Australian Competition & Consumer Commission

Assessment

Collective bargaining notification

lodged by

the members of the Wangaratta Anaesthetic Group

Date: 17 December 2007

Notification no. CB00006

Public Register no. C2007/2172

Commissioners: Samuel
Sylvan
King
Martin
Smith
Willett

Summary

The ACCC does not object to the collective bargaining notification lodged by the members of the Wangaratta Anaesthetic Group, who propose to collectively negotiate with BUPA Australia Health Proprietary Limited (trading as HBA) in relation to the provision of no-gap billing for anaesthesia services to HBA members.

The small business collective bargaining notification process

Collective bargaining refers to two or more competitors collectively negotiating terms and conditions with a supplier or customer. Without protection, it can raise concerns under the competition provisions of the Trade Practices Act.

Small businesses can obtain protection from legal action under the Act for collective bargaining arrangements by lodging a notification with the ACCC. Provided the ACCC does not object to the notified arrangement, protection commences 28 days after lodgement.

The ACCC may object to a collective bargaining notification if it is satisfied that the proposed collective bargaining arrangement is not in the public interest (and in some cases, that the notified arrangement will substantially lessen competition).

The notification

On 21 November 2007, collective bargaining notification CB00006 was lodged by a group of anaesthetists who are members of the Wangaratta Anaesthetic Group (WAG), proposing to collectively negotiate with BUPA Australia Health Proprietary Limited (trading as HBA) in relation to anaesthesia fees. Specifically, the group proposes to collectively negotiate a value above the Commonwealth Medicare Benefit Schedule fee (MBS) for the provision of no-gap billing to members of HBA.

The collective bargaining notification process is transparent involving public registers and interested party consultation. The ACCC received four submissions, none opposing the notification.

ACCC's assessment

The ACCC considers that the proposed collective bargaining arrangement may result in some public benefits in the form of increased input into contracts and efficiency savings.

The ACCC identified a number of features which mitigate against the potential for anti-competitive impact, in particular the voluntary nature of the proposed arrangements. The ACCC considers that the proposed collective bargaining arrangements will only lead to an agreement if this is mutually beneficial to both parties.

On the information available, the ACCC is not satisfied that the detriments likely to arise from the notified arrangement would outweigh the identified benefits. Accordingly, it does not object to the notifications.

Protection afforded by notification CB00006 will commence on 19 December 2007 and will cease three years from the date of lodgement (21 November 2010). As with any notification, the ACCC may review these notifications at a later stage should concerns arise.

1. Introduction

1.1. The Australian Competition and Consumer Commission (the ACCC) is the independent Australian Government agency responsible for administering the *Trade Practices Act 1974* (the Act). A key objective of the Act is to prevent anti-competitive arrangements or conduct, thereby encouraging competition and efficiency in business, resulting in greater choice for consumers in price, quality and service.

1.2. In the context of the Act, collective bargaining involves two or more competitors agreeing to collectively negotiate terms and conditions (which can include price) with a supplier or a customer (the *target* or *counterparty*).

1.3. Arrangements will amount to collective boycott where the collective bargaining group agrees not to acquire goods or services from, or not to supply goods or services to, the counterparty unless it accepts the terms and conditions offered by the group.

1.4. Collective bargaining and collective boycott arrangements can have a detrimental effect on competition and consumers and are likely to raise concerns under the competition provisions of the Act.

1.5. The Act, however, allows businesses to obtain protection from legal action in relation of collective bargaining and collective boycott arrangements in certain circumstances. One way in which small business bargaining groups may obtain protection is to lodge a collective bargaining notification with the ACCC.

1.6. Provided the ACCC does not object to the notified arrangement, protection commences 28 days after lodgement. The immunity from a collective bargaining notification expires three years from the date it was lodged.

1.7. The ACCC may object to a collective bargaining notification if it is satisfied that the proposed collective bargaining arrangement is not in the public interest (and in some cases where it believes the arrangements will substantially lessen competition).

1.8. The collective bargaining notification process is transparent involving public registers and interested party consultation. Where the ACCC proposes to object, it must first issue a draft objection notice setting out its reasons and providing an opportunity for interested parties to request a conference. If the ACCC issues a draft objection notice before the expiration of the 28 day statutory period, legal protection from the notification does not commence.

