Hospital
13. Crystal Brook District Hospital
14. Cummins and District Memorial Hospital
15. Eudunda Hospital
16. Gawler
17. Great Northern War Memorial Hospital
18. Gumeracha District Soldiers Memorial Hospital
19. Jamestown Hospital and Health Service
20. Kangaroo Island CHC
21. Kangaroo Island General Hospital
22. Kapunda Hospital
23. Karoonda and District Soldiers' Memorial Hospital
24. Kimba District Hospital and Health Services
25. Kingston Soldiers' Memorial Hospital
26. Lameroo District Hospital
27. Laura and District Hospital
28. Leigh Creek Hospital
29. Lower Murray District Hospital
30. Loxton Hospital Complex
31. Mannum District Hospital
32. Meningie and District Memorial Hospital
33. Mid West Multi Purpose Service (Health Service)
34. Millicent and District Hospital and Health Service
35. Mount Barker District Soldiers' Memorial Hospital
36. Mt Gambier and Districts Health Service
37. Mt Pleasant District Hospital
38. Murray Bridge Soldiers' Memorial Hospital
39. Naracoorte Hospital and Health Services
40. Noarlunga
41. Northern Yorke Peninsula Regional Health Service (Hospital)
42. Orroroo and District Health Service
43. Penola War Memorial Hospital
44. Peterborough Soldiers' Memorial Hospital and Health Service
45. Pinnaroo Soldiers' Memorial Hospital
46. Port Augusta Hospital
47. Port Broughton District Hospital and Health Service
48. Port Lincoln Community Health and Welfare Centre
49. Port Lincoln Health and Hospital Services
50. Port Pirie Regional Health Service (Hospital)
51. Pt Pirie CHS
52. Quorn and District Memorial Hospital
53. Renmark and Paringa District Hospital
54. Riverland CHC
55. Riverland Regional Health Service (Hospital)
56. Riverton District Soldiers Memorial Hospital
57. Snowtown Memorial Hospital
58. South Coast District Hospital
59. Southern Yorke Peninsula Health Service (Hospital)
60. Strathalbyn and District Soldiers' Memorial Hospital
61. Tanunda War Memorial Hospital
62. Tumby Bay Hospital
63. Waikerie Hospital and Health Services
64. Whyalla Hospital and Health Service
65. Woomera Hospital

Appendix B: submissions from interested parties

1. Ceduna Hospital SA **25.08.97**

Ceduna argues that the agreement allows rural public hospitals to attract doctors at reasonable rates. There is a shortage of practitioners willing to practice in rural areas. The agreement does not prevent the appointment of out of area practitioners. Ceduna supports the agreement because 'this type of agreement has served all concerned parties in the past'. Ceduna agrees with the public benefits put forward by the AMA.

2. The Royal Australasian College of Radiologists (RACR) **03.09.97**

The agreement has no direct implications for RACR (SA). It supports the AMA proposal because the AMA has traditionally represented all facets of the medical profession. It believes that the arrangements are in the best interests of medical practitioners, hospitals, the SAHC, the AMA and the people of rural South Australia.

3. Adelaide Central & Eastern Division of General Practice **09.09.97**

The ACEDGP discusses the shortage of doctors in rural areas. It indicates that demand for services is greater than supply, so the agreement is unlikely to affect competition. It is of the opinion that the AMA agreement prevents cost blowouts. There is little geographic overlap between hospitals.

4. SA Premier and Cabinet **17.09.97**

The SA Department of Premier and Cabinet argues that the SA Health Commission is not carrying on a business in negotiating the Heads of Agreement on fee for service Arrangement so the SAHC is not subject to the Trade Practices Act. The immunity extends to the AMA under the *Bradken* principle. For this reason there is no need for SAHC nor AMA to seek authorisation.

Premier and Cabinet agrees that the AMA in its preliminary discussions with members may possibly be in breach of the Trade Practices Act.

5. Queensland Health **14.09.97**

Queensland Health is concerned that the proposed arrangements would dramatically affect prices for medical services to rural public hospitals if such an arrangement influenced other States. Queensland has unique arrangements with remuneration for private doctors under the award, not on a fee for service basis.

6. Health Department of Western Australia **17.09.97**

The WA Health Department is of the opinion that the AMA has not demonstrated why the VMO Agreement is the best way to organise medical services to rural hospitals in South Australia compared to alternatives, such as individual negotiation, that are more consistent with competition.

WA Health considers each of the claimed public benefits in turn, and notes that 'unequal bargaining power' is potentially the most important point in the list and very little has been made of it.

WA Health notes that the relevant market has not been clearly defined and the nature of competition in that market has not been analysed. As a consequence the current operation of the agreement and the way it hinders or assists competition is not adequately explained.

7. Dr Peter Rischbieth, Bridge Clinic, Murray Bridge Hospital 31.10.97

Dr Rischbieth outlined the incentives provided by some rural hospitals to attract doctors. He discussed the shortage of doctors in the rural area and specialist training for GPs working in rural areas. He outlined the process for specialists to visit particular hospitals. Dr Rischbieth said that Murray Bridge is one hour from Adelaide and can possibly attract more doctors and visitors than more remote areas.

8. Dr Peter Joyner, Past President, Rural Doctors Association, SA 3.11.97

Dr Joyner was one of the key negotiators in the last round of negotiations between the AMA and the SAHC. He said that the common service contract provides standard terms so doctors and hospitals can have a clear understanding of financial framework. Dr Joyner explained that the contract was not obligatory, but most hospitals encourage doctors to use it and it is often hard to bargain outside those terms.

Dr Joyner discussed the role of the Rural Doctors Association in South Australia in the negotiations of the common service contracts. There are 250 GPs in rural SA at the moment, they are short by 30. There are 65 hospitals outside the urban area.

Dr Joyner's opinion is that the problem is not competition between doctors but trying to attract enough doctors to rural areas. Often doctors have to live alone and in personal isolation with no professional support.

