Application for Authorisation

Australian Medical Association Limited and South Australian Branch of the Australian Medical Association Incorporated

in relation to the Fee for Service Agreement in rural SA public hospitals

Date: 31 July 1998

Authorisation No:
A90622

File No:
CA97/13

Commissioners:
Fels
Asher
Bhojani
Lieberman
Shogren
Smith
Carver

Summary

The South Australian and Federal Australian Medical Associations (jointly referred to as the AMA in this document) have applied to the Commission for authorisation for the AMA and its members to negotiate and give effect to a common service agreement for the remuneration of visiting medical officers practising in South Australian rural public hospitals. It is known as a Fee for Service Agreement.

South Australia has 65 rural hospitals ranging from hospitals with one doctor, in for example Karoondah and Coober Pedy, to hospitals with 25-50 doctors, in for example Mt Gambier and Port Augusta. There are very few resident specialists in rural SA and hospitals arrange periodic visits by particular specialists to cover their needs. Emergency support for complicated matters is available from 'recovery' teams that fly out from Adelaide or by airlifting patients to Adelaide.

A major issue in the South Australian rural medical system is trying to attract doctors. Current estimates indicate that the system is short by 30-40 doctors.

The Commission considers that the Fee for Service Agreement has anti-competitive effects because the agreement acts as a price floor for all hospitals in South Australia. Hospitals in regions that have little trouble attracting doctors have to pay the same rate for medical services as hospitals in regions that have difficulty. Sometimes negotiations are conducted to provide doctors with a package over and above that provided by the Fee for Service Agreement, but negotiations never result in a discount to the hospitals.

The Commission agrees that the provision of medical services provides many public benefits to residents of rural South Australia and the rest of Australia. However, the Commission is not convinced that the Fee for Service Agreement is the only method that would produce these public benefits. The Commission does, however, recognise that the South Australian Health Commission and the AMA and its members have established collective negotiation techniques. In light of the fact that doctors carrying on their professional businesses in SA without incorporating were not subject to the Trade Practices Act until July 1996, the Commission recognises some public benefit in allowing the parties to phase in a less regulated system.

The Commission considered all submissions and information provided at the pre-decision conference and has determined that the public benefits from the conduct outweigh the anti-competitive detriment from the proposed agreement.

Accordingly, the Commission hereby grants authorisation for the conduct applied for in the AMA application, including necessary consultation with South Australian rural doctors, in so far as it relates to the current arrangements that expire on 30 June 1999. The authorisation will not extend to the making of new agreements.

The authorisation is granted until 30 June 1999 subject to the condition that all parties covered by the authorisation are not permitted to conduct boycott action.

Contents

1. The application

1.1. On 21 July 1997 the Australian Medical Association Limited and the South Australian Branch of the Australian Medical Association Incorporated (jointly referred to as the AMA in this document) lodged an application for authorisation with the Australian Competition and Consumer Commission. The application was made under s. 88(1) of the *Trade Practices Act 1974* (the Act).

1.2. The application originally requested a five year authorisation. However after the draft determination was issued, it was amended to seek authorisation only in so far as the application relates to the current Fee for Service Agreement that expires on 30 June 1999.

1.3 The applicants now request authorisation until 30 June 1999 for the following conduct.

- Entering into understandings between themselves (and their members) as to the rates and conditions to be negotiated with the South Australian Health Commission (SAHC) for the provision of medical services to public patients in rural public hospitals.

- Negotiating with the SAHC from time to time as to the said rates and conditions.

- Appointing, in conjunction with the SAHC, arbitrators to determine any dispute arising between the SAHC and the applicants in the event of any breakdown in negotiations.

- Entering from time to time into contracts, arrangements or understandings with the SAHC whereby:

  (a) the SAHC and its hospitals agree to offer to the applicants (and their members) standard and agreed rates and conditions for providing medical services; and

  (b) the applicants agree to provide medical services upon such standard and agreed rates and conditions.

- Authorisation is **not** sought for the making of any contract, arrangement or understanding which:

  (a) contains any provision, the substance or effect of which would be to prevent or limit any of the applicants negotiating and agreeing upon variations to the standard and agreed rates as special circumstances may require;

  (b) includes any proposal for determining rates and conditions in the arbitration process on conditions inconsistent with the scope of the activity for which authorisation is being sought; and

(c) affects the rates and terms and conditions under which medical services, other than rural public hospital services, are provided in those hospitals listed in the application (see appendix A)[1].

1.4. The conduct relates to the provision of medical services by doctors to hospitals, not the provision of services to the public by the hospitals.

1.5. The conduct for which authorisation is being sought has taken place in the past and resulted in an agreement between the AMA and the SAHC. The agreement, entitled 'AMA-SAHC Agreement on fee for service Arrangements 1996/97 — 1998/99', commenced on 1 July 1996 and is due to expire on 30 June 1999. It covers the provision of medical services by private doctors at 65 rural public hospitals (see Appendix A).

1.6. While the agreement covers some general administration issues such as the in-patient/outpatient interface, consultation and priority of treatment, it is predominantly concerned with remuneration levels. It specifies the terms and conditions on which medical practitioners are paid for providing medical services to public patients in public hospitals in rural South Australia, including changes to the standard Medicare Schedule Fee. A copy of the agreement is at Appendix C.

1.7. The applicants have sought authorisation because the negotiation process and the resultant agreement may be considered to be in breach of s. 45 and s. 45A of the Act.

[1] AMA submission supporting application for authorisation July 1997, p. 3.

2. Background

2.1. Recent developments in competition policy

2.1.1. The Commission is aware that collective negotiation between doctors who practise in rural South Australian public hospitals (including members of the AMA) and subsequent negotiation between the AMA on behalf of all these doctors and the South Australian Health Commission (SAHC) is, and has been, an established feature of setting the terms, rates and conditions of contracts for private medical practitioners providing services to public patients in public hospitals for many years. Unincorporated medical practitioners were able to engage in such conduct in the past because they were not subject to the Trade Practices Act.

2.1.2. In recent times, however, there have been fundamental changes in competition policy in Australia. One change was the extension of the Trade Practices Act to cover the professions, including the medical profession. To understand why this has occurred it is useful to bear in mind the following brief background.

- In October 1992 an Independent Committee of Inquiry was established to report on the need for a national competition policy and its basic principles.
- In August 1993 the Committee reported to Australian governments (Hilmer Report).
- In February 1994 the Council of Australian Governments (COAG) agreed to enact legislation to achieve the universal application of competition laws to all businesses throughout Australia.
- In particular, the aim was to apply competition laws to unincorporated businesses and government businesses (thus covering all medical practitioners).

2.1.3. Since then the Commonwealth and each State and Territory governments have passed legislation enabling the universal application of competition law to everyone in business in Australia. These laws took effect from 21 July 1996.

2.1.4. As a consequence of these changes some of the potentially anti-competitive practices which the medical profession had previously engaged in may be in breach of the Trade Practices Act unless authorised by the Commission. It is with this in mind that the AMA made its application.

2.2. The Medicare system

2.2.1. The foundation of the Australian health care system is Medicare. Its principles dictate the way in which health services are provided, the terms and conditions associated with their delivery and the way in which the market for medical services operates.

2.2.2. The responsibility for funding and delivering services under Medicare differs depending on the service to be provided. For the purpose of this determination the two areas of Medicare of interest are 'hospital benefits' and 'individual benefits'.

2.2.3. 'Hospital benefits' refers to the scheme for the provision of public hospital services. This scheme, which is detailed in the Medicare Agreement between each State and the Commonwealth, gives responsibility for to each State. The States have agreed to certain principles and the responsibility for running them in return for funding from the Commonwealth. The primary principles of each Medicare Agreement are that:

- eligible persons must be given the choice of receiving public hospital services free of charge as public patients;
- access to public hospital services is to be on the basis of clinical need; and
- to the maximum practicable extent, a State will ensure the provision of public hospital services equitably to all eligible persons regardless of their geographic location.

2.2.4. While the Commonwealth makes a contribution towards operating public hospitals, it is up to the individual States to finance their respective hospital systems. The Commonwealth payments cover approximately half the total cost of running the public hospital system.

2.2.5. 'Individual benefits' refers to payments to individuals for services obtained from a medical practitioner in locations other than public hospitals (for example a visit to a GP or a specialist). The payment may be made to the patient or directly to the medical practitioner (if he/she bulk bills). The responsibility for these payments rests with the Commonwealth.

