Department of Human Services

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OUR REF:

YOUR REF: CB00004

30 October 2007

Ms Isabelle Arnaud
Director, Adjudication
Australian Competition and Consumer Commission
GPO Box 3131
Canberra ACT 2601
By fax (02) 6243 1211

Dear Ms Arnaud

Collective bargaining notification CB0004 lodged by the Australian Medical Association (Vic) Pty Ltd on 11 October 2007 – Submission on draft objection notice.

I refer to the Australian Competition and Consumer Commission's draft objection notice (**draft notice**) dated 12 October 2007 containing an invitation for further submissions.

DHS agrees with the ACCC's conclusion that the benefits likely to arise from the notified arrangements would not outweigh the detriments. DHS therefore submits that the ACCC should issue a final objection notice in similar terms to the draft notice.

The following submissions are additional to our prior submission and reference headings from the draft notice.

ACCC Assessment

DHS notes that the ACCC has identified that the anti-competitive effect of collective bargaining arrangements constituted by loss of efficiencies is likely to be more limited where:

- the current level of negotiation between individual members of the group and the proposed counterparties is low;
- participation in collective bargaining arrangements is voluntary;
- there are restrictions on the coverage or composition of the group; and
- there is no boycott activity.

Victoria

Current level of Negotiations

In the present instance, the ACCC finds that there is 'some evidence to suggest that there are currently limited negotiations with the hospital'. To the extent that this conclusion may be drawn from the fact that particular craft groups are generally paid the same fee for service, it should be noted that this does not necessarily reflect a lack of negotiation, but rather that hospitals have found it to be unacceptable to the members of a craft group not to be paid the same fee for a particular service. In effect, practitioners already enjoy some of the benefits of having collectively negotiated, by reason of individual members within a craft group insisting on receiving the same fee for service as their colleagues at that hospital.

DHS therefore believes that there may be a greater degree of negotiation than the ACCC has suggested. A factual finding that a 'reasonable degree' of negotiation occurs would be consistent with the ACCC's related conclusion that 'there does not appear to be significant disparities in the bargaining positions of VMOs and the LRH'.

Voluntary participation

DHS agrees with the ACCC that 'whilst the arrangements are voluntary, there may be a high level of pressure placed on LRH to participate in negotiations due to the size of the group'. Indeed DHS considers that the fact that the proposed participants are a substantial proportion of the incumbent VMO suppliers to LRH is an issue that should be significant weight by the ACCC. Each practitioner, as an incumbent supplier of services to LRH, has an enhanced degree of bargaining power because (in most instances) LRH is looking to retain their services. This is influenced by two factors: first, that they are familiar with the LRH and its systems; secondly, that sourcing supply of such services from a new provider is challenging for LRH.

If a number of incumbent service providers are able to collectively negotiate, their collective level of bargaining power is magnified. In essence LRH cannot afford to lose access to multiple suppliers simultaneously and therefore will become the weaker party in any such negotiations.

Coverage or composition of the group

Given the higher degree of bargaining power held by incumbent VMOs, DHS believes that the size of any bargaining group made up of incumbent providers would need to be very small in order to avoid an anti competitive effect. Certainly, in this instance, DHS agrees that the size and composition of the group is such that allowing them to collectively negotiate with LRH would have a significant anti competitive effect. Further DHS considers that, even in areas where there is a greater supply of doctors, the level of competition from doctors outside the group would remain limited due to the difficulty of sourcing the appropriate skill mix and replacing a number of doctors simultaneously.

No Boycott Activity

While the AMA notes that there will be no boycott activity, the nature of the process of collective negotiation of fees and the resultant communications between members of the group can only heighten the risk of tacit boycott activity. DHS submits that this increased risk would itself be an anti-competitive effect of allowing the proposed collective negotiation.

Public Benefits

DHS agrees with the ACCC's conclusion that the public benefits that may derive from allowing the proposed arrangement are 'marginal' and relate to:

- assisting with retention of medical practitioners in the LRH region;
- transaction cost savings; and
- improved relationship with LRH.

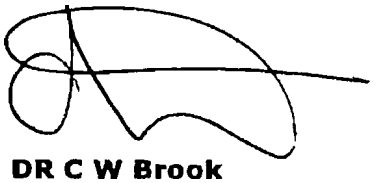
DHS submits that:

- retention issues are actually improved by LRH having the ability to contract with the individual and thereby being able to tailor an offer to that practitioner. Collective negotiation will lessen this ability, and may even negatively impact retention.
- the suggested transaction cost savings are illusory, as the AMA is proposing collective bargaining that will result in a contract that includes 'individual tailoring' to take into account the individual requirement of each medical practitioner and separate appendices to address pay rates for individual craft groups. DHS considers that such an outcome will require a similar degree of involvement by individual practitioners, and therefore similar transaction costs to the current individual negotiation approach.
- relationships between practitioners and the LRH are largely a function of the personalities involved. This will not be changed by introducing a collective bargaining approach.

These and any other claimed benefits are achievable without recourse to collective bargaining, and DHS therefore submits that the public interest justification for the proposed arrangements are at best marginal, while the anti competitive effects would be comparatively significant.

Please do not hesitate to contact me if you wish to discuss these issues further.

Yours sincerely



DR C W Brook
Executive Director
Rural and Regional Health and Aged Care Services