AMA Victoria Response to Draft Objection Notice CB00004

We write in response to the ACCC Draft Objection Notice dates 12 October 2007 (C2007/1749) ("**Draft Objection**").

We submit that the ACCC has erred in its Draft Objection in relation to a number of key points. These key points relate to:

- **the market definition**, which the ACCC says is Gippsland and we say is Gippsland and metropolitan Melbourne;
- **commonality of interests between the doctors,** which the ACCC says is low and we say is extremely high;
- **under-estimation of the public benefits of the proposed arrangements**; and
- **over-reliance on the various submissions of the Department of Human Services** ("**DHS**") in assessing potential public detriments of the proposed arrangements.

1. Market Definition

AMA Victoria submits that the market definition proposed by DHS and accepted by the ACCC is far too narrow and not consistent with the evidence.

Gippsland and metropolitan Melbourne market

Based on information and data promulgated by DHS and public hospitals, AMA Victoria submits that the relevant market in which competition exists is Gippsland and metropolitan Melbourne. The following section provides information in support this submission. AMA Victoria notes that the Draft Objection focuses heavily on the geographical definition of the market whilst discounting all other elements that form part of any analysis of market definition, which are clearly relevant to the notification

In August 2007 the Rural and Regional Health & Aged Care Services Division of the Victorian Department of Human Services released a discussion paper entitled *Rural directions for a better state of health 2007, Further defining the roles of public hospitals in rural Victoria* ("**Rural Directions**").

According to the DHS, regional hospitals are a point of referral for complex care, and these centres need to take a leadership role within their region and with specialist statewide services in metropolitan Melbourne.

The DHS further details in Rural Directions that regional hospitals are the major specialist service providers for their regions, with medical care provided by specialist surgeons and physicians. Where regional hospitals have developed clear collaborative relationships with sub-regional and local hospitals, there will be opportunities to share resources, including the specialist clinical workforce. Regional services should take a lead role in the appointment of specialists who could then work across a number of hospitals in a sub-regional or regional area.

In its regional profile of Gippsland, DHS further identified that the region has more sub-

regional hospitals than other areas, including West Gippsland which is on the Melbourne metropolitan fringe and provides services to the growing population at the western end of the Primary Care Partnership which abuts the rapidly growing metropolitan areas of Cardinia. Another health service in the Gippsland catchment, Kooweerup, is in fact located in a metropolitan local government area.

The Southern Health Annual Report states that Southern Health provides services to a primary catchment including the cities of Cardinia, Casey, Greater Dandenong, Kingston and Monash and provides specialist services to a rural catchment including Gippsland. The medical workforce of Southern Health in 2006 was 988 EFT [124 full time specialists; 186 sessional specialists; and 678 junior medical staff].

It is also of note that fifty per cent of residents of Gippsland who require critical care services currently travel to metropolitan hospitals for it [Rural Directions, p18],

The Medical Directory of Australia identifies that 106 specialists practise in the Gippsland region, with about twenty per cent of them having a principal practice address in metropolitan Melbourne.

Too much weight has been given in the Draft Objection Notice by the ACCC to the geographical dimension of the market, without taking sufficient account of the functional and temporal dimensions of the market in which LRH operates. This is especially so in light of the ACCC's concessions that "LRH will attempt to recruit VMOs from throughout Victoria", and also that "there may be competition on the margin from specialists coming from Melbourne and more broadly Victoria."

The above data demonstrates the Target is not an island and does not operate in isolation. LRH clearly operates as the geographic and functional hub of the Gippsland region, in addition a shared boundary with the giant Southern Health Network, a booming outer metropolitan growth corridor and the high proportion of specialists who already visit Gippsland from metropolitan Melbourne are all factors that support AMA Victoria's submission that the market is Gippsland and metropolitan Melbourne.

Alternative position of market definition

AMA Victoria submits that the ACCC should re-define the market in light of the evidence above related to the interconnectedness of the Gippsland market to metropolitan Melbourne. However, if the ACCC rejects this argument, then in the alternative AMA Victoria submits that the ACCC must expand the market to be the regional hospital market of Victoria.