2.2.6. Individual benefits are relevant in this case because they represent one area where costs can be transferred from the States to the Commonwealth. For example, if a person goes to a public hospital to be treated as an outpatient then he/she would generally be covered by the hospital benefits side of Medicare and hence the financial burden would fall on the State. However, if the same person were to visit their local GP, the financial burden would fall on the Commonwealth. In this case the agreement between the SAHC and the AMA states, at clause 3.6, that 'Outpatient and Casualty services are provided as an extension of the medical practitioner's surgery, and therefore part of the Commonwealth/Medicare payment system'.

2.2.7. The other relevant element of the Medicare system is the Commonwealth Medicare Benefits Schedule (the CMBS). The CMBS specifies the magnitude of the benefit payable for each particular medical service. For example, the CMBS specifies the benefit for a consultation with a GP is $21.00.[2]

2.2.8. The CMBS is important to this case because it is used as the basis for determining the fees payable to individual medical practitioners by public hospitals in rural South Australia. While the fee paid for each service may not be precisely the same as specified in the CMBS, it is related to the benefit specified in the CMBS.

[2] An item 23 basic consultation. The scheduled fee is $24.70, the Commonwealth Medicare Benefit is $21.00.

- Level 2 services are 'health care services usually provided by specialist medical practitioners, and include treatment for patients with complicated medical history and/or risk factors which usually necessitate support services, increased staffing levels and training'.[5] They require that additional pathology, radiology and blood transfusion services are readily available.

- Level 3 services are 'usually those services provided by super-speciality units within teaching hospitals. The only Level 3 services currently provided in rural SA are Intensive Care facilities at regional hospitals and the renal dialysis satellite services at Port Augusta Hospital'.[6]

2.3.7. Often doctors are accredited to perform services at a higher level, but the hospital does not have a corresponding accreditation. In order to maintain this accreditation a doctor will go to neighbouring hospitals to perform procedures together with colleagues from other hospitals.

2.3.8. Specialist functions, such as anaesthesia, obstetrics and general surgery are performed by both visiting specialists and resident general practitioners with particular specialist accreditation. Visiting specialists will sometimes form a team with the resident GP who will perform the anaesthetics or other part of the operation.

2.3.9. There are very few resident specialists in rural SA hospitals although the doctors that are in those areas are usually trained in at least one specialist skill, particularly those practising in the large regional hospitals. For example, two of the seven GPs in Murray Bridge Soldiers' Memorial Hospital have obstetrics skills, one has anaesthetic skills and one has general surgical skills. Together they can form teams to provide many level two services. Often a doctor working in a small regional health service will visit neighbouring hospitals with appropriate accreditation to perform level two procedures and form a team with on-site doctors. For example, a doctor in one town who is a renowned surgeon may work with anaesthetists in neighbouring hospitals approximately once a week and may support more major procedures in the region on a bi-monthly basis.

2.3.10.Doctors practising in rural South Australian public hospitals are generally paid on a fee for service basis. That is, they are paid a specified sum for each procedure that they perform in any one session. The fee for service system in rural SA varies from historical Fee for Service Agreements because of the recently introduced Rural Enhancement Package, discussed below. A small number of doctors are employed by the hospitals. The prevalence of the Fee for Service Agreements can be attributed to the lack of throughput in many of the smaller public hospitals, making it uneconomic to hire full time doctors.

2.3.11.The SAHC negotiates the rates for the Fee for Service Agreement with the AMA approximately once every three years. The Fee for Service Agreement is approved by the SA Cabinet before adoption by SA rural hospitals. All doctors in rural SA are consulted or

[5] Id
[6] Id

participate in meetings conducted by the Rural Doctors Association in conjunction with the AMA before the AMA takes its proposals to the SAHC.

2.3.12.The current Fee for Service Agreement runs for three years and in 1995 set most rates paid to doctors practising in rural hospitals at 102 per cent (the SA schedule) of the Commonwealth Medicare Benefits Schedule (CMBS) rates. The rates were then inflated by 3.25 per cent as from 1 July 1997 and an additional 3.25 per cent as from 1 July 1998, resulting in a figure of 108.5 per cent of the CMBS. These rates are affected by the Rural Enhancement Scheme, discussed below, for doctors that are resident in rural areas. This adds approximately a further 22 per cent bringing the payment for each service to 130 per cent of the CMBS. Some rates are set higher. Payments for after hours services have loadings that start at 50 per cent of the SA schedule.

2.3.13.It is estimated that South Australian rural GPs obtain approximately 10 per cent of their income from hospital work, whereas specialists rely on hospital work for up to two thirds of their income.[7] Hospitals consulted by the Commission indicated that this is because GPs also maintain a private practice, practising specialists often do not. Private practices will often be attached to the hospital and the GP will see his or her own patients in the time that they are not involved with the hospital.

2.3.14.It is widely acknowledged that all rural areas in Australia have some problems in attracting doctors. Submissions estimated that rural SA currently has between 30-40 vacancies.[8] A discussion of reasons for such shortages can be found in the AMWAC Report 1996.8 entitled The Medical Workforce in Rural and Remote Australia.[9] Several of the more remote regions in rural South Australia have developed incentives to address some of the shortages.

Variations and incentives[10]

2.3.15.Although the Fee for Service Agreement underlies the contracts for each doctor in rural SA, the Commission's enquiries appear to show that the Fee for Service Agreement is rarely the sole remuneration for the doctor providing services to public patients in public hospitals. Some of the variations that doctors receive or negotiate are discussed below.

2.3.16.*Federal Government incentives*

- The Commonwealth Government provides relocation fee and background specialist training funding up to $50,000 for doctors willing to transfer to rural areas.

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[7] Interview note from video conference with Mr Mark Diamond, SAHC and Regional General Managers 22 December 1997

[8] E.g. see Australian Medical Workforce Advisory Committee Report 1996.8, *The Medical Workforce in Rural and Remote Australia,* Sydney, p. 13 (estimated 28 shortages in 1994) or note of video conference meeting with Dr Brian McNamara, President, SA Rural Doctors' Association on 3 December 1997 who estimated a shortage of between 30 to 40 doctors.

[9] See pages 22-24 for a list of disincentives and attractions of rural medical practice.

[10] For a more detailed discussion of various incentives, see AMWAC, 1996.8 (*op. cit.)* Appendix A.

- Upper Spencer Gulf Accident Care agreement: This is a five year agreement negotiated between the Commonwealth and certain doctors working in Port Pirie, Port Augusta and Whyalla. It relates to the provision of free emergency services at these regional hospitals. It consists of provisions under which GPs who attend between 8 a.m. and 6 p.m. are paid under a contract between the GP and the patient, as opposed to the hospital and the patient. This system operates in a similar manner to the casualty section of the hospital in these regions and is funded by the Commonwealth.

  Doctors working in these hospitals are also guaranteed a certain amount of money each year by the North and Far Western Regional Board. The Commission was informed that this serves as an incentive to ensure that these important regional hospitals are serviced by doctors.[11] These hospitals are along the Eyre Highway and receive many road trauma cases.

2.3.17.*State Government incentives*

- fee for service payments.
- Subsidisation of cost of, or provision of, premises for private practice (eg a clinic on the side of the hospital building).
- Casualty/outpatient privileges.
- Contractual top ups.
- Obstetricians: The State Government has agreed to pay insurance for obstetricians working in certain hospitals through the South Australian Captive Insurance Commission (SAICORP).
- Rural Enhancement Package: This package consists of a $100 per day on call fee and a loading on top of the Fee for Service Agreement that brings the payment rate to approximately 123-130 per cent of the Medicare schedule. This package is only payable to doctors who reside in rural areas and is not paid to visiting medical specialists. The Commission was informed that this results in lower fee for service payments being made by hospitals in close proximity to Adelaide as they use a greater percentage of services provided by visiting medical specialists who reside in Adelaide. On the other hand, services provided to hospitals in the more remote areas are largely provided by doctors who reside in rural areas and these hospitals are required to pay the loadings.

2.3.18.*Local council incentives*

- In some towns, the local government funds or provides further incentives to attract a doctor to the area. These incentives include houses, cars or airfares. For example, some doctors in Ceduna on the Eyre Peninsula were given accommodation, in Peterborough doctors were offered accommodation and a guaranteed salary of $200,000 — 'significantly more than the average achieved in the country and certainly a lot more than the average for the city'.[12] It was commonly acknowledged in submissions that local

[11] See, for example, interview note from video conference with Mr Mark Diamond, SAHC and Regional General Managers 22 December 1997 (*op. cit.*).
[12] Taken from information provided by Peter Joyner, former President of the RDASA at meeting 30 October 1997.

councils generally only participate in smaller and more remote towns where it was harder to attract doctors to the town or to maintain the one doctor there. Unlike other incentive schemes Local Government incentives are also aimed at ensuring medical services are provided at locations other than public hospitals.