9. Mr Ken Maynard, CEO, Ceduna Hospital SA 3.11.97

Ceduna is one of the most remote hospitals in SA. Ceduna has some luck in attracting doctors because it is on the coast, but it would not be able to afford to pay any more in incentives if it had to compete with other hospitals to attract doctors. Some hospitals in larger areas or with richer residents may be able to pay more. Regionalisation is occurring around SA. In the future this may be an alternative to State-wide negotiations.

10. Karoondah Hospital (Dr Peter Michelmore, GP and Mr Grant Petras, CEO) 15.10.97

Karoondah informed the Commission about the negotiation process. Dr Michelmore indicated that as a single GP in a town it would be very hard for him to negotiate with his clients about money and still maintain a professional relationship.

11. SA Health Commission 16.10.97

The SAHC talked to us about the logistics and operation of the contract. Competition implications of the agreement were discussed and a submission was to be lodged - see below.

12. Meeting with AMA 12.11.97

The AMA provided information regarding market definition and numbers of doctors in each hospital. It discussed the accreditation process. The AMA argues that the market is the provision of medical services by doctors to public hospitals. The market is in relation to the sale of services to hospitals, as opposed to the sale of medical services to patients.

13. SA Health Commission 24.11.97

Public benefits include:

- an efficient and effective medical service to small populations at economical cost;
- protection from exploitation for vulnerable populations, where doctors are hard to recruit;
- a common schedule of fees which can be centrally produced and distributed to all rural hospitals, eliminating a multiplicity of regional or local schedules;

- an ability to budget for the annual expenditure on fee for service, again eliminating a multiplicity of administrative effort throughout the State; and
- a cost effective means of negotiating.

The SAHC submission goes on to discuss the following.

- The jurisdictional argument.
- The effect of joint negotiations on prices in SA would be negligible. Existing arrangements are the best which can be put in place to ensure that the medical needs of rural residents are met on the most efficient and cost effective terms.
- Rural hospitals do not compete — no leakage between regions. Doctors do not compete.
- It is a continual problem to attract doctors to rural areas.
- Hospitals can and do engage out of area medical practitioners.
- The SAHC agrees with the public benefits in AMA submission.

14. Department of Human Services, Victoria 21.11.97
Victoria has moved to casemix funding for hospitals and each hospital negotiates individual agreements with their doctors. Many small hospitals adopt a standard agreement.

Consider that centralised arrangements of the type for which authorisation is sought impedes competition and fosters a culture of reliance on collective decision making which discourages innovation.

15. Meeting with Dr Chris Brooks, Dept of Human Services, Vic 01.12.97
An 'Award' system existed in Victoria in the 1980s, which was essentially a schedule of fees, similar to the current SA system. Fee for service agreements led to cost increases for the Victoria Government over the ten years of their existence. In addition, some practitioners would admit patients as public patients where the fee for service rate was higher than the private Medicare reimbursement. Opthamology was one such example. Victoria had a problem with certain hospitals bringing in patients for certain surgical procedures from all over Victoria/Southern NSW. The purpose of this was to give particular hospitals appropriate throughput for higher budgets, however it was transferring a lot of cost from Commonwealth Medicare scheme or private health funds to the Victorian government. Victoria introduced casemix funding to address this issue.

16. Mr Tom Neilson, Regional General Manager, Wakefield Region (Telecon) 26.11.97
Provided background information. Doctors work in regional area - may do one specialist function per week at neighbouring hospital if accredited. Doctors may also provide help in neighbouring area if can do so within the 'golden hour'. Two major scenarios:
- doctors can have skills above the delineated role of the hospital;
- doctors can have skills lower than the delineated role of the hospital.

17. Meeting with Bacchus Marsh Hospital, Vic **02.12.97**

The individual negotiation system has led to definite savings for the hospital in Bacchus Marsh. Bacchus Marsh is close to Melbourne and a large hospital. The CEO has had success negotiating with doctors. It has sometimes negotiated rates of between 80 per cent and 97 per cent of Commonwealth Medicare Benefits Schedule rate. Doctors are willing to discount services if throughput is not restricted.

One specialist has agreed to perform all of the hospital's requirements for in-patients in return for use of the day theatre for operations on private patients.

18. Meeting with Ballarat Base Hospital, Vic **02.12.97**

The Ballarat Base Hospital traditionally used a sessional based system (like the city hospitals) while most regional hospitals formerly operated on a fee for service basis. For this reason, the transition to the Lochtenberg system was easier for the Ballarat Base Hospital than some other hospitals. Individual negotiations are time consuming, although most doctors adopt and adapt the guideline contracts issued under the Lochtenberg system.

One of the major advantages of the new system is that it has made performance appraisal an important factor. This has improved the quality of the service that the hospitals are receiving.

There is some limited competition between Ballarat Base Hospital and Bendigo hospital for patients on the border between the areas.

The system in South Australia works better than the old Victorian system ever did.

19. Dr Brian Macnamara, President SA Rural Doctors' Association **03.12.97**

Feels that the RDASA is not duly acknowledged in the AMA application for authorisation and would like the RDASA to also be authorised to negotiate. Said that only 30 per cent of doctors in rural SA were members of the AMA, but almost all are members of the RDASA.

20. Stawell Hospital, Victoria **09.12.97**

Moved to individual negotiations. Individual doctors have a stronger negotiating position than the hospital as it is very hard to get doctors to move to rural areas. There is very little of no competition for positions. The individual contract system enabled local issues to be taken into consideration when negotiating contracts, including different payment scales.

21. Wimmera Health Service **10.12.97**

It is hard to recruit doctors to rural areas because of social issues (lifestyle, schooling, opportunities for spouse) rather than work related issues. The process of negotiating with individual doctors is awkward in small, rural hospitals. The doctors have the negotiating power due to the difficulty in replacing them. The introduction of individual contracts saw a lot of 'leap frogging in demands'. When one hospital conceded a particular benefit that became an accepted norm for other hospitals to match. Preferred the previous system in Victoria where a standard fee was negotiated across all Victorian hospitals. This removed conflict at the hospital level, made management of hospitals easier and ensured adequate funding as the Department had to supplement budgets if it agreed to fee increases.