2. Background

The proposed arrangement

2.1. Notification CB00006 was lodged on 21 November 2007 by:

- Dr Roger Barker
- Minical Pty Ltd, a company controlled by Dr Fraser Barry
- Russell Bourne Pty Ltd, a company controlled by Dr Russell Bourne
- Dr Andrew Haughton
- Dr Peter Hebbard
- Dr Mark Radnor
- Robin Sharp Pty Ltd, a company controlled by Dr Robin Sharp

2.2. The above applicants are the members of an associateship of anaesthetists in Wangaratta (Victoria) known as the Wangaratta Anaesthetic Group (WAG).

2.3. The applicants propose to collectively negotiate with BUPA Australia Health, trading as HBA, a value above the Commonwealth Medicare Benefit Schedule fee (MBS) for the provision of no-gap billing to BUPA members.

2.4. The proposed collective bargaining arrangement relates to the provision of anaesthesia services by WAG members in public and private hospitals to persons who are members of BUPA.

2.5. The applicants propose to collectively negotiate a rate for a unit of relative value for anaesthesia services (as a percentage above the MBS). This value would be known as the unit value and would be the agreed rate at which the members of WAG would invoice BUPA patients for anaesthesia services. The expectation of WAG is that this unit value would be appropriate to meet the full cost of the anaesthesia services. Patients would not be required to pay any further expenses for their in-hospital anaesthesia services.

Provision of anaesthesia services in the Wangaratta region

Wangaratta Anaesthetic Group

2.6. WAG is an associateship practice of specialist anaesthetists or the companies controlled by them who provide anaesthesia services to patients undergoing medical procedures mainly in Wangaratta. WAG has been operating for approximately 12 years.

2.7. Services are provided on a shared basis. There is a rotating roster for both private and public theatre lists. However, patients can request a specific anaesthetist if they wish.

2.8. Secretarial and support services are centralised and each associate pays a fixed monthly sum for management expenses that cover the running costs of the practice.

2.9. Each associate decides their own private fees individually. This may vary from patient to patient depending on the circumstances. Patients may contact WAG to obtain a quote for a service.

2.10. Each of the applicants determines their own private fees for each episode of care by applying a unit value to a total number of relative value units derived from the Australian Society of Anaesthetists' *Relative Value Guide* (RVG). The ACCC understands that the RVG is also used by Medicare and all health funds in determining their own respective schedule of fees. Apart from minor differences the only variable is the unit value. The applicants indicated that their average RVG unit value for providing anaesthesia services is $39. The ACCC understands that the current Medicare schedule fee for one anaesthetic unit is $17.90.

2.11. The applicants are all accredited to practise at Wangaratta Private Hospital and Northeast Health Wangaratta. Some of the members of WAG also provide anaesthesia services in other geographical areas such as Melbourne and Albury.

2.12. The applicants provide anaesthesia services for both scheduled and emergency procedures. Patients are usually referred to the applicants. The origin of the referral usually depends upon whether the procedure is scheduled or provided in emergency. Patients undergoing scheduled procedures are usually referred by a proceduralist, such as a surgeon. Typically, an anaesthetist will work with a proceduralist on a regular list.

2.13. Patients undergoing emergency procedures may require the services of the anaesthetist who is rostered on-call for the hospital. The on-call roster at Wangaratta Private Hospital and Northeast Health Wangaratta is agreed by the applicants and the administrators of those facilities. If a patient requires an emergency procedure, the hospital will contact one of the applicants to request anaesthesia services.

Other providers of anaesthesia services

2.14. There is another specialist anaesthetist in Wangaratta who operates independently. The ACCC understands that this anaesthetist uses Ezyclaim for patients who are members of BUPA.

2.15. The ACCC understands that there are other anaesthetists who operate in other hospitals in the region surrounding Wangaratta and who can be used by patients from Wangaratta.

The private health insurance industry

2.16. At the end of September 2007, 44% of the population had private health insurance. The coverage was 42.9% in Victoria.[1]

2.17. There are currently 37 registered providers in Australia, 24 of which are open to the general public (open membership fund) and 13 operate on a restricted membership basis.

