Australian Competition & Consumer Commission

Objection notice

in respect of
a collective bargaining notification
lodged by

**Australian Medical Association (Vic) Pty Ltd
on behalf of a group
of doctors at Latrobe Regional Hospital**

Date: **19 December 2007**

Notification no. CB00004
PublicRegisterno.C2007/1749

Commissioners: **Samuel**
King
Martin
Smith
Willett

Summary

The ACCC issues a final objection notice in relation to the collective bargaining notification lodged by the AMA Victoria (Vic), on behalf of a group of doctors, for negotiations of their contract of engagement as Visiting Medical Officers with Latrobe Regional Hospital in Victoria.

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 arrangements will substantially lessen competition).

The notification

On 17 September 2007 collective bargaining notification CB00004 was lodged by the AMA Victoria (Vic) on behalf of a group of 39 medical practitioners providing services as Visiting Medical Officers (VMOs) to Latrobe Regional Hospital (LRH) in Victoria. The AMA Victoria proposes to collectively negotiate, on behalf of the doctors, the terms and conditions (including price) of their VMO contracts with LRH.

The collective bargaining notification process is transparent involving public registers and interested party consultation. Most submissions expressed reservations about the notification, with one submission opposing the notification.

Draft objection notice

On 12 October 2007 the ACCC issued a draft objection notice proposing to give notice to AMA Victoria under section 93AC of the Act, objecting to notification CB00004. The ACCC sought further submissions from AMA Victoria and interested parties in relation to the draft objection notice.

ACCC's assessment

Having considered the information before it, the ACCC considers that the public benefit to result from the arrangement would be limited.

There is not a strong case as to such a disparity in bargaining position between doctors and the hospital such that collective bargaining is necessary to provide doctors with an efficient level of input into contracts. Hospitals are faced with workforce

shortages and the need to engage specialists placing doctors in a reasonable bargaining position.

The presence of doctors from different craft groups, and therefore less commonality of interests, further reduces the public interest justification.

That said some benefits may arise in collective bargaining by addressing common issues and the potential for cost savings.

Against this limited public benefit case, the ACCC notes the size of the group constitutes a significant proportion of the specialists that would be available to undertake VMO services at the hospital.

Whilst the ACCC considers that the voluntary nature of the arrangements and the absence of collective boycott aspects would usually limit the detriment, the ACCC is concerned that the coverage and composition of the Group would lead to sufficient increases in doctor bargaining power to lead to potentially anti-competitive outcomes.

The ACCC therefore gives notice to AMA Victoria under section 93AC of the Act, objecting to notification CB00004.

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 arrangements

2.1. Notification CB0004 was lodged by the AMA Victoria on behalf of a group of 39 doctors. (See Attachment A for a full list)

2.2. The AMA Victoria seeks to collectively negotiate, on behalf of the group of doctors (the Group) the terms and conditions of their engagement (including pricing) with LRH.

2.3. The details of the collective bargaining arrangements proposed are as follows:

1. The participants will nominate a group of up to five medical practitioners who are each member of the collective (Reference Group) to form a steering committee for negotiations.
2. The participants will be entitled to meet to collectively discuss (with or without the AMA Victoria's involvement):
    i. pricing
    ii. rostering – the weekly, fortnightly or monthly hours for which participants are rostered to attend LRH
    iii. provision of Out of Hours service – hours in addition to rostered hours, including on-call (where the doctor is on standby to attend the hospital outside the hours for which the doctor is rostered) and recall (where the hospital requires an on-call doctor to attend the hospital outside the hours for which the doctor is rostered)
    iv. other conditions of engagement – including terms relating to attendance by participants at meetings convened by the LRH, Continuing Medical Education and facilities to which the participating doctors will have access.
3. The AMA Victoria will negotiate with LRH with a view to finalising an agreement between the participating doctors and LRH
4. The AMA Victoria, upon receiving approval from the participating doctors, will enter into an agreement with LRH for three years.