22. Queensland Health **18.12.97**

Proposed arrangement is anti-competitive as the arrangements can potentially establish a monopoly which could be imposed on other States as the accepted standard. Any move to alter the Queensland arrangements through a wider application of the South Australian proposal would be viewed as anti-competitive given Queensland Health's unique situation.

Raised other issues such as how doctors would be made aware that the agreement is not compulsory and that cost of services alternative to fee for service arrangements will also increase due to lack of competition for Fee for Service Agreements.

23. Regional General Managers **22.12.97**

The Regional General Managers in South Australia provided the Commission with background information and details about how visiting medical officers are engaged. Information was provided about incentive programs offered by various hospitals in some regions and the role of the regional boards. The RGMs said that the agreement acts as a price floor and it would be unlikely that with a system of individual negotiation they would face any lower fee for service rates.

24. Dr Peter O'Brien, Director of Medical Services, Warrnambool **14.01.98**

Dr O'Brien said that hospitals can remunerate doctors more in line with market forces and can have flexibility between various doctors. Importantly, since individual negotiation was introduced hospital management talks to each of the 50 doctors and discusses the individual and mutual problems faced by the parties. This has improved the relationship between management and doctors. Warrnambool has some problems attracting doctors to the area and previously suffered threats of boycott action. The new agreements have helped to level the playing field in negotiations. Move to individual negotiations was a shock initially, but now that both parties have adjusted it is much better.

Rural Victoria and Rural SA are not greatly different and the same principals are likely to apply in regard to paying Doctors and attracting Doctors to rural areas.

25. Victorian Hospitals' Industrial Association **28.01.98**

Many of the public benefits are unrelated to remuneration and price arrangements. Negotiations in Victoria are conducted individually. Collective negotiations are consistent with employee, not contractor, status. Prices for different medical services diverge between various rural hospitals. Attracting medical practitioners to rural areas and hospitals is not merely a matter of price and therefore not just a matter for collective negotiation. Collective agreements may limit productivity gains. Since individual negotiation, hospitals and medical practitioners have come to a great variety of arrangements to take account of particular circumstances. Authorisation, if granted, should be granted for a period of less than five years. ACCC must ensure that the authorisation does not maintain what can be seen to be a cartel type arrangement that does not promote competition and efficiency. The situation in each state must be tested on its merits.

26. Commonwealth Department of Health and Family Services **02.02.98**

The Commonwealth Government provides financial assistance to States and Territories to meet the cost of providing public hospital services. This assistance is determined in accordance with the Medicare Agreement and the Commonwealth would not be exposed to any financial risk by the arrangement. There is no direct link between the prices and costs in the public hospital sector and Commonwealth grants. As a general principle, doctors who are not members of the AMA should not be excluded from working in public hospitals where an arrangement has been negotiated between the State government and the AMA. Rural hospitals would not normally compete with each other or

with metropolitan hospitals for public patients. The submission questions some of the public benefits claimed.

27. Chamber of Commerce and Industry Western Australia 12.02.98

The CCI indicated that it was particularly concerned about the likely precedent that granting the AMA application would set for the other states. It was of the opinion that the agreement as it stands in South Australia and as it operates in some other states including Western Australia, is prima facie in contravention of the Trade Practices Act in that it is effectively a price fixing arrangement that results in a lessening of competition.

It was also of the opinion that while the AMA application points to may failings in the wider health system and provides a number of assertions on the issue of a public benefit, it does not demonstrate or provide evidence of a clear public benefit to the community from the existence of the AMA agreement. The CCI asserted that it considered that the issues raised in the AMA application were more of a private, than a public benefit and that none of the arguments provided a convincing case for maintaining the current arrangements. It addressed many of the public benefits individually.

The CCI was of the view that it would be instructive for the Commission to examine how the arrangements operate in other states and territories to provide some indication of the possible costs and benefits of the agreement.

28. South Australian Health Commission 31.03.98

The SAHC re-affirmed its support for the AMA application for authorisation.

The SAHC submission indicated its strong support for national competition policy and the Trade Practices legislation. It indicated that the SAHC is committed to ensuring that any arrangements that pertain between it and medical practitioners in South Australia, and bodies representative of medical practitioners, are not anti-competitive or liable to produce adverse effects for the community, public hospitals or individual medical practitioners.

The submission indicated that 'the practical outcome of the Heads of Agreement and the standard contract is an agreed schedule of fees to be paid by Government hospitals to private medical practitioners (ie doctors who are not employed by the hospitals) for services provided to public patients in country hospitals, together with certain other standard conditions and requirements.'

The SAHC submission stated that there are considerable public benefits in the current arrangements which have worked well for Government and the medical profession without adversely affecting community/consumers, hospitals or individual medical practitioners.

The SAHC submitted that although the arrangements appear to be a price fixing agreement, in effect the agreement does not legally bind either the SA Country hospitals or individual practitioners.

It further argued that the country hospital services are part of a system that is a Government funded monopoly in which doctor payment arrangements are merely an incidental item. It argues that if there is no competitive market, it follows that the medical payment negotiation arrangements cannot be anti-competitive from the hospitals' perspective.

The SAHC argued that the agreement has provided considerable public benefit to the SAHC including ensuring a strong level of commitment from the medical profession at large. It feels that the AMA has taken a co-operative approach and negotiated reasonable and realistic fee rates.

The SAHC acknowledged that a potential negative effect 'might be seen to be that the convenience and uniformity of the arrangements militate against innovation in attracting, retaining and rewarding medical practitioners in country areas.' However, it argues that recent Commonwealth and State Government initiatives work to address this.

The SAHC noted that 'as a result of our discussions with the ACCC, the AMA, Regional General Managers of SA Country Health Regions, legal advisers and others, the SAHC is committed to examining closely its processes of consultation and negotiation with interested parties on the determination of payment arrangements for medical practitioners providing services to public patients in country hospitals.' It continued, 'SAHC will ensure that such processes and any formal legal or administrative documentation are carefully designed to be consistent with the requirements of national competition policy.'