It is noted that VHIA (on behalf of the Target) states that the market is a regional market. Such regional market would comprise the 5 Victorian regional health services as determined under the *Health Services Act* 1988 (Vic), namely Ballarat Health Services, Barwon Health, Bendigo Health Care Group, Goulburn Valley Health and Latrobe Regional Hospital. This definition represents the minimum alternative position that the ACCC should contemplate in terms of market definition.

2. Commonality of interests between the applicants

In the Draft Objection, the ACCC has noted that "less commonality of interests further

reduces the public interest justification." This statement makes it clear that the ACCC has given weight to its determination that a lack of commonality exists, other than due to the "presence of doctors from different craft groups". In fact, there is almost entire commonality of interests between the Applicants.

It is expected that the contract for different craft groups will contain the following standard obligations:

The Practitioner shall:

a. provide timely and competent medical services for Hospital Patients within the Practitioner's current area of credentialing;
b. complete pre-operative and pre-procedural investigations at least one working day before admission of patients where possible; and
c. schedule ward rounds at reasonable times and in consultation with the nurse in charge;
d. comply with the Hospital's By-Laws, and any other rules, policies, protocols and procedures;
e. ensure maintenance of accurate and legible medical records;
f. attend mutually agreed meetings as are necessary for proper delivery of medical services;
g. participate in such activities relating to quality assurance, including post-graduate education and peer review, as agreed between the Hospital and the Practitioner;
h. maintain at all times full membership of a recognised medical defence association or other acceptable professional indemnity insurance;
i. be available for recall and consultation in accordance with an agreed roster developed in consultation with other medical practitioners on the roster;
j. immediately notify the hospital of an actual or potential adverse event involving a patient;
k. maintain registration under the *Health Professions Registration Act* 2005;
l. immediately notify the Hospital in writing should any professional registration be suspended, revoked or amended;
m. give advance written notice during which the Practitioner will not be available to provide medical services;
n. participate in Internal and External Disaster Plans.

The Hospital shall:

a. supply nursing staff to assist the rostered practitioner in the care of inpatients and emergency patients;
b. supply such basic equipment, drugs, dressings and stationery necessary for the care emergency patients;
c. ensure an efficient means of communication is available for the Practitioner when rostered on call;
d. provide word processing support for any papers the Practitioner may contribute to compulsory meetings;
e. ensure a safe working environment as far as practicable;
f. ensure the Practitioner is entitled to treat Private and Compensable Patients using Hospital facilities and consumables; and
g. assist the Practitioner to participate in an approved continuing education program.

In practical terms the above obligations encompass the breadth of clinical practice and the terms of employment in Victorian rural public hospitals.

Additional terms that could be incorporated relate to: the further development of clinical services at the hospital; support for the education and training of medical students and junior medical staff; the development of new models of care; and working in teams. Consequently there is an extremely high degree of commonality of contract terms for all craft groups.

In relation to price discussions, there is some commonality between Applicants, notwithstanding the various craft groups from which the Applicants derive. Specifically, method of payment, percentage of CMBS and payment of on-call are issues that could potentially be discussed between Applicants.

To the extent that Applicants are not competitors of one another (for example anaesthetists and general surgeons, urologists and obstetricians), they are already free to communicate the regard to price and non-price elements of their contractual arrangements without fear of breaching the Trade Practices Act.

In summary, we submit that:

- there is substantial commonality between the Applicants on all elements of the negotiations and contractual terms; and
- to the extent that there is a lack of commonality between Applicants, this commonality is between non-competitors, between whom price and non-price contractual discussions are already lawful.

3. Public interest

Public benefit …[is] ‘anything of value to the community generally, any contribution to the aims pursued by the 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’.[1] In addition, the ACCC accepts a broader definition of public interest that recognises social benefits.