2.18. BUPA Australia Health Pty Ltd is a registered provider of health insurance, covering over 1 million Australians. BUPA forms part of a worldwide health and care specialist organisation, British United Provident Association (BUPA Group). HBA is the trading name used by BUPA for its operations in Victoria, NSW, Queensland, Western Australia and Tasmania. HBA has been in operation under various ownership for around 70 years. [2]

2.19. BUPA is the second largest private health insurer in Victoria with 22% of membership, behind Medibank with 36%.[3] The applicants estimate that currently about 25% of their patients are BUPA members. However, the ACCC understands that BUPA membership in Wangaratta may be higher, closer to 30%, indicating some BUPA members may choose not to be treated by the applicants because of medical gaps.

Regulation of private health insurance

2.20. Private health insurance is heavily regulated under Commonwealth legislation, principally the Private Health Insurance Act 2007 (Cth) (PHI Act). Private health insurance regulation is overseen by the Department of Health and Ageing (DHA), the Private Health Insurance Administration Council (PHIAC) and the Private Health Insurance Ombudsman (PHIO).

2.21. The key regulatory features of private health insurance in Australia include:

- mandatory registration - providers obtain a single national registration which allows them to have customers in all states
- the principle of Community Rating, including the requirement that each customer who holds a particular policy in a particular membership category in each state will pay the same premium
- the regulation of premiums – in particular, premiums can only be increased once a year with the approval of the Federal Health Minister and are subject to prudential and reporting requirements administered by PHIAC
- the regulation of private health insurance products
- product disclosure requirements

[1] Private Health Insurance Administration Council, Quarterly Membership Statistics, September 2007
[2] http://www.hba.com.au/public_insurance_sales/vic/content/about.htm
[3] Private Health Insurance Administration Council, *Operations of the Health Benefit Organisations Annual Report 2005-06*.

- portability - under the PHI Act, customers who transfer from another health fund into an equivalent product retain their entitlements.

Cover for in-hospital medical services

2.22. When patients receive medical services in hospital as a private patient, Medicare covers 75% of the MBS. When the patient has private health insurance, the fund must pay a minimum benefit equal to the remaining 25% of the MBS.

2.23. Until 1 April 2007, health funds could only cover for doctors' charges above the MBS where an agreement or gap cover scheme exists, involving the fund, doctors and/or hospital.[4] Unlike agreements, gap cover schemes do not require a contract to exist between a fund and a doctor, which makes them more attractive to many medical practitioners.[5]

2.24. Where an agreement or scheme is in place, the patient has either no out-of pocket expenses ('no-gap') for doctors' services provided in hospital, or the patient will know in advance what costs he/she will have to pay ('known-gap').[6]

2.25. Doctors are legally required to obtain informed financial consent from patients where services are provided under a negotiated agreement or gap cover scheme, and the doctor charges the patient an additional amount above the benefit provided by the health fund. Informed financial consent is the consent to treatment obtained by a doctor from a patient, prior to treatment whenever possible, after the doctor has sufficiently explained his or her fees to the patient to enable the patient to make a fully informed decision about treatment.

2.26. The applicants contend that for patients to benefit from these arrangements, the treating doctor must participate in the health fund's scheme or arrangement. 'Participating' means agreeing to the health fund's rules and regulations regarding billing and account processing, and most importantly only charging fees as directed by the fund. In the case of no-gap arrangements, the treating doctor must restrict their fees to the level as published in the level published in the fund's schedule for the higher, above MBS payment, to be available to patients.

2.27. If the doctor charges patients more than the MBS and does not participate in the gap arrangements with the health fund of which the patient is a member, then the patient would have to pay a gap in relation to medical services provided by the doctor.

2.28. The applicants note that the operation of the schemes and agreements will deliver benefits for consumers only where both doctors and the fund cooperate in the arrangements. According to the applicants, by far the most common reason for an arrangement not being in place for a particular medical service is that the doctor providing the treatment is not willing to limit his/her fees to the health fund's schedule.

[4] The new PHI Act 2007 has deregulated this aspect of the private health insurance system.
[5] http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-privatehealth-gaps-consumers-fundcover.htm
[6] http://www.health.gov.au

2.29. In a recent report on the state of the health funds, the Private Health Insurance Ombudsman (PHIO) noted that doctors are free to decide, for each individual patient, whether or not to use a particular fund's gap cover arrangements. Factors that can affect the acceptance of the scheme by doctors include:

- whether the fund has substantial share of the health insurance market in a state or region
- the level of fund benefits paid under the gap arrangements (compared with the doctor's desired fee) and
- the design of the fund's gap cover arrangements, including any administrative burden for the doctor.[7]

2.30. During the 2007 September quarter, the coverage in Victoria of in-hospital medical services with no-gaps across all areas of medical practice was 88%, compared to the national average of 83.6%.[8] This figure is affected by the number of services billed at different rates.