2.3.19.*Other*

- An ability for doctors to run a private practice. (This is not necessarily something over and above conditions open to doctors in metropolitan areas.)

2.4. The Fee for Service Agreement negotiation process

2.4.1. The Commission was informed that the agreement is between representatives from the SAHC and a group consisting of representatives from both the AMA and the Rural Doctors' Association of South Australia (RDASA).[13] Negotiations are taken back to the RDASA for teleconference discussions with members. The AMA has always traditionally signed the agreement off, but the 'grass roots' liaison of the contract has been left to the RDASA over the last few years as it has more effective channels of communication with doctors in rural areas.[14]

2.4.2. The SAHC negotiates the Fee for Service Agreement on behalf of hospitals. The seven SA Regional Health Services (on behalf of the SAHC) decide the budget of the hospital that will be spent using the Fee for Service Agreement. The terms determined to attract doctors to particular hospitals are negotiated by one of the following methods:

- the Regional Managers negotiate on behalf of the hospitals;
- the hospital CEO negotiates directly with the doctor; or
- the Fee for Service Agreement is adopted without addition or amendment.

2.4.3. In some smaller, remote areas the town council is involved in attracting doctors to the area through the offer of incentives such as accommodation, car use or airfares. These incentives were discussed above in section 2.3.

2.5. Interstate experience

Rural health care in other Australian States

Victoria

2.5.1. The Victorian government informed the Commission that in 1993 Victoria introduced casemix funding and commenced the shift to a purchaser/provider model in which the

[13] A group of rural doctors formed approximately ten years ago in SA to discuss and promote issues pertinent to rural South Australian doctors.
[14] Taken from information provided by Peter Joyner, former President of the RDASA at meeting 30 October 1997.

Department of Human Services is responsible for purchasing health services and public hospitals are responsible for delivering services to the community. The Department of Human Services stated that this has led to a clear separation between the respective roles of the Department and public hospital managers, the establishment of an 'arms length' relationship and the removal of centrally imposed restrictions on the way public hospitals can manage their affairs.

2.5.2. The Department of Human Services indicated that the capacity to select staff or contractors and to negotiate their terms and conditions of employment or engagement is a fundamental aspect of Victorian hospital management. Centralised arrangements are not considered appropriate in Victoria because they would restrict the capacity of public hospitals to manage their affairs independently and efficiently. Victoria considers that this approach fosters efficiency and therefore maximises overall community welfare.

2.5.3. On the whole, Victorian hospitals said that they experienced some friction and some difficulties in shifting from centralised arrangements to individual negotiation, but have acknowledged that the results are better under individual negotiation. That is, they are able to obtain more competitive rates from doctors in certain cases. Certain hospitals said that their relationships with doctors have improved immensely as a result of talking and negotiating with each other in a face to face manner for the first time ever. The Commission was informed by a Victorian Hospital Director of Medical Services that the chance to discuss and solve mutual problems has improved the rapport between management and the doctors.

2.5.4. The AMA provided a report by Access Economics Pty Ltd which argued that, on the information and data presently available with regard to Victoria, it is not possible to draw any meaningful conclusions about the cost and price experience under the Fee for Service Agreements. The AMA stated that only 13 per cent of Victoria's estimated full time equivalent hospital medical workforce is covered by Fee for Service Agreements and the remaining doctors are covered by collective negotiations as well as by limited individual negotiation.

Queensland

2.5.5. The Queensland Health Department informed the Commission that it has unique organisational arrangements for the delivery of medical services in rural areas. The Department indicated that various Health Districts employ Medical Superintendents and Medical Officers with the Right of Private Practice and private rural general practitioners provide relief and assistance to rural hospitals when required. Remuneration for these private doctors relates to the number of hours worked, as specified in the relevant award, rather than on a fee for service basis. The Queensland Government indicated that these services will ensure significant savings to the Queensland public hospital system.

2.5.6. The AMA submitted that the remuneration and terms and conditions of service for all public hospital doctors in Queensland are centrally negotiated between the Queensland Health Department, the AMA and relevant trade unions. The AMA stated that there are no individual negotiations in this State in relation to remuneration or conditions of service of

doctors in the public hospital system.

2.5.7. The AMA considers that the centralised and collective system of negotiations over the provision of medical services in rural public hospital in Queensland does not differ significantly from the collective nature of the bargaining systems applying in most other States, including South Australia.

Western Australia

2.5.8. Western Australian public hospitals engage medical practitioners on both a salaried and a fee for service basis. There are five teaching hospitals in Perth that employ doctors on a salaried basis and other hospitals in the State are generally covered by Fee for Service Agreements. This system has been in place since the early to mid 1980s. The WA Department of Health negotiates a Fee for Service Agreement for Visiting Medical Practitioners with the AMA. The current agreement has a three year term and expires in September 1998. At the time of this determination the relevant parties had not yet begun negotiation of a new agreement. The general rate is approximately 110 per cent of the Commonwealth Medicare Benefits Schedule, with higher rates for some speciality procedures such as obstetrics and anaesthetics. The fee for service rates in Western Australia are generally uniform throughout rural and metropolitan areas. GPs in and out of Perth obtain specialist rates if they perform specialist procedures.

2.5.9. There are 344 doctors practising in regions outside Perth, approximately 70 are proceduralist doctors. In remote areas, especially the north-west, most practitioners are salaried. On average, practitioners receive approximately 40 per cent of their income from the fee for service arrangements and the remainder from private practice. The State currently has 40 vacancies, which is said to be the highest in any Australian state and 30 per cent of the existing rural doctors are overseas trained. Shire and town councils and mining companies will sometimes provide incentives such as housing or provision of a surgery for doctors to come to their areas, especially solo doctor towns where it is difficult to recruit and retain doctors.[15]

New South Wales

2.5.10.The AMA informed the Commission that the rates and conditions for both sessional and fee for service visiting medical officers (VMOs) in New South Wales are centrally negotiated. The AMA states that these negotiations take place within the legislative framework provided by the *Public Hospitals Act* 1929 which has recently been superseded by the *Health Services Act* 1997.

2.5.11.The AMA indicated that the terms and conditions of employment/engagement of all other public hospital doctors in New South Wales are covered by centrally negotiated awards and agreements made under the jurisdiction of the NSW Industrial Commission.

[15] Information provided in telephone conversations between ACCC and WA Department of Health officials on 13 February 1998.

2.5.12.The Rural Doctors' Association of Australia (RDAA) reported that there were eight Rural Area Health Services in NSW. VMO remuneration outside the Base Hospitals such as Wagga Wagga, Tamworth, Lismore, Orange and Bathurst is based on centrally negotiated Fee for Service Agreement. The RDAA reported that the NSW Rural Vacancy Medical Handbook listed over 90 vacancies in 60 towns across NSW. The RDAA informed the Commission that regionally based Fee for Service Agreements were abandoned after a prolonged dispute between government and VMOs in 1987.

Northern Territory

2.5.13.The Northern Territory operates on a system of centrally determined agreements allocating sessional rates for doctors. The AMA has indicated that the current VMO agreement was negotiated in 1995, with effect from November 1995 and continuing through to November 1998. Fee for Service Agreements are not common in the Territory.

2.5.14.There are two tiers of medical service in the Northern Territory. The Territory Government sponsors hospitals in Darwin, Alice Springs, Tennant Creek and Gove. The larger (of two) hospitals in Darwin and the hospital in Alice Springs have resident specialists and all hospitals engage visiting medical officers. In addition, the Northern Territory has an 'outreach' program — a network of private sector doctors who charge Medicare rates for services.

Australian Capital Territory

2.5.15.The ACT does not have any rural hospitals. There are two private, and one Government run, hospital in that Territory. One of the private hospitals also provides public hospital services for the Government. Current VMO contracts are expiring in the ACT and the hospitals are moving to an individual negotiation system.

2.5.16. The AMA indicated at the pre-decision conference that the ACCC should look to the ACT for an example of a system changing to individual negotiation. The ACCC notes that there is industrial action occurring in the ACT as a result of current reforms. The AMA advised that the process of individual bargaining by visiting medical officers had given rise to major disruptions to medical services in public hospitals. The AMA said that hospitals have been unable to reach agreement with individual VMOs in some specialities over the price or fees for their services. The AMA said that there had been enormous transaction costs from individual bargaining in the ACT and the process had 'effectively crippled the senior management of the Canberra Hospital' as they had no time for any other work.