Other responses (offering no comment)

29.	Local Government Association of SA	13.08.97
30.	Kimba District Hospital & Health Services	07.08.97
31.	Private Doctors of Australia Ltd	17.08.97
32.	Australian Association of Neurologists	17.08.97
33.	Port Broughton District Hospital & Health Service Inc	17.08.97
34.	Port Lincoln Health Services Inc	22.08.97
35.	Australian Council of Allied Health Professionals	03.09.97
36.	Country Women's Association Incorporated (SA)	04.09.97
37.	Mount Gambier and Districts Health Service Inc.	04.09.97
38.	Australian Association of Gerontology Inc	15.10.97

The Pre-decision conference and further submissions

Full versions of the record of pre-decision conference and further submissions are available on the Commission's public register for this matter.

Pre decision conference

39. Session one 19 May 1998

The first session of the pre-decision conference raised preliminary matters and was adjourned upon application by the AMA in order to give the AMA adequate time to complete its submission.

The SA Country Women's Association stated that it was concerned whether patients would be double charged under the arrangements and wanted to ensure that the outlying areas of SA would not miss out on the provision of medical services.

The SAHC outlined its proposal for post June 1999 and explained the major issues involved.

The SAHC explained that one primary issue facing rural Australia is the recruitment and retention of doctors. It indicated that the rural incentive program is designed to attract doctors to the rural sector, but it is not part of the retention program. The SAHC indicated that approximately 30 per cent of the income of a rural doctor is from State Government income.

The AMA indicated that it may withdraw its application.

40. Session two 11 June 1998

The AMA reiterated the substance of the AMA's further submission, outlined below in this appendix. In addition, the following points were presented.

- The Medicare system is important in the public health system as it is the CMBS, not the South Australian Fee for Service Agreement that sets the floor price for public hospital medical services in South Australia and throughout Australia.

- The Victorian system is not based on individual negotiation and the ACCC had not provided any evidence to show any appreciable difference in outcomes to that in South Australia.

- Errors in relation to the ACCC's background information relating to other states and countries.

- Problems with the ACCC's evaluation of the AMA's public benefit arguments.

- The correlation between location of hospitals in Victoria and their relation to Melbourne or the nearest base hospital. It stated that, according to Access Economic analysis of GP consultation rates, there was no correlation.

- The 'jurisdiction issue' as discussed in the AMA submission.

South Australian Health Commission

The SAHC indicated that it has decided to discuss the appropriate characteristics of a new approach to remuneration for VMOs. It said that the new system will involve:

- wider consultation
- a system consistent with National Competition Policy

- The system will address:

  - the supply of doctors;
  - the relative attractiveness of some locations over others

South East Regional Health Service

The SARHS said that transaction costs are not insignificant issues and gave examples of costs of around $3,000 to have particular contracts developed. It stated that it would not be unreasonable, based on these examples to conclude that transaction costs may be up to $10,000 for each negotiation. The SARHS said that Victoria had more of the appearance of individual negotiation rather than the substance.

The SARHS said that Medicare sets the price for negotiations and that the SA medical system could not be understood unless the Medicare system is understood.

The SARHS stated that it was of the opinion that the ACCC has been impartial, however the legislation the ACCC administer compels it to take a certain view.

Rural Doctors' Association

The RDA stated ACCC's consultation with Victorian VMO's was not broad. It presented information on the Victorian situation.

The RDA considered that there were errors in the Background Information contained in the Commission's draft determination and provided some supplementary information.

The RDA considered that the draft determination contained an error in the market definition, which led to errors in the conclusions. The RDA considered that although it could not make a conclusion on the actual market, it considered that there had to be more than one.

The RDA said that there are a number of barriers to entry to the rural medical workforce including:

- family situation;
- bureaucratic requirements;
- social isolation;
- lack of professional support;
- adverse conditions.

The RDA considered that these factors also provided triggers for existing practitioners to leave and referred the Commission to a publication titled 'Why rural GPs leave their practices' in which 10 of 17 doctors cited negative reaction to bureaucracies.

The RDA considered that doctors in smaller areas do not like to negotiate individually.

The RDA briefly discussed a number of points which it said were to be discussed in more detail in a submission from the RDA. The points were not raised in the later submission.

Western Australian Department of Health

The Department of Health (WA) questioned whether the AMA could amend an application for which a draft determination had already been issued. The Department submitted that it may be necessary for the application to be withdrawn and another submitted.

The Department submitted that it considered that the question of jurisdiction to be a matter for the Court.

41. AMA Submission 5 June 1998

In this submission the AMA presented an amendment to its application for authorisation. The amendment is as follows:

> Authorisation is sought for the conduct set out in paragraph 3.2 of the AMA's application, but only insofar as it relates to the current Fee for Service Agreement that expires on 30 June 1999.

The following is an extract from the AMA submission:

> The AMA considers the ACCC's draft determination is fundamentally flawed. The AMA takes this view for the following reasons:
>
> - The draft determination is too quickly dismissive of the transaction costs of individual contract negotiations.
> - The draft determination adopts a desultory approach to the analysis of the claims of the Victorian Department of Human Services in regard to the results of individual contract negotiations in that state.
> - The ACCC shows little understanding of the pervasive incidence of Medicare upon the health financing system and t5he market for public hospital medical services in rural South Australia.
> - The ACCC's approach, in compartmentalising the causal factors behind the public benefits of delivering hospital care in rural South Australia, ignores the inter play and the complexity of the interface between the SAHC and its hospital care providers. The AMA considers it is simplistic to seek to artificially separate and attribute the public benefits delivered by hospital care to either the SAHC or service providers. The benefits flow from their relationships and co-operation.
> - As a consequence, the ACCC takes too narrow a view of the public interest and the sections of the ACCC's draft determination dealing with public benefits read more like a document in which the author was requested to criticise each of the claimed public benefits rather than properly investigate their validity.
> - The ACCC's claim that the rates of remuneration and contracts for doctors in the Victorian public hospital system are primarily established on an individual negotiation basis is incorrect. Furthermore, in the very limited area of the Victorian public hospital system that uses fee for service visiting medical officers (VMOs), the competitive effects the ACCC alleges would apply in South Australia, were it to adopt the claimed Victorian individual bargaining model are, according to the independent analysis prepared by Access Economics, not even evident in Victoria.
> - The ACCC's understanding of the arrangements for negotiating the provision of medical services for both rural and urban public hospitals in other states and territories and overseas is substantially flawed. This is reflected in the significant number of factual errors contained in the draft determination in this regard. The existence of these errors of fact is a major flaw in the determination and raises questions over the processes used by the ACCC to gain its understanding of the various health and hospital systems. The reliance on hearsay evidence, the lack of rigorous analysis and the lack of verification of verbal claims made by some parties suggests the ACCC entered the process of investigation with preconceived views as to the nature of the arrangements that apply in the various states and