2.4. The type of terms and conditions expected to be negotiated collectively include:

1. pricing
2. rostering
3. provision of Out of Hours service
4. any other conditions of engagement

2.5. The proposed collective bargaining arrangement would include dispute resolution procedures.

2.6. It is proposed that disputes between participating doctors throughout the collective bargaining process will be resolved by:

1. referring the matter to the Reference Group for discussion
2. failing resolution, or in the case where the Reference Group is an inappropriate forum for discussion of the dispute (such as if the dispute involves a member of the Reference Group), the matter will be referred to the AMA Victoria for mediation.

2.7. The AMA Victoria notes that any participating doctor is entitled to opt out of collective negotiations should they choose to do so for any reason, including being unhappy with the resolution of a dispute between participating doctors.

2.8. The AMA Victoria proposes that disputes between participating doctors and LRH throughout the collective bargaining process will be resolved using the following Dispute Resolution Procedure:

1. Notice of Dispute will be served on the other party detailing the grounds for dispute and seeking to invoke the Dispute Resolution procedure.
2. If the dispute is between the participants' representative and the hospital, the matter will be referred for discussion in good faith between the hospital and the Reference Group in first instance.
3. Should the dispute fail to be resolved by the above Dispute Resolution Procedures, the AMA Victoria notes that this arrangement is voluntary and each party and participant has the right to withdraw individually and voluntarily from the collective process.

2.9. It is proposed that disputes throughout the term of the Agreement will be:

1. determined using the Dispute Resolution Procedure;
2. determined by consent to refer to arbitration should the dispute fail to be resolved by the Dispute Resolution Procedure; and
3. limited to the terms of the agreement.

Specialist medical and hospital services in the Gippsland region

Hospital services

Latrobe Regional Hospital

2.10. LRH is a 257-bed public hospital located 160km east of Melbourne in the Latrobe Valley. LRH is one of five base hospitals in Victoria.

2.11. LRH is a teaching hospital affiliated with the Monash University School of Rural Health. The hospital services an immediate population of nearly 70,000 in the Latrobe Valley, and in conjunction with the region's other healthcare providers, over 250,000 across Gippsland.

2.12. LRH submits that as the base hospital in the region, it is required to offer a full range of services. LRH's medical services include elective surgery, maternity,

pharmacy, rehabilitation, aged care, cancer care and mental health care. LRH has an intensive care unit, with high dependency beds included. LRH does not offer neurosurgery or cardiothoracic surgery.

Hospitals within the Region

2.13. The AMA Victoria has identified 5 hospitals, that in addition to LRH, service Gippsland:

- Maryvale Private Hospital
- Gippsland Southern Health Service
- Central Gippsland Health Service
- West Gippsland Healthcare Group
- Bairnsdale Regional Health Service

2.14. These hospitals are both public and private hospitals, and have capacities of between 31 and 77 acute beds.[1]

2.15. LRH noted that 3 of these hospitals also have high dependency beds. However, these are district hospitals compared to LRH which is a base hospital.

Medical services

2.16. VMOs are medical practitioners appointed as independent contractors by a hospital board to provide medical services for hospital (public) patients on an honorary, sessionally paid, or fee for service basis.[2] These services may be provided as in-patient or after-hours services.

2.17. The Department of Human Services (**DHS**) has indicated that Victorian public hospitals are statutory corporations with their own boards of governance and for many years they have negotiated contracts of engagement with VMOs at the local level.[3] In 2004, 45.8 per cent of the public hospital medical workforce in Victoria were VMOs. Registrars and staff specialists were more likely to be located in metropolitan areas than rural regions.[4]

2.18. DHS indicated that non full-time medical practitioners who work at metropolitan hospitals are almost invariably paid on a sessional basis, whereas medical practitioners servicing regional hospitals, such as LRH, are paid on a fee for service basis.