3. Submissions prior to the draft determination

3. 1 AMA submissions

3.1.1. The AMA provided information to the Commission on several occasions.

3.1.2. In its original application, the AMA provided the following information.

- Collective negotiation between the AMA and the SAHC has been an established feature for many years for settling the terms, rates and conditions of contracts for private medical practitioners providing services to public patients in South Australian rural public hospitals as independent contractors.

- The process of negotiation is as follows. The AMA initiates a process of consultation with relevant members regarding the terms of the agreement some months before the existing contract expires. Proposals from this consultation are provided to the SAHC and negotiations commence. Consultation with doctors is ongoing. Following the signing of the heads of agreement the SAHC takes action to ensure each rural public hospital offers a contract based on the heads of agreement with relevant doctors. Individual doctors are free to seek amendments to the contracts they are offered and the SAHC and its hospitals are free to enter into contracts which contain such amendments. There is also provision for amendment of contracts during the life of the heads of agreement.

- The application provides background information on the Australian Health and Medicare Systems. Of relevance, the application discusses the system in which State and Territory governments employ or engage visiting medical officers on contract with hourly/sessional payments, fee for service payments or a system of salaried medical officers.

- The AMA estimated that there are 4,763 medical practitioners in South Australia of whom 39.3 per cent are general practitioners, 15.7 per cent are doctors in training, 11.4 per cent internal medicine physicians, 10.2 per cent surgeons and the remainder a range of other disciplines.

- The applicants claimed a range of public benefits which are addressed in section 4.

- The application covered a number of material factors which the AMA considered removed or reduced any anti-competitive detriment that may arise out of the activities for which authorisation is sought including:

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  - price impact of the arrangement for total market for medical services is negligible;
  - SAHC controls hospital budgets and could legislate to dampen unreasonable fees;
  - remuneration in private hospitals exceeds payments in public hospitals;
  - the SAHC could use contracted medical practitioners with salaried doctors;
  - medical practitioners cannot vertically integrate;

- the activities for which authorisation are sought do not involve new barriers to entry into the market, collective agreements on output, inhibitions on expansion for hospitals or individual medical practitioners, any effects on the price of medical services in the private market and the protection of poor quality medical practitioners;
- the arrangements allow for local individual variation of conditions and rates;
- there is no competition because of the Medicare system — the SAHC would pay more if it operated in the market environment prevailing in the private sector;
- hospitals can use overseas recruited doctors;
- authorisation will not affect policy decisions which may change the system of contract negotiation — SAHC could withdraw the arrangements.

3.1.3. In a meeting dated 12 November 1997 the AMA provided the following information.

- The market is the provision of medical services by doctors to public hospitals. It is in relation to the sale of services to hospitals, as opposed to the sale of medical services to patients. The AMA considered that it would not be practical for GPs to contract with hospitals not in close proximity so the hospitals may each be in separate geographic markets. Public hospitals do not compete with each other. The geographic market would be likely to be different for GPs and specialists as the latter cover a larger catchment area.

- There are probably 20 or 30 specialists living in rural SA. They would be likely to be at Mt Gambier, Whyalla, Pt Augusta and possibly Pt Lincoln. Rural GPs tend to be more multi skilled than urban GPs. Rural GPs do basic procedural work and these GPs generally provided basic obstetric, anaesthetic and other surgical services. Specialists were utilised for the more complex cases. Most (historical) payment differences for similar procedures done by GPs and specialists had been removed.

- The main concern for people in rural South Australian towns is to have doctors in the towns. The contractual arrangements with the local hospital assists in retaining these doctors. Some South Australian towns are quite small and have a very low number of doctors. Some may have only one or two, while some have five or six.

- The AMA said that an increase in fees by practising doctors would only happen at the time of renegotiation of the common service contracts. Hospitals could look to other medical service providers to provide medical services. For example, for some time obstetric services in Albury were provided by a company on a fly in, fly out basis.

- Many doctors would find it difficult to negotiate with the local hospital administrators and board in small towns because these people were also their patients.

- The SA health regions were relatively new. The situation may be very different again in five years' time depending on SA public sector management policy. The NSW health system has regionalised and recentralised several times.

- The AMA indicated that it had a letter of support from the SA Health Commission for its application for authorisation and subsequently provided a copy of this letter.

3.1.4. The AMA has also provided other data to the Commission including estimates that 70 per cent of SA rural doctors are members of the AMA.

3. 2 SAHC submissions

3.2.1. The SAHC provided background information to the Commission in a meeting on 16 October 1997.

3.2.2. In a submission dated 24 November 1997 the SAHC provided the following information.

3.2.3. 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.

3.2.4. The SAHC submission discusses:

- A jurisdictional argument. The SAHC argued that the public hospitals are not carrying on a business for the purposes of the Trade Practices Act in treating public patients, because they are implementing the State's obligations under the Medicare Agreement. The SAHC submitted that the SAHC's immunity from the Trade Practices Act extends to the AMA and, arguably, to relevant agreements between the AMA and its constituent organisations and members, under the principles enunciated in the Bradken decision[16]. For this reason the SAHC argued that the Commission should not consider the application for authorisation. The SA Government acknowledged that there was some doubt as to the applicability of any Crown immunity to doctors in respect of pre-contractual negotiations.
- 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 the AMA submission.

[16] *Bradken Consolidated Ltd v BHP Co Ltd* (1978) 145 CLR 107.

3.2.5. The Commission also had video conference meetings with the Regional General Managers of the South Australian Health Commission. Information from these meetings is summarised in section 3.3.

3.2.6. The South Australian Health Commission lodged a further submission on 31 March 1998. The SAHC re-affirmed its support for the AMA application for authorisation in this submission and provided the following information.

- The submission indicated that 'the South Australian Government, Department of Human Services and the South Australian Health Commission strongly support national competition policy and the trade practices legislation. 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 noted 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 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 argued 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 felt that the AMA has taken a cooperative 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 argued 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'.

3.3 Other submissions

3.3.1. An analysis of the information provided at meetings and in submissions received by the Commission appears below. The full version of each submission is available on the Commission's public register. A summary of submissions is attached at Appendix B.

3.3.2. The consistent theme throughout all the submissions and meetings was that there is a shortage of doctors in rural hospitals and hospitals find it hard to attract doctors to the more remote areas. Hospitals in the Adelaide Hills or areas where doctors can live in Adelaide and travel to work have less problems. It is estimated that there is currently a shortage of 30 to 40 doctors around rural South Australia.

3.3.3. The Commission was informed by the Regional General Managers that incentives for doctors such as the Rural Enhancement Package and specially negotiated packages offered by certain hospitals, such as Bordertown, have not served to attract doctors to remote areas.

3.3.4. Many doctors in smaller health services indicated to the Commission that they would be uncomfortable about negotiating with their local councils or hospitals about terms of remuneration as they are seen as a community leader or a community figure and are often already considered to be the richest person in the community.

3.3.5. It was not clear from submissions as to which party had bargaining power in the negotiations. While the applicants claimed that one of the benefits of the Fee for Service Agreement was to address the imbalance of bargaining power, thus implying that the SAHC had the bargaining power, it was put to the Commission by most industry participants that the doctors had the power because small one-doctor towns felt very vulnerable without a doctor. However, a doctor explained to the Commission that there is usually a close personal relationship between the doctor, the hospital administration and patients. This means that doctors are prevented from taking any significant industrial action.

3.3.6. Australian governments provided varying opinions.

3.3.7. The SAHC supported the application and said the agreement provided an immediate public benefit as outlined in paragraph 3.2.3.

3.3.8. The Queensland and Western Australian Governments as well as a Medical Director in a Victorian hospital expressed concern that any decision made by the Commission would impact upon other States. The Commission was informed that a system similar to the one operating in rural South Australia would disrupt processes being developed in these three States.

3.3.9. The Queensland Government's submission expressed concern 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 under an award system.

3.3.10.The Western Australian Government's submission did not agree with the benefits argued by the applicants, except that a lowering of transaction costs might be beneficial if it can be adequately demonstrated.

3.3.11.The Victorian Government's submission considered that centralised arrangements impede competition and foster a culture of reliance on collective decision making which discourages innovation. This restricts the ability of public hospitals to negotiate agreements which better reflect local circumstances. It limits the opportunity for productivity gains through changes to medical staff structures and work practices. It also hinders the development of a culture in which medical practitioners and hospital managers recognise their mutual dependency and work cooperatively together to ensure the viability of their hospital.

3.3.12.The Commission was informed that while some hospitals and doctors accept the centrally negotiated terms as the entirety of the agreement between them, many other hospitals negotiate further incentives on top of the Fee for Service Agreement. The Commission was informed that many doctors receive a range of other benefits, individual to each contract. These were explained in section 2.3.