Public benefit of potential price rise for Applicants

The ACCC, in simply analysing the potential price effects of collective bargaining as a potential detriment, has not examined the public benefit of such potential price rise. Such public benefit would include that a price rise for doctors working at the Target would enhance the likelihood of doctor retention and greatly increase the attraction for doctors considering working at Latrobe Regional Hospital. Further, it may attract more specialists and higher quality specialty care to the Gippsland region.

Compared to other regional health services such as Ballarat and Bendigo, Gippsland is poorly served for a hospital medical workforce. For instance compared to Ballarat, LRH which serves a catchment population fifteen per cent more, employs only 55 per cent the number of medical staff. Gippsland as a whole has only about fifty per cent the number of medical specialists compared to AIHW national workforce benchmarks.

Rural Directions also notes particular disadvantage for Gippsland, even with respect to other rural regions, specifically:

- current utilisation rates for subacute services are lower than other regional areas;

[1] *Re 7-Eleven Stores Pty Ltd* [1994] ATPR 41-357

- the need to develop renal dialysis services; and
- 50 per cent of residents of Gippsland region requiring critical care received these services in metropolitan hospitals.

In relation to a potential price rise resulting from collective negotiations, the ACCC has taken a simplistic view of correlating such price rise to public detriment without considering the public benefit of such price rise should it occur. In fact, AMA Victoria submits that a price rise to Applicants would not necessarily be a public detriment at all, and certainly not on balance.

The major public benefit of a potential price rise to Applicants is that the local region may attract and retain a greater number of doctors, especially some of the doctors on the fringe of the market. An increase of the appeal to doctors of practising at LRH will lead to greater access to medical services for the community of Gippsland, which includes a catchment area of 249,896[2]. An increase in access to medical services is commensurate with an increase in quality of such services.

In addition, such price increase will increase the competitive pressures on all specialist providers in the medium term.

Collaboration

Currently in Victorian rural hospitals, such as Latrobe Regional Hospital, Visiting Medical Officers ("**VMOs**") and hospitals undertake individual contract negotiations. This traditional approach to staff contract employment arrangements is the antithesis of how modern hospitals and health care needs to be organised. It is now widely accepted that a team based, co-operative and collaborative approach to health care provides the best prospect of improving the quality of patient care and reducing adverse outcomes. Cementing a competitive "go-it-alone" and "divide and conquer" culture to negotiations at LRH will decrease the public benefit to the community as compared to a collaborative approach.

Australian Medical Workforce Advisory Committee and Australian Institute of Health & Welfare data identifies that Latrobe Regional Hospital is under resourced for the population it is expected serve, consequently the current medical workforce that it has at its disposal must be utilised to best advantage. Establishing a common view of medical practitioner and hospital obligations would provide a good platform for this to occur.

Noted health economists Ehsani, Jackson & Duckett [MJA 2006] identified with respect to Victorian public hospitals that 7 per cent of admissions involve a significant adverse event, which incur on average $6826 of additional expense, which totals about 16 per cent of all hospital costs. If these figures are applied to Latrobe Regional Hospital's patient load of 25,500 cases, then $12.2 million of additional expenses are incurred.

Collective bargaining on its own will not be enough to remedy this situation, but as the hospital moves through transitional stages to its evolution as a key regional hub, with high levels of self-sufficiency, the establishment of a common mandate with the medical staff will:

- better facilitate the recruitment of more specialist staff;
- assist the development of new clinical services;
- help establish structures to support the education and training of medical students and junior medical staff; and
- provide a mechanism to canvass the introduction of new models of care.

[2] DHS 2007 statistics

In practical terms the slow progress in the development of Latrobe Regional Hospital warrants close scrutiny and the adoption of new measures which at least offers the prospect of meaningful and useful change.

Summary

AMA Victoria therefore argues that collective bargaining for participating practitioners will lead to:

- improved quality of care;
- reduction of costs associated with adverse events;
- better recruitment of specialist staff to the public hospital, leading to increased competition in the region, especially in the private medical market;
- economic development through the establishment of new clinical services;
- improved educational opportunities for medical students and junior medical staff; and
- industrial harmony.