territory hospital systems and was satisfied with any submissions that supported these views.

- The subsequent heavy reliance by the ACCC on this flawed description of these arrangements, particularly in relation to Victoria, throws considerable doubt on the findings made by the ACCC on the AMA's authorisation application.

- The problems emerging in the 1998 VMO contract renewal process in the Australian Capital Territory underscore the public benefits of an orderly system of contract negotiation on a collective basis and the risks to the public associated with applying inappropriate market and competition concepts to public hospital medical provision.

- No attempt was made by the ACCC throughout the course of its investigation to verify the facts as to membership of the AMA among rural doctors, despite correspondence from the AMA inviting officers of the ACCC to examine a list of members in order to verify its existence and its contents. Despite this invitation the ACCC seeks to rely on the uncertainty it has generated over the level of AMA membership in expressing concern over the potential need for doctors in rural South Australia to join the AMA in order to attract the protection of the authorisation.

- The AMA concurs with the position put by the SAHC that the ACCC must address in detail the matters of jurisdiction raised by the SAHC if it is to lawfully determine the AMA's application. The ACCC cannot simply rely on the fact that it has an application for authorisation from the AMA before it to establish it may lawfully determine that application.

The AMA submission included a analysis of the draft determination by Access Economics Pty Ltd that presented the following broad observations:

- is too quickly dismissive of the transactions costs in individual contract negotiations;

- adopts a desultory approach to the analysis of the claims of the Victorian Department of Human Services in regard to the results of individual contract negotiations in that State; and

- shows little understanding of pervasive influence of Medicare upon the health financing system;

Accordingly the conclusions reached by the ACCC are not soundly based.

The Access Economics report also discusses ACCC inconsistencies in approach to dealing with Competition Policy, indicating that the ACCC does not implement Competition Policy in an intelligent way. It states in a footnote:

> There are many inconsistencies of approach. For example, it is very arguable that the ACCC has proved to be a benign regulator in the area of telecommunications where Telstra still exercises extensive monopoly powers and constantly engages in anti-competitive behaviour with blatant disregard of the public interest. Yet the ACCC has taken a very aggressive attitude with regard to minor 'transgressions' in the professional area.

The AMA submission included several attachments including:

- A list of collective agreements, awards and contract covering medical practitioners - Victorian public hospitals;
- Extract of Health Services Act 1997 (NSW)

- NSW Health Department Circular - Visiting Medical Officers - Sessional - Increased Remuneration
- Memorandum from Territory Health Services to Sessional Medical Officers - Implementation of Agreement
- Extract from 'contract employment for salaried senior medical/dental staff in New Zealand Crown Health Enterprises' association of Salaried medical specialists, New Zealand, March 1997
- Request for additional information by ACCC 22 October 1997
- Correspondence from AMA to ACCC regarding AMA membership 10 December 1997

42. Rural Doctors Association of Australia Ltd supplementary submission 26 June 1998

The Rural Doctors Association of Australia Ltd (RDAA) indicated that if upheld, this determination will set rural communities back ten years in their attempts to attract permanent medical staff.

The RDAA considered that the draft determination was made on the basis of incorrect information and felt that 'some might accuse the Commission of only listening to those it chooses to hear'.

The RDAA provided its views on the Victorian system and also outlined the impact that it thinks the Commission's draft determination would have.

43. Further Comment on the Application by the AMA to the ACCC for Authorisation of the South Australian VMO Agreement Health Department of WA 26 June 1998

The Department of Health (WA) (the Department) considered that the public benefit arguments of the AMA are not directly connected to the existence of the proposed contract arrangement.

The Department considers that the 'AMA has not demonstrated why the VMO Agreement is the best way to organise the provision of medical practitioner services to rural hospitals in South Australia compared to alternatives

The Department considers that there is very little information regarding actual transaction costs and the case is hard to prove one way or the other. Therefore it is hard to accept that 'the transaction cost argument for persisting with a contract arrangement that is considered anti-competitive...'

The Department points out that other professions negotiated individual fees and do this on the basis of advice from their association.

The Department considers that the submissions to the pre decision conference did not clearly address the issue of the relevant market.

The Department states that there are many claims of factual inaccuracy with regard to the data presented to the Commission for the draft, but considers that the 'best that can be said at this stage is simply that the available evidence is limited and does not amount to a categorical case in favour of any particular arrangement'.

The Department stated that the arguments that Medicare and the CMBS fee schedules combined with bulk billing eliminate the potential for price competition is confused (and not correct).

The Department further argues that the AMA submission makes the point that 87 per cent of Victorian public hospital doctors are covered by collective agreements, however, this is the salaried

doctors figure and these doctors are employees, not independent contractors while the proposed agreement applies to VMOs and should be compared with VMO data for Victoria.

The Department considers that the CMBS will remain as a reference for central agreements on price and its existence will also have the effect of reducing transaction costs to the extent that parties accept it or accept it as a reasonable starting point. The Department concludes with an explanation of the non price aspects of individual versus centralised negotiation.

44. Dr Ashleigh C Thomas of the Royal Flying Doctor Service in Port Augusta 3 June 1998

Dr Thomas stated that the ACCC 'must decide in favour of promoting Medical Practitioners to work in rural areas'. He stated that he was surprised that the ACCC 'would even contemplate interfering/compounding the issue with this type of 'intervention'.