3.3.13.Some hospitals consider that they would have to pay more to doctors if they had to negotiate contracts on an individual basis. Ceduna hospital said that it may not be in a position to offer any further incentives to doctors and may not be able to compete with hospitals in more affluent areas. The Regional General Managers said that the Fee for Service Agreement probably represents the base price that they would have to pay even if the SA system changed to a less regulated system.

4. Statutory test and authorisation procedure

4.1. This application was made under s. 88(1) of the *Trade Practices Act 1974*. The Act provides that the Commission may grant authorisation if the applicant satisfies the relevant tests in s. 90(6) and s. 90(7). Subsections 90(6) and 90(7) provide that the Commission shall grant authorisation only if it satisfied in all the circumstances that:

- the provisions of the proposed arrangement have resulted, or would result or be likely to result, in a benefit to the public; and

- that benefit would outweigh the detriment to the public constituted by any lessening of competition that has resulted, or would result or be likely to result, from the arrangement.

4.2. In deciding whether it should grant authorisation the Commission must examine the anti-competitive aspects of the arrangement, the public benefits arising from the arrangement, and weigh the two to determine which is the greater. Should the public benefits or expected benefits outweigh the anti-competitive aspects the Commission may grant authorisation, or grant authorisation subject to conditions.

4.3. If this is not the case the Commission may refuse to grant authorisation or alternatively, in refusing authorisation, indicate to the applicant how the application could be constructed to change the balance of detriment and public benefits so that authorisation may be granted.

4.4. Authorisation provides protection from action by the Commission or other party for breaches of the Act. It does not take effect until granted by the Commission.

4.5. Authorisation can be initiated only by parties to the conduct. Third parties cannot apply for authorisation and the Commission cannot demand an application for authorisation.

4.6. Authorisation does not provide a blanket exemption from the requirement to comply with all provisions of the Act. It covers only the sections of the Act that have been expressly authorised in the determination.

4.7. The Commission's process involves public consultation which has occurred before the release of a draft determination, in this case on 3 April 1998. After the draft determination is issued any interested party may call a pre-decision conference. Such a conference was called and held, over two periods — 19 May and 11 June 1998. After further submissions and information from the pre-decision conference is considered, the Commission issues a final determination, as is this document.

4.8. There are certain specified procedures for review and revocation of determinations if the Commission has made a decision based on information that is materially false or misleading or a condition of an authorisation has not been complied with or there has been a material change in circumstances since the authorisation was granted.

- 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.[17]

6.4. Submissions received from the AMA, the Rural Doctors' Association and some SA doctors considered that the Commission placed too much weight on the Victorian case. Submissions from these parties argued that the quality or volume of medical service provision in Victoria has decreased since the reforms. The AMA presented a survey of GP consultation fees in Victoria which did not indicate any trends or correlation between the rates paid by particular hospitals and distance of that hospital from Melbourne or any correlation between the particular hospital and the distance from the nearest base hospital. The AMA indicated that GP consultation fees in Victoria varied only slightly across the

[17] AMA Submission to ACCC: June 1998. Submission by the Australian Medical Association Limited (ACN 008 426 793) and the South Australian Branch of the Australian Medical Association Incorporated to the Australian Competition and Consumer Commission in relation to the draft determination of 3 April 1998 dealing with application for authorisation A90622.

entire State and ranged between 100 per cent and 105 per cent.[18] The Western Australian Department of Health considered that this survey did not prove the case either way and it further did not take into account all factors that constitute the relative attractiveness of a location, such as equipment and service provided by the hospital.

6.5. The AMA and the RDAA indicated in the pre-decision conference that the Commission's rebuttal of public benefits with reference to systems in Victoria and Queensland was not soundly based. The RDAA provided further feedback for other sections of the draft determination that the AMA alleged were inconsistent with the Commission's treatment of the public benefits in this case.

6.6. The WA Department of Health considered 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, such as individual negotiation that are more consistent with competition.
>
> In large part this appears to be because 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.
>
> It seems to be accepted in the submission that competition is constrained by the Agreement, although the submission appears inconsistent on this issue at some points. However, if competition is reduced then public benefits need to be demonstrated that can be achieved under the VMO Agreement but not, or not to the same extent, under alternative regimes. It is net benefit that is relevant.

6.7. The Rural Doctors' Association of Australia informed the pre-decision conference that VMOs in Victoria are extremely unhappy and the new system in Victoria had led to a decrease in services provided. The RDAA considered that the Commission had greatly understated the extent to which there were unfilled vacancies across Australia.

6.8. Doctors and the RDAA indicated that bureaucratic interference was a cause for some doctors to leave rural hospitals. The RDAA provided a publication *Why Rural Doctors Leave Their Practices*[19] to illustrate this point. The issue of transaction costs was also raised and some illustrations provided.

6.9. Several submissions discussed the impact that Medicare has on the market and indicated that Medicare sets the floor price for the agreement.

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[18] The AMA survey did not extend to other procedures, but the Commission was informed by the CEO at Bacchus Marsh hospital that rates had been negotiated at 89 per cent of CMBS.

[19] Hays, R.B., et al, 1997, *Why Rural Doctors Leave Their Practices: A qualitative interview survey of Queensland GPs who left rural practice between January 1995 and March 1996*, Final Report.

7. Commission assessment

7.1. The Commission has before it a valid authorisation application[20]. In the Commission's opinion the applications relate to provisions of contracts, arrangements or understandings which would or might have the effect of substantially lessening competition within the meaning of s. 45 of the *Trade Practices Act 1974* if they are not authorised. The Commission's view is that the AMA's constituent organisations and members would not be protected by any extension of Crown immunity, particularly in respect of negotiations between themselves prior to the negotiation of the Fee for Service Agreement.[21] The Commission therefore has an obligation to consider the matter.

7.2. Notwithstanding submissions from the South Australian Health Commission regarding its view on the ACCC's lack of jurisdiction, the AMA has not only not withdrawn its application for authorisation but has amended the application for the Commission to consider. The AMA was aware that if it considered the Commission did not have jurisdiction to consider the matter that it should withdraw its application. It did not do so.

7.3. Market definition

7.3.1. The first step in assessing the competitive effects and the public benefit/detriment of the conduct for which authorisation is sought is to consider the relevant market(s) in which that conduct occurs.

Interested parties views of the Commission's market definition

7.3.2. Few of the submissions received following the release of the draft determination commented on the Commission's definition of the market. The RDAA, however, contended that the Commission had failed to understand that in rural medical practice there is no market as such.[22] The RDAA's position appears to be based on the observation that there is a shortage of doctors in rural South Australia. Other submissions draw on this observation to make comments about the degree of competition in the relevant markets. The Commission will give its response to such views later in this chapter. It is sufficient, at this point, to note that the RDAA has not convinced the Commission that the market definition presented in the draft determination is incorrect.

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[20] Note the comment of the Trade Practices Tribunal *in Re Application from Concrete Carters Association (Victoria)* (1977) 31 FLR 193 at 245-246 in which it stated that it may be sufficient for a valid application if someone 'believes on what appear to him good grounds, that his conduct (if not authorised) may be in breach of the Act and he applies for authorisation accordingly'.

[21] refer 3.2.4.

[22] Rural Doctors' Association of Australia Submission to the ACCC, 26 June 1998.

Markets generally

7.3.3. Section 4E of the Trade Practices Act states that a market for goods or services includes other goods or services that are substitutable for, or otherwise competitive with, the first goods or services[23]. The courts have established that both demand and supply side substitution must be taken into account in determining the relevant market. *QCMA* is often cited when seeking to explain how markets are defined[24]:

> A market is the area of close competition between firms or, putting it a little differently, the field of rivalry between them ... Within the bounds of a market there is substitution between one product and another and between one source of supply and another, in response to changing prices. So a market is the field of actual and potential transactions between buyers and sellers amongst whom there can be strong substitution, at least in the long run, if given a sufficient price incentive ... Whether such substitution is feasible or likely depends ultimately on customer attitudes, technology, distance and cost and price incentives.
>
> It is the possibilities of such substitution which set the limits upon a firm's ability to 'give less and charge more'. Accordingly, in determining the outer boundaries of the market we ask a quite simple but fundamental question: If the firm were to 'give less and charge more' would there be, to put the matter colloquially, much of a reaction?

7.3.4. In establishing the market boundaries the Commission seeks to include all those sources of closely substitutable products to which consumers would turn in the event that the firm attempted to exercise market power. The Commission looks at both the demand and supply side of the market and defines up to four different dimensions:

- product market — based on whether products are close substitutes for one another;
- geographic market — which may be State, local or national depending on where trade occurs;
- functional market — defines at what level the conduct in question occurs, eg retail or wholesale;
- temporal market, i.e. — what period of time does the analysis apply to? The next two years? The next ten?

