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29 October 2007

Ms Isabelle Arnaud
Director, Adjudication
Australian Competition and Consumer Commission
GPO Box 3131
CANBERRA ACT 2601

Dear Isabelle

Response to interested party submissions – CB00005

We write in response to the submissions below:

1. Department of Human Services (**"DHS"**)

   DHS has opposed the notification on the basis that it believes the "minor efficiency savings would not outweigh the considerable public detriment that will result from the Proposed Arrangement".

   Generally, AMA Victoria finds it peculiar that DHS would oppose an arrangement which seeks to further involve medical practitioners in their community through collaboration and a shared agenda. DHS, through its hospitals in Victoria, enters into collective agreement with an overwhelming majority of its medical workforce, and with almost all allied health services. Through extrapolation, it seems DHS is suggesting that there is significant public detriment in the existing arrangements it has with almost the entire health workforce.

   DHS' claim that the benefits of collaboration can be achieved without a collective agreement is without regard to the reality of the market. Medical practitioners are routinely omitted from discussions relating to accreditation, rostering and training and education. These terms are often imposed unilaterally by the Target, and on an ad-hoc basis, given the nature of contract negotiations. Whilst it is arguable that these matters can be cautiously discussed between competitors, the reality is that doctors are rightly reticent to do so due to the competition law risk. Further, the Target does not provide a forum for these discussions, so again the reality is that they do not happen. As such, these are clear public benefits to be gained from collective bargaining that have not occurred in the market and would not occur applying the counter-factual.

   Further, the Target asserts that doctors have strong bargaining power in their negotiations with hospitals. Again, the reality is completely different. The ACCC must consider the Target as operating as part of a health network and under DHS. Therefore, the industrial power of the Target is in fact its own power and the power of DHS, which has the right pursuant to section 42 of the *Health Services Act* 1988 (Vic) to impose its will on the Target.

Further, when examining the way in which the market actually works with regard to relative market power, it is clear that the Target acts with considerably more power. For example, the Target continues to approach its medical practitioners directly with regard to contract negotiations, notwithstanding the fact that these doctors are represented. This behaviour is indicative of an understanding by the Target that it is more likely to achieve its outcomes through a "divide and conquer" approach.

Further, in June 2007, the Target sent to many of the Applicants a letter stating that "following discussion with the Australian Medical Association (AMA) we agreed to progress individual contracts". This statement implies that AMA has agreed with the Target that contracts should be negotiated on an individual basis. AMA made no such statement. This statement has misled a number of doctors into signing agreements on the incorrect understanding that AMA Victoria was agreeable to the Target's approach. Further, this conduct demonstrates the information imbalance between the parties, and the extent to which the Target has used this imbalance in its negotiations in the market.

In relation to public detriments, DHS states that "the fact that CMBS attributes different values to similar activities for different craft groups reflects that there are different markets for each craft group." It is equally arguable that having one CMBS Schedule apply across all medical procedures implies one market. However, with respect to the DHS position, market is not defined by the CMBS schedule.

DHS argues that there is "little in common, even within craft groups". DHS asserts that this lack of commonality means there is little basis for a claim of an increase in efficiency from collective negotiations. This argument needs to be explored further. To the extent that doctors are complementary and not competitive, they are already free to discuss price, terms and conditions on a collective basis (as discussed in the DHS assessment of benefits). To the extent that doctors act in competition, AMA Victoria fails to see how it could be said that these doctors do not share a common purpose and common issues.

The understanding that non-competitors can already discuss price, terms and conditions is illuminating with respect to the DHS argument about leveraging of pricing. The CMBS Schedule already differentiates pricing as between different craft groups, and this is knowledge held by all craft groups. Further, as above, non-competitors can already avail themselves of their relative market position and use it as leverage. This is no more the case in a collective process.

The DHS has stated that "of negotiations break down under the Proposed Arrangement, there would be a risk that the Werribee Mercy Hospital would lose the services of approximately 60% of its non full time medical staff at one time". This argument is mischievous. Firstly, AMA Victoria has not sought the power to collectively boycott. There is no evidence that this may be an outcome of failed negotiations. Secondly, the proposed collective bargaining arrangements are voluntary, and each side is able to opt in and out of the arrangements at any time. Thirdly, should negotiations fail, there is a dispute resolution process that is to be enacted. Finally, whilst break down of the negotiation may cause individual doctors to independent decisions not to re-contract with the Target, it is fanciful to suggest that all doctors would act in the same way at the same time.

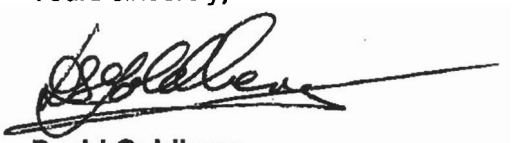
In relation to substitutes in the market, DHS basically asserts that there are none. This assertion needs to be challenged. DHS concedes that the market in which the Target

operates in metropolitan Melbourne. Other than the fact the Target has a VMO workforce, there is very little else to differentiate it from any other metropolitan hospital. It seems therefore that DHS is asserting that there are no viable doctor substitutes in Melbourne at all. In that case, it is pertinent to ask what solution DHS proposes in the case that a number of doctors leave any metropolitan hospital in a short space of time. Clearly, DHS has in the past and will in the future procure doctors to service the Target from available and additional (Australian, overseas) resources, as well as to offer patients a number of options in their geographic region as substitutes for the Target.

2. Target submission

The Target has stated at paragraph 29 of its submission that "If this [budget of the hospital] is the major determinant [on pricing] and accepted by the AMA then the Target would accede to this application immediately". AMA Victoria notes that it has stated in its submission exactly that "the budgetary restriction of the Target is by far the biggest determinative factor of wages". On that basis, we submit that the Target has actually agreed to be a participant to the proposed arrangement.

Yours sincerely,



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