44. Dr G Kerrigan, Meningie Health Service 12 May 98

1. Considers there are a number of logical errors in the draft determination:
   a. public hospital treatment is free so consumers are not being overcharged;
   b. local hospital does not have a say ion the level of fees because it has no input into direct funding. Could only negotiate downwards.
2. The agreement is monopolistic, but Medicare is worse.
3. Hospitals do not suffer from agreement because they are funded to cover doctors' fees
4. Hospitals are in not in the stronger bargaining position, no one will offer to undercut the existing fees. SA is short 30-40 doctors in the bush. In reality doctors could request larger fees, but work for less because of their social conscience.
5. Victoria does not have isolated communities like SA. Wants evidence of how Victorian hospitals have benefited from Victorian reform.

The hospitals are in a very weak bargaining position, people are not clamouring to take their 'overpaid sinecures'. Considers prices will go up if individual negotiations.

45. Dr Geoff White, President RDAA 12 May 98

Met with Commission. Indicated that the situation in rural Australia is worse than the figures in the AMA application for authorisation indicate. Provided reference for article on 'Why Rural Doctors Leave their Practice: a qualitative interview survey of Queensland GPs who left rural practice between January 1995 and March 1996.

46. Dr TJP Hodson 6 May 98

- Will attend second session of pre-decision conference. Provided submission.
- Does not have a particular wish to be represented in the negotiations by the AMA. 'To this end I am perhaps supporting the Commission's draft determination. Is concerned that these matters were considered without being asked to provide comments at an earlier stage.
- A number of alternatives to the Fee for Service Agreement are available, but the problem of a less regulated system is that the doctor has time to take away from his practice to negotiate.
- The Victorian analogy is no use, because the access of patients to medical services has been severely curtailed.
- SAHC will not have extra funding. It will be likely to offer doctors an agreement with a schedule not dissimilar to the current arrangement.

47. AMA - meeting 30 Apr 98

AMA indicated that it is considering various options. May amend its application for authorisation.

48. Dr CW Brook Victorian Department of Human Services 17 Apr 98

Notes that that Commission's draft determination is that the agreement has anti-competitive effects and that the Commission proposes to grant an authorisation only until 30 June 1999 to enable the parties to adapt to a less regulated system in a phased manner. Also notes that should the AMA wish to engage in collective negotiations in Victoria, it would be necessary for a separate application for authorisation to be made to the ACCC.

49. Dr TJP Hodson 15 Apr 98

Called a pre-decision conference. Aggrieved that he was not consulted during the process. Does not consider that individual negotiation will lead to a decrease in costs. Possibly the opposite will happen.

50. Dr Geoff White, President, RDA 9 Apr 98

RDAA is extremely concerned that the recent ACCC decision may adversely and dramatically affect retention and attraction rates for doctors in rural Australia, thus undermining a lot of good work over many years by many patients and their doctors. Wants a copy of the full decision.

Other responses since ACCC draft determination 03.04.98 (offering no comment)

51.	**Victorian Hospitals' Industrial Association**	14 May 98
52.	**Dr W A Kutcher, Podiatrist**	14 May 98
53.	**Health WA**	14 May 98
54.	**Dr Brian McNamara, president RDASA**	13 May 98
55.	**Specialist Anaesthetic Services - Ms TA Micallef**	12 May 98
56.	**Dr Chris Brook, Human Services, Vic**	12 May 98
57.	**Dr Guy Maddern**	11 May 98
58.	**Australian Country Women's Association Incorporated**	11 May 98
59.	**Commonwealth Department of Health and Family Services**	08 May 98
60.	**Adelaide Central & Eastern Division of General Practice**	08 May 98
61.	**Chris Overland, RGM, SE Regional Health Service Inc.**	04 May 98
62.	**SAHC**	04 May 98
63.	**Queensland Health**	27 Apr 98
64.	**SA Dept of Premier and Cabinet**	21 Apr 98
65.	**Tasmanian Department of Community and Health Services**	20 Apr 98

Appendix C: Heads of Agreement and Fee for Service Agreement

Heads of Agreement Between
The Australian Medical Association (SA Branch)
and the South Australian Health Commission
on fee for service Arrangement

1. Fee for service shall be provided in accordance with the document titled - '1996/99 fee for service Arrangements'.

2. An amount of $398,000 shall be provided for Continuing Medical Education purposes for general practitioners during the period 1/7/1996 to 30/6/1997 and indexed according to the CPI for 1997/98 and 1998/99.

3. Specialist Medical Practitioners CME Fund

   To acknowledge the services provided by resident specialists in rural areas and their support to local general practitioners, all resident specialist medical practitioners in rural areas shall be entitled to up to $3,500 per year for education expenses during the term of this Agreement. As with the general practitioner CME reimbursement scheme, entitlements not spent within the term of the Agreement cannot be carried over into another period. An amount of $60,000 will be allocated for this financial year, and indexed according to the CPI for the two subsequent financial years, with unspent funds carried over from one financial year to the next.

4. Superannuation Guarantee Levy

   This Agreement recognises that a separate agreement has been reached to reduce FFS payments per practitioner by the equivalent of the Superannuation Guarantee Levy payment, which is paid on behalf of the practitioner where applicable.

5. Medical Indemnity

   This Agreement recognises that a separate agreement has been reached with regard to Medical Indemnity Cover for country general practitioners and resident country specialists.

Signed (signed) 10/7/1996
Part President, Australian Medical Association, SA Branch

Signed (signed) 10/7/1996
Chief Executive Officer, South Australian Health Commission

AMA-SAHC Agreement on

fee for service Arrangements
1996/97 - 1998/99

1. APPLICATION

This Agreement supersedes all prior agreements and shall apply to medical services provided for public in-patients of certain hospitals defined hereunder from 1 July 1996.

For the purposes of this Agreement 'hospital' means all country hospitals incorporated under the South Australian Health Commission Act 1976 together with Gawler health Service Incorporated and Noarlunga Health Services Incorporated.