7.3.5. If market boundaries are too narrow so that actual or potential sources of competition are excluded then the proposed conduct will appear to have greater anti-competitive effect

[23] The Commission identifies the relevant market by determining the smallest area over which a profit maximising monopolist would impose a 'small but significant and non-transitory increase in price' (SSNIP), or equivalent exercise of market power. By including all substitution possibilities, the process of market definition identifies all the sources of competition that effectively constrain the price and output decisions of the relevant entities. Market definition is not an end in itself but rather a tool of analysis. The market must be defined only to the extent necessary to determine the effect of the proposed conduct on competition.

[24] *Re Queensland Co-op Milling Association Ltd & Defiance Holdings Ltd* (1976) ATPR 40-012.

than is actually the case. On the other hand, the market may be defined too widely to include products or geographic areas that are not close substitutes. In such circumstances the anti-competitive effects of the proposed conduct will appear to be weaker than they actually are.

7.3.6. This application relates to a proposal by the Australian Medical Association Limited and the South Australian Branch of the Australian Medical Association Incorporated (the AMA), on behalf of its members to enter into negotiations with the South Australian Health Commission (SAHC) for the terms, rates and conditions of contracts for private medical practitioners providing medical services to public patients in South Australian rural public hospitals as independent contractors. Accordingly it is necessary to consider the relevant markets in which these activities are conducted.

7.3.7. For the purpose of this application the most important dimensions of the market are the product and geographic dimensions.

7.3.8. The product and geographic dimensions of the relevant entities form the starting point of market definition. The boundaries are then expanded to include all of the actual or potential sources of close competition on both the demand and supply sides.

7.3.9. The applicants' original submission does not state explicitly how they consider the relevant market should be defined. However, the application seeks authorisation for the process of developing and implementing common service contracts for private medical practitioners delivering services to public patients in South Australian rural hospitals. The fee for service arrangements for which authorisation is sought refer to medical services provided for public in-patients to rural hospitals incorporated under *the South Australian Health Commission Act 1976* together with Gawler Health Service Incorporated and Noarlunga Health Services Incorporated. In-patients have been admitted to hospital and may include those who have previously presented at outpatient and casualty services provided by the relevant hospital. The term in-patient also covers day-patients who have been admitted and discharged on the same day. These activities might form the starting point for defining the product and geographic dimensions of the relevant market.

Product market

7.3.10. An issue is whether the various levels of medical services represent separate product markets. In a meeting with the Commission, the AMA stated that for the purpose of this application there is no effective distinction between the three levels of service. Rural GPs generally provide basic procedural, obstetrics, anaesthetists and other surgical services. The more complex cases are handled by specialist practitioners. This often involves the patient transferring to an Adelaide hospital. However, a number of metropolitan specialists are engaged to provide specialist services to rural areas. These services may be provided on one day per month, for example.

7.3.11. In relation to the product market, public patients do not enter into a direct agreement with private medical practitioners for the provision of medical services in public hospitals. Under the Medicare Agreements such services must be provided free of charge to public

patients. Their provision is the responsibility of State governments. Various mechanisms are in place in Australia for public hospitals to engage private medical practitioners to provide medical services to public patients in public hospitals.

7.3.12. Some Level 2 services can only be supplied by a medical specialist. This means that supply side substitution is weak. The Commission considers that level 2 services that can only be provided by specialists and Level 3 services are likely to constitute separate product markets. However, the provision of such services is small in the public hospitals covered by this application relative to the services that can be provided by either a GP or specialist. Thus, for the purposes of analysing the competition effects of the proposed conduct and assessing the public benefits and detriment, it would not be remiss to include all three levels of service in the same product market.

7.3.13. The Fee for Service Agreement applies to medical services provided to public hospitals by private practitioners. The AMA contends that the SAHC and its hospitals have the option of substituting contracted medical practitioners (those subject to this application) with salaried doctors or to tender out specific medical services.[25]

7.3.14. The Commission accepts that these sources of supply are close substitutes in certain circumstances. However, it appears unlikely that salaried medical officers (SMOs) are close substitutes to private medical practitioners in the hospitals subject to this application. This is because the workload of the hospital is often insufficient to economically employ an SMO.[26] This view is supported by statistics provided by the AMA which show recurrent expenditure by South Australian Health Unit in 1995/96. On the basis of those figures it appears that only Mt. Barker, Murray Bridge, Port Pirie, Riverland, Mt. Gambier, Port Lincoln, Port Augusta and Whyalla hospitals employed salaried medical staff in 1995/96.[27] The figures indicate that a total of $276,000 was spent on salaried medical staff by SA rural health services in that year compared with $24.3 million on fee for service practitioners.

7.3.15. The AMA also provided the Commission with an example of tendering for obstetric services in Albury following a dispute between the NSW Department of Health and the obstetricians at the hospital. For some time obstetric services in Albury Public Hospital were provided on a fly in, fly out basis. The Commission does not have further details of this example; in particular whether the obstetricians in dispute were employees or contractors, and the basis on which the replacement obstetricians were remunerated. Regardless, a tender process is simply another way of obtaining private medical services.

7.3.16. The Commission concludes that for the purposes of this application SMOs are not close substitutes for private medical practitioners and would therefore be unable to defeat an

[25] AMA submission accompanying application July 1997 (submission) p. 20.
[26] SAHC submission 24 November 1997, p. 7.
[27] Information obtained directly from Murray Bridge Soldiers' Memorial Hospital indicates that as of 15 December 1997, there were no salaried medical staff at that hospital. That hospital has 56 beds and contracts with 57 private medical practitioners, including specialists, under the Fee for Service arrangements. (Fax dated 15.12.1997 from Bonnie Fisher, Executive Officer/Director of Nursing, Murray Bridge Soldiers' Memorial Hospital to Kevin Eglinton, Regional General Manager, Hills Mallee and Southern Health Region, in response to request for information from the Commission.

7.4.7. SAHC representatives have informed the Commission that in fact there is some variation in prices between those hospitals in the more central regions and those in remote locations because of the operation of the SAHC's Rural Enhancement Package.[33] This package provides an on-call allowance of $100 per day and a loading estimated to be 23 per cent of the CMBS. The package applies only to doctors who are resident in a rural area and does not apply to visiting specialists. A large percentage of work done in the areas closer to Adelaide is done by doctors who are resident in Adelaide and so does not attract the loading. These doctors travel to areas within one hour of Adelaide, such as Murray Bridge. Thus these hospitals do not always pay the Rural Enhancement Package loading. Hospitals in more remote areas tend to get work done by resident GPs although specialist work is often done by visitors. These hospitals in remote locations are more likely to pay the Rural Enhancement Package premium. The Commission recognises that the scheme ameliorates some of the distorting effects of the Fee for Service Agreement. However, the Commission considers that it is more appropriate to remove impediments to competitive outcomes rather than seeking to artificially replicate those outcomes. Furthermore, payment of the package does not address concerns that the agreement removes price competition from within geographic markets.

7.4.8. The Regional General Managers of the SAHC informed the Commission that it would be unlikely that they could negotiate a lower rate with individual doctors. The Commission recognises that due to historical precedence set by the existence of a commonly negotiated agreement over many years it is unlikely that any hospital would pay less in the short term for VMO services than it currently does. In the longer term, however, it is likely that some of these residual rigidities would be eroded by competition.

7.4.9. The Commission notes that it is not compulsory for doctors and hospitals to use the common service contract. There appears, however, to be an understanding between the relevant parties that the agreement will be used. Although approximately only 60 per cent of doctors in rural SA are members of the AMA, non-AMA doctors also use the agreement.

7.4.10. This issue raises further concerns for the Commission. If authorisation is granted to only the applicants — that is the AMA and its members — the Commission would be concerned if all doctors practising in rural South Australia felt that they must join the AMA in order to attract the protection of the authorisation. The Commonwealth Government also indicated to the Commission that '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.[34] Estimates of current membership of the AMA varied between 35 per cent[35] and 58 per cent[36], while it was estimated that approximately 70 per cent of rural doctors practising in South Australia are

[33] Explained in more detail in section 5.3.
[34] Submission by the Commonwealth Department of Health and Family Services 2 February 1998.
[35] Estimated provided by Dr Peter Joyner, Past President, South Australian Rural Doctors Association in Video Conference on 30 October 1997. This corresponds with an estimate by David Watts, Director of Legal Services, South Australian Health Commission in interview on 16 October 1997.
[36] Figure provided by AMA in letter dated 10 December 1997.

members of the South Australian Rural Doctors' Association.[37] The actual level of membership is irrelevant to the Commission's concerns that the remaining doctors may feel compelled to join the AMA due to the effect of the Commission's authorisation determination.