2.31. The average gap payment for all insured in-hospital medical services was $19.58 in the September quarter 2007, including services where there was no-gap. The average payment by patients for services where there remained an out-of-pocket cost for the patient was $119.33 in the September quarter 2007.

2.32. DHA have indicated that compared with other areas of medical practice, private anaesthetics services have a relatively high rate of being provided with no-gap to patients at 72%.

2.33. DHA noted that where gaps are paid, the average gaps to patients tend to be low compared to other areas of medical practice, mostly falling in a range of up to $150 per patient. A recent survey showed the average gap paid by consumers for anaesthesia services was $298.[9]

2.34. DHA indicated that medical services in general that are subject to no-gap arrangements tend to be billed at less than 125% of the Medicare Schedule fee. The applicants indicated that maximum health fund rebates under no or known-gap arrangement for anaesthesia services, when combined with the Medicare rebates, represent 160% to 165% of the MBS depending on the location of the services, the fund's product and the fund itself.

BUPA Ezyclaim system

2.35. Ezyclaim is BUPA's gap cover arrangement. The ACCC understands that medical practitioners must first register with Ezyclaim in order to use the system. When they do so, they agree to Ezyclaim terms. The terms of Ezyclaim include the medical practitioner agreeing to accept the BUPA payment as full payment when using Ezyclaim, except when medical practitioners are allowed to charge a known-gap.

[7] PHIO, State of the Health Funds Report, p32
[8] Private Health Insurance Administration Council, Medical Services Statistics - September quarter 2007
[9] IPSOS 2006 survey

2.36. In the case of anaesthetists, BUPA does not provide an option for charging a known-gap using Ezyclaim, just the option of no-gap. Should anaesthetists agree to use Ezyclaim, they agree not to charge a fee higher than that provided for by BUPA, and that there will be no out of pocket expenses for patients.

2.37. Practitioners registered with Ezyclaim do not have to use the system all the time for all patients. It is an opt-in, opt-out system.

2.38. When medical practitioners elect to use Ezyclaim for a particular treatment, benefits are paid electronically into the practitioners' account within 20 working days.

2.39. The ACCC understands that currently the unit value for anaesthesia services paid under the Ezyclaim system is $29.85[10]. If the anaesthetist fee exceeds this amount, the total rebate received by the patients will be the MBS amount of $17.90 per RVG unit.

2.40. The applicants estimate that 42% of their patients who are BUPA members receive an invoice that has a gap payment. The remaining patients are billed through Ezyclaim.

ACCC consultation

2.41. The ACCC sought submissions from interested parties potentially affected by the notified arrangement including industry associations, consumer organisations, medical colleges, regional hospitals and government departments.

2.42. The ACCC received submissions from the following parties:

- Consumers Health Forum of Australia
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists
- BUPA Australia Health
- The Department of Health and Ageing

2.43. None of the submissions oppose the notification.

2.44. Copies of public submissions are available from the ACCC website (www.accc.gov.au) by following the 'Public registers' and 'Authorisations and notifications registers' links.

[10] Submission by Department of Health and Ageing

Important dates

DATE	ACTION
21 November 2007	Lodgement of collective bargaining notifications and supporting submission completed.
22 November 2007	Public consultation process commenced.
30 November 2007	Closing date for submissions from interested parties.
4 December 2007	Closing date for response from the Participants to issues raised in public consultation process.
17 December 2007	ACCC assessment of notified arrangement issued.

Public benefit test

2.45. The ACCC may revoke a collective bargaining notification where the relevant test in section 93AC of the Act is satisfied.

2.46. For notifications that involve collective boycott, conduct within the meaning of s. 45(2)(a)(i) or (b)(i) of the Act (exclusionary provisions), or a collective arrangement under which competitors will negotiate prices, the ACCC may object to a collective bargaining notification if it is satisfied:

- that the benefit to the public that would result, or is likely to result, from the proposed arrangements does not outweigh the detriment to the public.