2.19. The AMWAC 2004 report on the public hospital medical workforce in Australia noted that rural and regional areas have much more difficulty

[1] An acute bed is used for patients other than elective surgery.
[2] Australian Institute of Health and Welfare, *Public Hospital Establishments National Minimum Data Set: National Health Dictionary*, Version 12, (2003), **http://www.aihw.gov.au/publications/hwi/phe/phe.**
[3] Department of Human Services, Victoria, Submission to the ACCC in relation to A90795, 20 February 2007.
[4] AMWAC, *The Public Hospital Medical Workforce in Australia*, August 2004.

recruiting and retaining medical staff than their urban counterparts. This is due to a number of factors, including a smaller number of doctors willing to work in rural areas, higher workloads and fewer staff to cover them and less specialised services.[5]

2.20. In its report on Australia's health workforce, the Productivity Commission found that Australia is experiencing workforce shortages across a number of health professions despite a significant and growing reliance on overseas trained health workers. The shortages are even more acute in rural and remote areas.[6]

2.21. The Department of Health and Ageing (DOHA) noted that parts of the Gippsland region serviced by Latrobe Regional Hospital are classed as district of workforce shortage.

2.22. The AMA Victoria notes that there are approximately 40 specialists and 220 general practitioners working in the Region. All specialists in the region work at hospitals in the Region, and the AMA Victoria notes that 20% of all general practitioners are appointed as VMOs in the Region

VMOs at LRH

2.23. LRH indicated that it has approximately 60 VMOs currently servicing the hospital. In addition, LRH has 10 employee doctors, who mainly work in psychiatry.

2.24. The group of 39 doctors the subject of the notification, comprises 11 general practitioners and 28 specialists. Doctors in the Group fall into the following craft groups:

- 2 paediatricians
- 6 surgeons
- 2 dermatologists
- 4 obstetricians
- 13 anaesthetists
- 4 ophthalmologists
- 1 physician
- 4 orthopaedic
- 1 oncologist
- 1 ear, nose and throat
- 1 vascular

2.25. The AMA Victoria indicated that the Group provides irregular service to LRH on an 'as needed' basis. Further, the AMA Victoria notes that a number of the

[5] ibid
[6] Productivity Commission, *Australia's Health Workforce*, 19 January 2006

proposed participants provide regular, though infrequent, service to LRH through fly-in, fly-out and drive-in, drive-out practice.[7]

2.26. However, LRH contends that VMOs do work in the hospital on a regular basis, and have regular sessions. Surgeons would have allocated theatre time.

2.27. LRH notes that VMOs have ongoing obligations to patients to do follow up check ups. Surgeons and physicians call in at the hospital regularly to follow up patients.

2.28. LRH submits that the majority of VMOs live in the Latrobe Valley, or Gippsland, and work outside of LRH. VMOs would see patients as private patients outside of LRH in their consulting rooms, and if the patient's condition requires it, then refer the patient to the hospital for treatment and treat that patient at the hospital, usually as a public patient. LRH notes that certain specialists come from Melbourne on a regular basis.

2.29. When recruiting, the ACCC understands that LRH goes broader than just the Gippsland region. However, it tries to attract doctors to settle in the region.

2.30. LRH currently offers three year VMO contracts. The price component is set as a percentage of the Commonwealth Medicare Benefits Schedule (CMBS), for example 110%.

2.31. LRH indicated that different craft groups have different pricing. This reflects how critical to the hospital a particular craft group is, and the difficulty in attracting such a craft group to the hospital. LRH further indicated that there is no difference in the price paid for doctors from the same craft group.

ACCC consultation

2.32. The ACCC sought submissions from 29 interested parties including LRH, medical colleges, industry associations, consumer associations and federal and state government departments.

2.33. The ACCC received submissions from the following parties:

- Victorian Hospitals Industrial Association (VHIA)
- DHS
- DOHA
- Catholic Health Australia (CHA)
- Rural Doctors Association of Victoria (RDAV)
- Australian Healthcare and Hospitals Association (AHHA)

2.34. DHS opposes the notification. Most of the other submissions expressed reservations.

2.35. Following the release of the draft objection notice on 12 October 2007, the ACCC sought further submissions from interested parties and AMA Victoria.

2.36. The ACCC received submissions from DHS and AMA Victoria. AMA Victoria opposes the ACCC's draft decision, while DHS supports the ACCC's

[7] AMA submission to ACCC, 18 September 2007.

draft decision, and continues to express opposition to the proposed arrangement. AMA Victoria and DHS's further submissions are outlined below.

2.37. 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.