7.4.11. Barriers to entry to rural practice are low for existing doctors, especially as the Commonwealth government provides relocation incentives and special training funding for doctors moving to rural areas. There are only limited substitutes for the private doctors in the area as the use of salaried medical officers is not economically viable for the hospitals on current throughput. The AMA claims that the anti-competitive effect of the agreement is in part ameliorated by the potential for the SAHC to recruit overseas trained doctors. The Commission understands that overseas trained doctors are often granted temporary residency and conditional registration to provide medical services to rural regions. However, if those doctors also become rural VMOs then it seems that they would also use the collectively negotiated standard agreement and face the same disincentives to vary it downwards as locally trained doctors.

Distortions in the SA market

7.4.12. Some submissions argue that the anti-competitive effect of the agreement is distorted for several reasons. These reasons include allegations that the Medicare Agreement affects free-market supply and demand, resulting in a shortage of doctors in rural areas. The Medicare system is discussed in Chapter 3. The Commission accepts that the Medicare system distorts some supply and demand decisions, especially the consumption and supply of medical and hospital services to patients. The Commission is not in a position to evaluate the impact of this distortion on the number of doctors in rural areas. However, the Commission notes that the reasons for shortages of doctors in rural areas are complex. It would appear to be an oversimplification to attribute shortages entirely to Medicare.

7.4.13. The AMA has presented compelling argument about the general distortions to the supply and demand for health services caused by Medicare[38]. The Commission does not dispute these. However, the AMA has not addressed the key issue of how, if at all, the Medicare system impacts on the way that visiting medical officers to rural South Australian public hospitals conduct negotiations about remuneration. In the absence of any argument to the contrary the Commission retains the view expressed in the draft determination that Medicare has only a limited impact on this application for authorisation. In particular, the existence of Medicare does not justify the collective negotiation of VMO remuneration.

7.4.14. Furthermore, the SAHC argues that doctors may not be operating under pure profit maximising motives with regard to the agreement because they understand that it has been endorsed by the AMA and is the normally accepted agreement, regardless of what they may be able to demand from the hospital in a less regulated system of negotiations. These issues have been discussed previously.

[37] Estimate provided by Dr Peter Joyner in video conference 30 October 1997.
[38] AMA submission, June 1998 pp. 4-5.

7.4.15. In addition, the fee for service rates are only a small part of the entire remuneration received by doctors in rural South Australia. Such doctors are also provided with other incentives from the Federal, State and Local Governments and receive income from private practice. The effect of the agreement on the supply of medical practitioners to rural areas of South Australia is therefore likely to be small. The Commission accepts this point but considers that it demonstrates the importance of defining market boundaries clearly when seeking to assess competitive effects. This application is concerned with the supply of medical services by private practitioners to public patients in rural SA public hospitals, not with the supply of medical practitioners to rural areas of SA. The latter is a somewhat broader concept. By implication the impact of the agreement on the market of relevance to this application is considerably larger than its impact on the overall supply of medical practitioners to rural areas.

Effect of the shortage of doctors

7.4.16. It has been put to the Commission that doctors do not compete with each other in rural South Australia because there is a shortage. The implication of this is that it does not matter if prices are fixed; Even if prices were determined individually there would not be an increase in competition. However, it is important to recognise that a shortage of doctors is an outcome rather than a process. It appears that the parties who hold these views may not realise that competition can still exist in markets where there is excess demand or a shortage of supply. The Commission is concerned with competitive processes and seeks to ensure that outcomes are determined in the most competitive way possible. The Commission's view is that the agreement, by fixing prices within and across regional markets, reduces competition in those markets regardless of whether there is a shortage or surplus of doctors in those markets.

7.4.17. In a competitive market the Commission would expect to see individual practitioners making their own decisions about how much to charge hospitals for their services. Hospitals would then decide how much to purchase at the prices and service levels offered. If an individual practitioner was charging too much, hospitals would be free to switch to a lower priced alternative. Under the existing fee for service arrangements doctors collectively decide how much to charge public hospitals and effectively remove the hospital's ability to switch to lower priced alternatives. It is the collective manner in which fees are determined, rather than a shortage of doctors, that reduces competition between doctors in rural South Australia.

7.4.18. The RDAA provides an example of competition within a geographic market in its submission dated 26 June 1998. It notes that 14 local doctors hold visiting rights at a local hospital in Ballina NSW. An additional 16 local doctors have chosen not to apply for visiting rights. This suggests that there are at least 30 doctors in that particular geographic market who make individual decisions whether to supply medical services to the local public hospital based on the competitive conditions that exist at any one time.[39]

[39] The Commission notes that the RDAA asserts in its submission dated 26 June 1998 (p. 2) that the 16 doctors who do not wish to apply for rights to treat public patients at the local hospital most commonly cite

7.4.19. Whether or not there is a shortage of doctors is irrelevant to the above analysis. In fact, the use of collectively negotiated fees is likely to exacerbate any shortage by restricting the incentives for hospitals and doctors to adjust payments to help to attract more doctors to a given hospital or area.

Would prices increase without the agreement?

7.4.20. It has been put to the Commission that prices may actually increase if the Fee for Service Agreement were to be removed from the South Australian Medical System.

7.4.21. The SAHC has indicated that one reason that the fee for service rates may increase is because doctors are currently willing to sign the agreement as they understand that it has AMA endorsement. The argument follows that even if the doctors thought that they could negotiate a higher rate for each procedure, they would not do so because they understand that the AMA believes the rates to be fair. The SAHC submits that if it were to unilaterally dictate the amount that it proposed to pay doctors the agreement would be unlikely to be supported by the AMA and doctors would attempt to vary the agreement and often negotiate a higher rate. The Commission accepts that in certain instances, doctors may be able to negotiate a higher rate than that specified in the standard contract. Such an outcome would be consistent with a competitive market. However, it is unlikely that most doctors would negotiate higher rates.

7.4.22. The Commission considers that a move to a less regulated system of negotiation would necessitate a review of the entire package of government assistance that is provided to rural doctors. It is uncertain about the effect on the overall payments made by hospitals.

7.4.23. Some hospitals have indicated to the Commission that they would have to pay more to attract doctors to their hospitals because they would be competing with other hospitals. In effect they are arguing that the agreement serves as a buying group pricing cap arrangement as well as the purposes that it serves for the AMA and the doctors. Some hospitals expressed concern that if one hospital made a lucrative agreement for one particular doctor all other doctors across the State would request similar packages. The Commission was informed by a small hospital in a remote area in Victoria that this tended to be the case.

7.4.24. There are a number of issues to consider here. Hospitals are already competing for doctors, although the manner in which they do so is restricted by the agreement. Furthermore, the Commission is not necessarily advocating that individual hospitals should negotiate with doctors. The precise details of how the SA Health Commission or hospitals want to acquire the services of private medical practitioners is up to them. For example, the SAHC may set a rate centrally for rural hospitals in South Australia or it may choose to empower individual hospitals or regions to negotiate contracts with medical practitioners individually. If individual hospitals are involved in negotiations it may be appropriate to

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'bureaucracy' as the reason for their decision. The RDAA states that bureaucracy is one of the competitive conditions in the market. If its level is changed, then the decisions of some of the 30 doctors in the market may also change.

change the manner in which they are funded to ensure that the hospitals have the necessary financial flexibility.

7.4.25. The Commission would be concerned if a 'lucrative' agreement negotiated by a particular doctor became a benchmark for all other doctors in the State. The Commission envisages that such agreements would be negotiated only in circumstances where a hospital has difficulty in attracting medical services. In such a situation the so-called 'lucrative' agreement is in fact an additional incentive that is not needed by other hospitals. Alternatively, a 'lucrative' agreement may be negotiated by a doctor who has a special skill or other attributes that are in demand. In such cases, the additional payment is a reward for those skills. In a competitive situation, it is unlikely that doctors who do not have high-demand skills or who wish to provide services to hospitals that do not have difficulty in attracting such services would be able to negotiate agreements that mirrored the 'lucrative' agreement.

Summary of anti-competitive effect

7.4.26. The Commission considers that the Fee for Service Agreement is anti-competitive because it acts as a price floor for all hospitals in South Australia. Sometimes negotiations are conducted to provide doctors with a package over and above that provided by the Fee for Service Agreement, but negotiations never result in a discount to the hospitals. The agreement removes competition within the various geographic markets and also distorts inter-regional resource allocation.