2.47. For notifications that do not involve collective boycotts (or other exclusionary provisions) or price fixing but involve conduct that may otherwise lessen competition within the meaning of s. 45(2)(a)(ii) or (b)(ii) of the Act, the ACCC may object to a collective bargaining notification if it is satisfied:

- that in all the circumstances the conduct would, or would likely result in a substantial lessening of competition, and
- the conduct has not resulted or is not likely to result in a benefit to the public or the benefit to the public would not outweigh the detriment to the public constituted by any lessening of competition resulting from the conduct.

3. ACCC assessment

Affected markets

3.1. In considering the benefits and detriments associated with collective bargaining arrangements, it often assists to identify the markets affected. Where a market starts and finishes will be influenced by the degree of substitutability of different products and across different geographic areas.

3.2. The ACCC considers that whilst it may not be necessary to precisely define all of the relevant market, the ACCC has identified the following areas of competition that it considers to be relevant to this collective bargaining notification.

3.3. In broad terms, ACCC considers the relevant areas of competition relate to the provision of private health insurance to consumers, the provision of anaesthesia services to patients and the acquisition of the right for consumers to be supplied with medical services in hospitals on specified terms (including price).

Provision of anaesthesia services

3.4. The applicants submit that the relevant market is the market for the provision of anaesthesia services in public and private hospitals in the vicinity of Wangaratta.

3.5. The ACCC notes there is very limited substitutability between services offered by different craft groups. The ACCC therefore considers that there are generally different markets for each specialty. Within these, there is some substitution between specialists and GP proceduralists. The ACCC considers that the market for the provision of anaesthesia services includes GP and specialist anaesthetists. The ACCC notes that consumers would require the services of anaesthetists in conjunction with other procedures and that the choice of anaesthetists is often made by the doctor performing the procedure or through the referring doctor.

3.6. The ACCC notes that the applicants primarily work at the two local hospitals in Wangaratta. However, some of the applicants provide anaesthesia services in other geographical areas including Albury and Melbourne.

3.7. The ACCC understands that patients prefer to be treated by medical practitioners in a hospital in their region and only travel outside their region for limited specialist services, usually when these are not available locally. The ACCC also understands that some patients may travel to avoid significant gap payments.

3.8. The ACCC understands that there are a number of hospitals in other towns in the region that are accessible to patients from Wangaratta. Anaesthetists providing services at these hospitals would be able to see patients from Wangaratta.

3.9. The ACCC considers that the relevant area of competition is the provision of anaesthesia services in the region surrounding Wangaratta.

Provision of private health insurance to consumers

3.10. The ACCC has previously considered that the markets for the provision of private health insurance to consumers are state/territory based.

3.11. Whilst consumers may be able to switch to private health insurance providers in other states in Australia, there are several state based factors which impact on the ability of health funds to adopt a wholly national approach to supplying private health insurance to consumers, and historical/legacy factors which suggests that the relevant geographic area is state/territory-based. Such factors include:

- risk equalisation liabilities which are calculated on a state/territory basis
- varying costs of medical specialist services per state
- varying costs of private hospital services per state
- distinctly different market shares of private health insurance providers in each state/territory
- difficulties private health insurance providers have in gaining significant market share outside their 'home' states
- the tendency for a state-based approach to marketing by private health insurance providers and
- the use by some private health insurance providers of different brand names in different states.[11]

3.12. The ACCC considers that the relevant area of competition is the provision of private health insurance in Victoria.

The future with or without test

3.13. The ACCC uses the 'future-with-and-without-test' established by the Australian Competition Tribunal to identify and measure the public benefit and anti-competitive detriment generated by the proposed arrangement.

3.14. The ACCC considers that, in the absence of the legal protection afforded by the notification, the most likely counterfactual would be the continuation of the present situation where the applicants would not be able to collectively negotiate with BUPA.

Effect on competition

Submissions

WAG

3.15. The applicants submit that BUPA members receiving anaesthesia services will have no-gap payment. The applicants submit that BUPA patients will not be disadvantaged in choosing their anaesthetist. Patients will receive the same anaesthesia services at the same insurance premium rates but without gap payments. The applicants agreement with BUPA will preclude further patient fees. The applicants consider that service fees will not rise under the proposed arrangement.

3.16. The applicants consider that it is not clear that there would be any added financial burden on the community from the arrangement. It may be simply that the same fees are charged but patients have no-gaps to pay.

[11] Public Competition Assessment – proposed merger of BUPA and MBF – 16 November 2007

Department of Health and Ageing

3.17. DHA submits that the main policy concern relevant to this matter is accessibility and affordability of health care. A major part of this is absence of gaps for patients.