2. IMPLEMENTATION

Upon settlement of the terms of the Agreement, the hospital shall forward to its visiting medical practitioners a full copy of the Agreement and an offer to enter into the arrangements provided by this Agreement.

3. GENERAL

3.1 CLINICAL PRIVILEGING

The medical practitioner shall only provide such medical services that are within the ambit of his or her clinical privileges current at the time of provision of service.

3.2 CONSULTATION

3.2.1 Where a hospital proposes to implement changes in program, organisation, structure or technology that are likely to affect medical practitioners, the hospital shall consult the medical practitioners during the planning process.

3.2.2 Where a hospital or medical practitioner plans to cancel elective procedures for any period, the hospital or medical practitioners will be given reasonable (ie at least 4 weeks) notice.

3.3 HOSPITAL PATIENTS

With respect to any patient who elects to be a hospital patient, the medical practitioner shall not raise an account with the patient.

3.4 PRIVATE PATIENTS

With respect to any patient who elects to be a private in-patient, the medical practitioner shall charge at the rate judged by the practitioner to be appropriate to the service, subject to informing the patient of the intended fee.

3.5 PRIORITY OF TREATMENT

With respect to priority for treating patients, clinical need is to be the primary factor to be considered when determining priorities. Where patients' clinical needs are not significantly different, the patient who had been waiting longest for medical services shall be given priority.

3.6 OUTPATIENT/IN-PATIENT INTERFACE

In South Australian country hospitals, with the exception of those covered by the Upper Spencer Gulf After Hours Agreement (Whyalla, pt Augusta and Pt Pirie), Outpatient and Casualty services are provided as an extension of the medical practitioner's surgery, and therefore part of the Commonwealth/Medicare payment system.

Problems with claims for payment can arise when a patient is seen in the hospital casualty area and then admitted for treatment as a public in-patient.

The agreed position is that:

the critical fact is when the decision to admit is made:

(1) if the majority of the consultation item is before this decision - the patient should be charged for the consultation.

(2) if the majority of the consultation time is after this decision - the hospital should be charged for the consultation.

(3) where additional (non consultative items) are charged it should be clear whether these services were rendered before or after the decision to admit.

(4) correct documentation of when the doctor sees the patient and when the doctor decides on admission will facilitate this process.

Failure to provide correct documentation as above will lead to non payment by the hospital for services rendered, with the medical practitioner required to bill the patient as a private patient for all services associated with the admission process.

3.7 HOSPITAL TO HOSPITAL TRANSFER

All acute patients requiring observation and/or stabilisation to be transferred from one hospital to another by ambulance should be admitted to their hospital of presentation.

4. PAYMENTS

4.1 The hospital shall remunerate the medical practitioner in accordance with the terms of this agreement.

4.2 The medical practitioner shall supply to the hospital not less often than once each calendar month a detailed statement of claim for medical services provided in the preceding period.

4.3 If the appointment of a medical practitioner is terminated, the hospital shall thereupon pay all fees to which the medical practitioner is then entitled within one calendar month of receipt of a detailed claim for medical services.

5. THE 'SA SCHEDULE'

The hospital fee for service rate shall be the 'SA Schedule'. The 'SA Schedule' will be the Commonwealth Medicare Benefits Schedule (MBS) fee as at 1 July 1996 adjusted as described below increased by 2 per cent with the exception of 5.1 and 5.2 where fees have been specified for the first year.

5.1 INTRAVENOUS THERAPY

Intravenous therapy (other than that associated with an anaesthetic) shall have an item number SA1 and will attract a payment of $11.60.

5.2 Emergency Care

Payment of emergency care will be at the CMBS rate for the relevant items applying as at 1 July 1996 with a loading of 50 per cent.

Where a general practitioner is required to return to a hospital in an emergency situation to provide complex medical care utilising a high level of skill on a patient previously admitted to hospital and the treatment lasts less than one hour, the Item shall be a described as Medicare Benefit Schedule Item 50 (Level D consultation in hospital) and the fee $123.85. In addition any other relevant procedural fees are payable until emergency care ceases, or transfer, or definitive operative intervention.

Where a medical practitioner returns to provide emergency medical care for one hour or more, the item description shall be Medicare Benefits Schedule Items 160 to 164 inclusive. The fees shall be: item 160 $134.55; Item 161 $219.75; Item 162 $304.95; item 163 $390.10; item 164 $460.85. In addition any other relevant procedural fees are payable until emergency care ceases, or transfer, or definitive operative intervention.

Where the emergency care is initiated after hours, as defined in 5.6.1 the appropriate loadings set out in this Agreement shall apply (as indicated in 5.6.2).

In a situation where:

- more than one patient has been admitted to hospital after initial treatment and investigations in a casualty or outpatients setting

and

- are awaiting transfer to another hospital

or

- are awaiting a specialist

and

- require intensive monitoring and ongoing treatment

and

- this treatment prevents the medical practitioner from leaving the hospital.

The payment shall be an item 50 (level D consultation in hospital **ie $123.85**)) for each patient requiring treatment for the initial 2 hours and every 2 hour segment or part thereof it the patient(s).

5.3 SOUTH EAST REGION

The South East Region (Health Commission Region No. 5) will be able, as a region, to opt for a higher payment for obstetrics (the schedule fee plus 33.3 per cent) in lieu of the 2 per cent loading referred to in paragraph 5 above. This option is open until 31 July 1996.

5.4 OTHER MEDICAL PRACTITIONERS

'Other Medical Practitioner' designated medical practitioners shall be paid at the vocational registered rate for public in-patient care.

5.5 SURGICAL PROCEDURAL RATES

Surgical procedural rates that have differential payments for specialist and non specialist medical practitioner shall be all paid at the specialist rate.

5.6 AFTER HOURS

5.6.1 DEFINITION

After hours shall be defined for weekdays as after 6.00pm and before 8.00am, for Saturdays all except 8.00am to 12 noon, and all of Sundays and Public Holidays.