7.5. Public benefits

7.5.1. In order to authorise the conduct as specified in the application the Act requires that the Commission must be satisfied that in all the circumstances the public benefits arising from the conduct outweigh any anti-competitive effect of the conduct.

7.5.2. The onus is on the applicants to satisfy the Commission that there is an overall public benefit. The mere assertion of a public benefit is not enough — it must be demonstrated. These requirements were stated clearly by the Tribunal in QCMA where it said:[40]

> It is not sufficient for an applicant to point to a clear public benefit and then leave it to others to try to show that, nevertheless, the authorisation would not be justified. The onus is upon the applicant to satisfy the Tribunal that there is sufficiently substantial public benefit to outweigh the detriment, especially any anti-competitive detriment and so justify authorisation. Given the value placed upon the promotion and preservation of competition by the Act as a whole, it is a heavy onus.

7.5.3. The applicant is also required to demonstrate that there is a causal link between the claimed public benefits and the conduct for which authorisation is sought. Furthermore, the

[40] *Re QCMA v Defiance Holdings Ltd* (1976)_ATPR 40-012 at 17,244.

benefit must be to the public, or at least a large cross-section of the community, and not just a private benefit.[41]

7.5.4. While the Trade Practices Act does not define public benefit, the Tribunal has stated:

> Public benefit has been and is given wide ambit by the Tribunal as, in the language of QCMA (at 17,242), 'anything of value to the community generally, any contribution to the aims of society including as one of its principal elements (in the context of trade practices legislation) the achievement of the economic goals of efficiency and progress'. Plainly the assessment of efficiency and progress must be made from the perspective of society as a whole: the best use of society's resources. We bear in mind that (in the language of economics today) efficiency is a concept that is taken to encompass 'progress' and that commonly efficiency is said to encompass allocative efficiency, production efficiency and dynamic efficiency.[42]

7.5.5. The Commission and the Tribunal have recognised a wide range of economic public benefits, including:

- fostering business efficiency, especially when this results in improved international competitiveness;
- industry rationalisation resulting in more efficient allocation of resources and in lower or contained unit production costs;
- expansion of employment or prevention of unemployment in efficient industries or employment growth in particular regions;
- promotion of industry cost savings resulting in contained or lower prices at all levels of the supply chain;
- promotion of competition in industry;
- promotion of equitable dealings in the market;
- growth in export markets;
- development of import replacements;
- economic development, for example of natural resources through encouraging exploration, research and capital investment;
- assistance to efficient small business, for example guidance on costing and pricing or marketing initiatives which promote competitiveness;
- industrial harmony;
- improvement in the quality and safety of goods and services and expansion of consumer choice; and

[41] For a discussion of what is a private and what is a public benefit see the decision of the (then) Trade Practices Tribunal in *RE Howard Smith Industries Pty Ltd* (1977) 28 FLR 385.
[42] *Victorian Newsagency decision*, ATPR 41-357 at 42,677.

- supply of better information to consumers and business to permit informed choices in their dealings.

7.5.6. The Commission has also accepted a range of non-economic public benefits, such as improvements in health and safety, avoiding conflicts of interest and the promotion of equitable dealings.

Public benefit claims by the applicants

7.5.7. The AMA's June 1998 submission in response to the Commission's draft determination criticised its assessment of the public benefits associated with the conduct for which authorisation is sought. The criticisms are extracted from the AMA submission below.[43]

- The draft determination is too quickly dismissive of the transaction costs of individual contract negotiations; and

- 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 cooperation.

- 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.

7.5.8. The Commission will address the AMA's claims in relation to transaction costs in the following section.

7.5.9. The Commission does not consider that its assessment of the public benefits in the draft determination suffered from the deficiencies identified by the AMA. Firstly, the Commission notes that the AMA itself chose to compartmentalise the public benefits in its original submission where it listed some 23 public benefits that it claimed arose from the conduct for which authorisation is sought. The Commission considers that this compartmentalisation is, in fact, necessary given the complexity of the issues under consideration. However, the Commission agrees with the AMA that it is also necessary to make an overall assessment of the public benefits. The Commission considers that it has done so.

[43] AMA submission, June 1998, pp. 1-2.

7.5.10. The Commission reiterates that its assessment of public benefits is within the context of the relevant markets. These were identified in Section 5.1. The Commission understands that the AMA has broader concerns about the delivery of hospital care in rural South Australia. However, this determination is concerned with the impact of the agreement on the market for the supply of medical services by private medical practitioners to public patients in public hospitals in rural South Australia. The Commission appreciates that this market is intricately linked with the broader concept of the delivery of hospital care in rural South Australia. However, in determining whether the conduct should be authorised this broader concept is relevant only to the extent that it can be demonstrated conclusively that the conduct for which authorisation is sought is inextricably linked with that concept. The Commission is not convinced that the link in this case is inextricable.

7.5.11. In assessing the AMA's claims the Commission has kept in mind the following market characteristics:

- the SAHC is the monopoly provider of public hospital services in South Australia;
- the private hospital sector is not a significant factor in rural areas and is unlikely to be so in the foreseeable future given the small population base of rural South Australia;
- medical practitioners are entitled to negotiate with the individual hospitals for additional remuneration and/or conditions;
- the standard contract is claimed to be optional although most medical practitioners use it;
- the small size of most hospitals and the sparse geographic distribution of the rural South Australia population makes the provision of salaried medical officers an uneconomic proposition in most cases;
- a minimum rate for every service is, in effect, set by the Medicare Schedule; and
- there is a shortage of medical practitioners in rural areas and some hospitals have difficulty in attracting doctors to their area.

7.5.12. Listed below are the public benefits claimed by the AMA in its application and the Commission's view in relation to each one. The AMA's claims are presented in italics.

(a) The arrangements are complimentary to a range of other dealings between the AMA and SAHC aimed at facilitating the efficient use of public health resources and improving the health of the South Australian population. The orderly process for securing medical services in public hospitals provides a sound basis and framework for dialogue between the SAHC and the medical profession on specific public health initiatives and the management of the interface between community based and hospital based care. The arrangements also facilitate the implementation of continuing medical education programs aimed at maintaining, improving and targeting the medical skills of contracted medical practitioners to the needs of the public hospitals and public patients.

The Commission agrees that the efficient use of public health resources and a well trained medical work force which continually updates its skills are public benefits. However, the AMA has not demonstrated that these benefits can only be achieved through collective negotiation.

Similarly, there is no substantiation of the claim that the arrangements help in providing a sound basis and framework for dialogue between the SAHC and medical practitioners on the interface between community based and hospital based care. It appears that this interface is achievable under arrangements that do not necessarily involve collective negotiation of fees.

The Commission accepts that the arrangements do facilitate the implementation of continuing medical eduction programs by making specific payments to individual medical practitioners. However, a similar outcome could be achieved by making an education payment to each doctor credentialled to a public hospital without recourse to collective negotiation of fees.

(b) The arrangements do not impose anything new on the pricing system for medical services in public hospitals.

The Commission does not consider this to be of any benefit to the public as it merely continues the status quo. An arrangement which lowered costs or redistributed them in a more efficient manner would be a public benefit.

(c) The arrangements for which authorisation are sought maintain competition and efficiency in relation to the provision of medical services to private patients in both public and private hospital facilities and private rooms. The arrangements clarify the outpatient/in-patient interface, ensure that patient consultations prior to hospital admissions are properly categorised as either private or public hospital services and provides for private consultations, private in-patient services and the fees for these services to remain a matter between the individual medical practitioner and the private patient. Public benefits, in terms of reduced hospital costs and improved patient choice achieved through clear definition of the interface between private and public services, accrue to both patients and hospitals.

The public benefits claimed under this item arise from making sure administrative arrangements are clearly understood and implemented. They have little to do with the fees paid to medical practitioners and would have to be resolved irrespective of pay scales. The Commission accepts, however, that the collective negotiation process over fees is a convenient forum in which to address other matters where common agreement or implementation issues can be settled.

The applicants do not elaborate on the impact of the agreement on the provision of medical services to private patients. The Commission assumes that the impact is minimal as the agreement is in relation to the provision of medical services to public patients.

The Commission notes that the agreement stipulates that outpatient services are to be operated as an extension of the medical practitioner's surgery and hence the cost is transferred to the Commonwealth instead of South Australia. This cost shifting may appear to reduce hospital costs and generate a benefit for South Australia by enabling its public hospital funds to be concentrated on in-patient services but this is achieved at the expense of the general Australian taxpayer. The total cost of running the hospital is not altered.