3.18. DHA submits that also important for maintaining accessibility and affordability of health care is avoidance of inflationary effects on the costs of medical services, and therefore, insurance premiums. DHA note that increases in benefits ultimately are reflected in premiums which fall on the insured and, through the private health insurance rebate, the taxpayer as well as also affecting decisions by the potentially insured.

ACCC assessment

3.19. Under collective bargaining arrangements, competitors come together to negotiate terms and conditions, which can include price, with a supplier or customer.

3.20. Generally speaking, competition between individual businesses generates price signals which direct resources to their most efficient use. Collective agreements to negotiate terms and conditions can interfere with these price signals and accordingly lead to inefficiencies. The capacity of new entrants to compete for the rights to undertake the business of existing market participants subject to the collective bargaining agreement also has implications for how competition is affected. However, the extent of the detriment and the impact on competition of the collective agreement will depend upon the specific circumstances involved.

3.21. The ACCC has previously identified that the anti-competitive effect of collective bargaining arrangements constituted by lost efficiencies is likely to be more limited where:

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

3.22. As noted by DHA the potential concern in the present case is that the collective bargaining arrangement could lead to higher payments made by BUPA to the anaesthetists. Although patients may not have to pay a gap for anaesthesia services, the effect of potentially higher costs on premiums must be considered.

Current level of negotiations

3.23. Where the current level of individual bargaining between members of a proposed bargaining group and the target is low, the difference between the level of competition with or without the collective arrangements may also be low.

3.24. The applicants have indicated that there is currently no negotiation between themselves and BUPA. The ACCC understands that under the present arrangements

BUPA sets the level of rebate for anaesthesia services under the Ezyclaim scheme. Participation in the scheme is offered to all anaesthetists should they choose to accept the terms of the scheme including price. Currently the applicants are eligible to use the scheme, however, they have chosen to use it in a limited way.

3.25. This limited use of Ezyclaim by the applicants suggests that although gap payments are unpopular with patients, the anaesthetists are not compelled by market forces to accept the terms set by the fund and continue to bill the patient directly, without direct contractual negotiations with the fund.

3.26. As noted above, patients prefer to be treated by medical practitioners in a hospital in their local area and only travel further in limited circumstances, usually where the specialist services are not available. It would therefore be important for health funds to ensure a competitive level of gap cover scheme participation by medical practitioners in the area where their members reside. However, despite this, BUPA still has a significant membership in Wangaratta.

3.27. This suggests that both the anaesthetists in the group and the fund can operate without the need to contract with each other.

Coverage or composition of the group

3.28. The ACCC considers that where the size of the bargaining group is restricted, any anti-competitive effect is likely to be smaller having regard to the smaller area of trade directly affected and having regard to the competition provided by those suppliers outside the group.

3.29. In this instance, ACCC notes that while the applicants make up a significant proportion of anaesthetists available to provide services to BUPA members in Wangaratta, there are other anaesthetists who can provide services to patients at hospitals located in other towns in the region. On the other hand, BUPA is the second largest fund in Victoria.

Voluntary participation

3.30. The ACCC notes that the proposed arrangements are voluntary for the anaesthetists and BUPA.

3.31. The ACCC considers that BUPA is under no obligation to participate in negotiations and should they commence, BUPA is able to opt out of the negotiations at any time. In particular, BUPA would not be compelled to agree to terms, including price, that it considers not commercially acceptable.

3.32. Both the fund and the anaesthetists can continue to operate in the market without direct dealing or contract between them, making the arrangement truly voluntary.

3.33. The ACCC considers that the collective bargaining arrangement will only lead to an agreement if it is mutually beneficial to both the fund and the applicants.

Boycott activity

3.34. The notified conduct does not provide for the applicants to engage in collective boycott activity. The extent to which such conduct occurred, the ACCC would investigate.

3.35. In particular, should the collective negotiations break down, agreement between the anaesthetists not to participate in Ezyclaim would likely raise issues under the boycott provisions of the Act.

Reduced scope for new market entry

3.36. The capacity for new entrants to compete for the rights to undertake the business of existing market participants subject to a collective agreement also has implications for how competition in the market is affected

3.37. The ACCC has considered whether the proposed collective bargaining between the applicants and BUPA could deter or prevent other anaesthetists to come and set up practice in Wangaratta.