5.6.2 GENERAL PRACTICE

Payment of all after hours general practitioner consultations at Level A and B and in-patient care for obstetric patients unrelated to confinement and postnatal care will be as per Item 97 (criteria and rate) except for services between 12 midnight and 8.00am which shall have the Item 97 rate increased by 50 per cent, rounded up to the nearest whole dollar.

Payment for after hours general practitioner consultations at Level C and D shall be as per Item 97 (criteria and rate), plus the fee for Level C or Level D (whichever is applicable), except for services between 12 midnight and 8.00am which shall have the Item 97 component increased by 50 per cent, rounded up to the nearest whole dollar.

If during or subsequent to the occasion of an Item 97 service, further patients are presented, the Item 97 fee will not apply to services rendered to those patients, during an unbroken period of time.

Payment for after hours procedural items, excluding obstetric Item 16519, shall be the 'SA Schedule' fee for the procedural item, plus the fee for Item 97, except for services between 12 midnight and 8.00am which shall have the Item 97 rate increased by 50 per cent rounded up to the nearest whole dollar.

5.6.3 SPECIALISTS

Payment for after hours specialist medical practitioner services complying with the attendance criteria of Item 97 shall be as follows:

For services prior to midnight, the fee shall be that which would apply in normal hours, plus the Item 97 fee rate, rounded up to the nearest whole dollar.

For the period between midnight and 8.00am the fee shall be that which would apply in normal hours plus the Item 97 rate increased by 50 per cent, and rounded up to the nearest whole dollar.

If further patients are presented during or subsequent to the occasion of a service as defined above, the subsequent services will not have the Item 97 rate applied if the services are provided during an unbroken period of time. Remuneration for these services will be provided according to the appropriate 'SA Schedule' item number.

5.7 OBSTETRIC/NEONATAL CARE

Where a medical practitioner is called to attend a baby of a public in-patient mother requiring resuscitation and significant unusual medical care outside that customarily provided under the relevant section of the CMBS, there can be a separate charge raised. This charge shall apply to the mother as the neonate is not normally a separately admitted person during his/her neonatal period following birth.

It should be noted that for all other services to neonates that the infant is designated a boarder, and services provided should be charged to Medicare.

5.8 CAESAREAN SECTIONS

The payment of unreferred Caesarean sections shall be paid as per Item 16520.

6. SUBSEQUENT YEARS

All items in the 'SA Schedule' will be inflated by 3.25 per cent as from 1 July 1997 and an additional 3.25 per cent as from 1 July 1998.

7. OTHER ALLOWANCES AND PAYMENTS

7.1 LOCUM ALLOWANCES

In towns which have only one resident medical practitioner, and in other certain special circumstances with the approval of the Country Health Services Division, a locum allowance for up to four weeks in any 12 month period shall by payable by the

hospital if the medical practitioner arranges for a locum to provide medical services during his/her absence.

Subject to the approval of the Board of Directors of the hospital in the period during which the allowance accrues, the allowance may be carried over for a period of up to 12 months.

The locum allowance will be at the rate of $1,900 per week if not provided by Divisions of General Practice or other arrangement.

7.2 TRAVEL ALLOWANCES

7.2.1 In circumstances where a general medical practitioner has to travel a director route distance to a recognised hospital of more than 20km from the place of his or her nearest established practice (which must be outside of the Adelaide Statistical Division) to provide medical services for which fee for service is payable by the hospital, a travel allowance shall be payable. The allowance shall be applicable for round trips in excess of 40 kilometres.

7.2.2 A travel allowance shall be payable for specialists medical practitioners in accordance with the previous paragraph, if the specialist is resident in the region where the service is provided. In other instances of specialist travel, travelling allowances shall continue to be payable to approved visiting specialists providing services to regional and subregional hospitals, and to other hospitals where SAHC approval has been given for other than resident regional specialist services to be provided in accordance with the role delineation and/or service agreement of that hospital. In the even of changes to the role delineation of a hospital there shall be a period of notice of not less than three calendar months prior to the implementation of any change.

7.2.3 The allowance shall be based on the per kilometre rate prescribed in SAHC Industrial circular 1.30, applicable to a vehicle with an engine of more than four cylinders.

7.2.4 This allowance is to be paid once per visit, not per patient, regardless of the number of patients seen.

7.3 ATTENDANCE OF MEDICAL PRACTITIONERS AT MEETINGS

Where the hospital requires attendance of a medical practitioner at a meeting for accreditation as a member of a formal committee (eg. Privileging Committee), fees aligned to those applicable to the Casual Medical Staff Rate (MOW-1 to MOW-3) shall apply according to qualifications.

This fee does not apply in the following situations:

1) Medical practitioners appointed to a Hospital or Regional Health Board by the Minister of Health.

2) A medical practitioner, who being a member of a Hospital or Regional Health Board, is then nominated by the Board to be a member of a sub committee of the

Board or as a Board representative on another Health Service or Health Commission committee.

3) Medical practitioners on Advisory committees (unless formal approval has been obtained from the SAHC) or ministerial advisory committees of SA Health Commission.

4) This section does not apply for the provision of payment as a Principal Medical Officer for other than hospitals with formal approval from the Health Commission to create such a position.

7.4 TELEPHONE

Where a hospital remote from the medical practitioner's usual base seeks advice from the medical practitioner by telephone in an emergency situation where the local doctor or his/her locum/cover cannot be contacted after hours (as defined in 5.6.1), as Level A consult shall apply for each telephone call if the medical practitioner is not required to see the patient.

This payment is not payable when the advice is related to medical care for which there is an aftercare component in the fee payable to the medical practitioner providing in-patient care.

8. END OF AGREEMENT

These arrangements shall terminate at midnight on 30 June 1999.

9. RENEWAL

The SAHC and the AMA shall commence negotiations for a renewal or replacement of this agreement no later than six months before the expiry of the term of this Agreement.

Signed (signed) 10/7/1996
Part President, Australian Medical Association, SA Branch

Signed (signed) 10/7/1996
Chief Executive Officer, South Australian Health Commission

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