3.38. The ACCC understands that the Ezyclaim scheme offered by BUPA is open to any medical practitioner who wishes to register with BUPA and who agrees with the terms and conditions of the scheme. It would appear to be in the interest of BUPA to have as many practitioners as possible participating in the scheme. There would be no restriction on any other anaesthetists to participate in Ezyclaim.

Public benefits

3.39. The applicants submit that the proposed collective bargaining arrangement will result in substantial public benefits. These benefits can be broadly described as:

- Efficiency savings
- Input into contract
- Facilitation of market dynamics
- Increase in equitable treatment and fairness
- Industrial harmony

Efficiency savings

3.40. The applicants submit that patients, BUPA and the applicants will all reduce the cost (time lost) through the proposed arrangements. The applicants would reduce operating costs through direct billing to BUPA. Similarly, BUPA would reduce expenses from receiving one consolidated account. The applicants note that it currently provides BUPA with individual patient bills. A more flexible and streamlined centralised process could be adopted as long as it was able to track individual payments, complied with accounting and legal requirements and suited the two parties.

3.41. Reductions in operating costs for the applicants would flow from reductions in account handling and distribution to individual patients and the elimination in costs associated with the need for pre-hospital detailed informed financial consent process.

3.42. The applicants also submit that if an anaesthetist did directly agree with BUPA for a unit value for use under the Ezyclaim scheme, this outcome would be ineffectual given the size of the number of other suppliers of the service. The applicants submit that direct negotiations would only benefit BUPA if it achieved agreement with all service providers. The applicants consider there is little certainty such an approach would deliver the same benefits as collective bargaining.

3.43. BUPA submitted that there may be efficiency in dealing with a group of medical practitioners in a single practice, rather than dealing with each medical practitioner in a practice individually.

3.44. DHA note that it is its understanding that the Ezyclaim system reduces complexity for the public and reduces administrative costs for medical practices.

3.45. The ACCC notes that the operating costs of a practice can be reduced by utilising the Ezyclaim system, as accounts can be submitted in bulk electronically to BUPA and the fund directly credits the doctor's bank account.

3.46. As the Ezyclaim system is already available to the applicants who use it on occasions, the ACCC considers that efficiency savings of the Ezyclaim system do not result from the proposed collective bargaining arrangement. However, the ACCC accepts that there may be further efficiency to be gained through the Ezyclaim system when the fund is dealing with a group rather than individual practitioners.

3.47. The ACCC also accepts that the proposed arrangement is likely to result in some transaction cost savings in the negotiation process compared with a situation where the fund would have to approach each individual applicant.

Input into contracts

3.48. The applicants submit that the process in setting the RVG unit value between the applicants and BUPA will become more transparent. The applicants submit that currently the rebate value for anaesthesia services is unilaterally set by BUPA. The applicants submit that collective bargaining will enable them to negotiate a value that is commercially sustainable for both parties and considerable saving will accrue to patients who hold health insurance with BUPA.

3.49. The applicants submit that individual anaesthetists do not have sufficient 'market force' to obtain a commercially viable agreement with a private health insurance company. The applicants submit that both parties have diametrically opposed objectives.

3.50. The applicants submit that subject to the negotiated arrangements, patients could expect to have zero 'out-of-pocket' expenses for all anaesthesia services for any procedure that required the services of the applicants. This will also ensure that BUPA members receive the full benefit from their health cover. The applicants

consider there are reasonable grounds to suggest that an agreement will significantly benefit private patients in Wangaratta.

3.51. The applicants further submit that currently the public does not understand the rebates provided by BUPA and the significant penalty a patient will suffer financially if the anaesthetist does not comply with the requirements of Ezyclaim. An agreement will remove all together the requirement for patients to understand the peculiarities of claiming a rebate from BUPA.

3.52. DHA note that this public benefit claim is about dissatisfaction with the unit value offered by BUPA. DHA note that the BUPA rebate is consistent with those of other insurers, and in practice the anaesthetic community accepts rebates at those levels as evidenced by the high rates of no-gap services to patients. In the absence of further information it is not clear, therefore, that the HBA rate is significantly non-'commercially sustainable'. DHA considers that the evidence suggests that the BUPA rates is generally at a level set by the prevailing market around Australia.

3.53. DHA submit that patients would not have to be concerned about gap fees under any no-gap arrangement between their doctors and insurers. There is no-gap for the patient then they do not care under which particular mechanics under legislation this was achieved. DHA note that this can be achieved under the mechanism currently offered by BUPA in Victoria for anaesthetic fees.

3.54. The ACCC acknowledges that medical gaps are a major concern to the public in the private healthcare system. The ACCC considers that arrangements which would assist in reducing or eliminating medical gaps can generate public benefits.

3.55. In the present case, the ACCC notes that the option for patients to benefit from no out-of-pocket expenses already exists through Ezyclaim which is available for all anaesthetists to use. Therefore, the ACCC does not consider that it is in a position to accept this issue as generating a benefit to the public.

3.56. The ACCC notes, however, that individual anaesthetists do not appear to currently have input into the terms of their arrangements with BUPA. The ACCC considers that the proposed collective bargaining arrangement could improve the ability of the applicants to have a greater input into the term of arrangements with BUPA.

3.57. The ACCC note that both BUPA and the applicants have some bargaining strengths. The ACCC does not consider that this would be significantly altered by the proposed collective bargaining, as there is no commercial imperative for both parties to contract with each other.

Facilitation of market dynamics

3.58. The applicants submit that it is not unreasonable to expect other health insurance providers will be encouraged to follow suit by negotiating a no-gap product to compete with BUPA. This will benefit all potential patients in Wangaratta.

3.59. DHA submits that it is not clear how movement from one set of no-gap arrangements to another set of no-gap arrangements at higher costs to the health system will benefit

the public in Wangaratta. DHA considers that new agreement with BUPA would most likely affect the market, but it is not clear in what sense it is facilitation.

3.60. As indicated above, BUPA's Ezyclaim system is a well developed product already in the market and available to all anaesthetists who wish to participate. Other funds already offer no and/or known-gap products. The ACCC does not consider that the claimed benefit would result from the proposed arrangements.

Increase in equitable treatment and fairness

3.61. The applicants note that currently BUPA does not have a 'known-gap' product for anaesthesia services. The applicants submit that, consequently, BUPA patients receiving anaesthesia services from the applicants are disadvantaged financially. Other insurers rebate the MBS and a proportion of costs above the MBS fee. BUPA will only provide benefits up to the MBS fee where their Ezyclaim arrangement is not utilised by doctors.

3.62. The applicants note that if the fee for the medical service exceeds the BUPA set unit value, the patient will receive nothing more than the MBS fee. The applicants submit that this is inequitable and patients are unaware of their reduced rebate until they receive a quote from their health care provider.

3.63. DHA submits that HBA not offering a known-gap arrangement foes not appear to be relevant, as all of the applicants arguments, and their stated goals, are aimed at no-gap arrangements.

3.64. The ACCC again considers that this public benefit claim could be realised in the present situation absent collective bargaining if the anaesthetists chose to use the Ezyclaim scheme.

Industrial Harmony

3.65. The applicants submit that currently there is no industrial disharmony with respect to the supply of anaesthesia services and consider the proposal for collective bargaining between the applicants and BUPA will not adversely affect the industrial harmony within Wangaratta.

3.66. DHA considers it is difficult to see the relevance of a suggestion that agreements would not affect the harmonious industrial status quo.

3.67. As the applicants have suggested that there will be no change to industrial harmony, the ACCC does not accept this as a public benefit.

4. Conclusion

4.1. The proposed collective bargaining arrangement involves an agreement on price and is therefore subject to the test described in paragraph 2.46.

4.2. Consistent with that test the ACCC will object where it is satisfied:

- that the benefit to the public that would result, or is likely to result, from the proposed arrangements does not outweigh the detriment to the public.

4.3. Having regard to the claims by the applicant and the issues raised by interested parties, the ACCC is not satisfied that the detriments likely to arise from the notified arrangement would outweigh the identified benefits.

4.4. The ACCC considers that the proposed collective bargaining arrangement may result in some public benefits in the form of increased input into contracts and some efficiency savings.

4.5. The ACCC considers that the potential for anti-competitive impact would be limited, in particular by the voluntary nature of the proposed arrangements.

4.6. Accordingly, the ACCC does not object to notification CB00006. Immunity from legal action provided by notifications CB00006 commences on 19 December 2007 and will expire three years after the date of lodgement (21 November 2010).

4.7. As with any notification, the ACCC may review these notifications at a later stage should concerns arise.