Important dates

DATE	ACTION
17 September 2007	Collective bargaining notification lodged with the ACCC.
17 September 2007	Public consultation commenced.
27 September 2007	Closing date for submissions from interested parties.
4 October 2007	Closing date for response from notifying party.
12 October 2007	ACCC issues draft objection notice
29 October 2007	Closing date for submissions from notifying party and interested parties
23 November 2007	AMA Victoria provides submission
19 December 2007	ACCC issues final objection notice

Public benefit test

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

2.39. 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.

2.40. 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. Whilst it may not be necessary to precisely define all of the relevant markets, in this instance the ACCC has identified the following area of competition that it considers to be relevant to this collective bargaining notification.

3.3. In broad terms the relevant area of competition relates to the provision of specialist medical services to hospitals. There are two aspects to consider – the geographic boundary of the markets and whether different specialties constitute different markets.

The provision of specialist medical services to hospital – geographic market

3.4. The AMA Victoria submits that while the relevant market for the purpose of this notification is Victoria, it is informative to explore the local region in which LRH operates.

3.5. AMA Victoria submits that the local region is most effectively categorised as the South Gippsland region (the Region). The AMA Victoria submits that within the Region, LRH competes with four public hospitals and one private hospital.

3.6. Following the release of the draft objection notice, the AMA Victoria contends that the market should be defined as Gippsland and metropolitan Melbourne. AMA Victoria submits that 50% of residents of Gippsland who require critical care services currently travel to metropolitan hospitals to receive such services. Further, the AMA Victoria notes that the Medical Directory of Australia has identified that 106 specialists practise in the Gippsland region, with about 20% of them having a principal practice address in metropolitan Melbourne.

3.7. AMA Victoria submits that the Gippsland and Melbourne metropolitan markets are interconnected, in that LRH is not an island and does not operate in isolation. AMA Victoria contends that LRH clearly operates as the geographic and functional hub of the Gippsland region, and has in addition a shared boundary with the giant Southern Health Network, a booming outer metropolitan growth corridor.

3.8. Further, AMA Victoria argues that the high proportion of specialists who already visit Gippsland from metropolitan Melbourne is also a factor that supports AMA Victoria's contention that the market is Gippsland and metropolitan Melbourne.

3.9. AMA Victoria is of the view that in light of the above information, which demonstrates the interconnectedness of the Gippsland market to metropolitan Melbourne, the market should be defined as metropolitan Melbourne and Gippsland. In the alternative, AMA Victoria submits that if the ACCC does not accept this definition, the market must be expanded to be the regional hospital market of Victoria.

3.10. VHIA submits that, rather than one regional market (Victoria), there are a number of markets in operation within Victoria. For example, VHIA contends that there is a metropolitan market, the large regional centres' market and the smaller rural localities market.

3.11. DHS submits that the differences in fees earned by medical practitioners employed in metropolitan and regional hospitals means that the metropolitan and regional markets are necessarily distinct. DHS notes that, as a further indication that there is a distinct regional market in which LRH operates, the majority of the Group reside in the local region surrounding LRH.

3.12. In addition, DHS considers that the markets for different craft groups may have different geographic boundaries. For example, craft groups who provide time critical services, such as emergency and critical care services, are likely to principally service the local region surrounding LRH, whereas craft groups providing less time critical services may to some extent service both regional and metropolitan areas.

3.13. The Australian Healthcare and Hospitals Association (AHHA) submits that the true market is not Victoria generally, but the proximate geographic region.

3.14. Information from interested parties suggests that specialist medical services are supplied to hospitals from the surrounding area or region. In the present case, the most relevant geographic market in the area surrounding LRH or the region of Gippsland.

3.15. The ACCC noted in its draft objection notice that due to workforce shortages LRH will attempt to recruit VMOs from throughout Victoria, Australia and even internationally. This may be done through recruitment agencies. However, the ACCC noted that in the event that VMOs are recruited from outside Victoria, LRH would attempt to relocate VMOs to the Region.

3.16. The ACCC considered that the most relevant area of competition is within the Region. However it should be noted that some doctors come on a regular basis, albeit less often, from Melbourne. The ACCC considers there may be competition on the margin from specialists coming from Melbourne and more broadly Victoria.

3.17. The ACCC continues to consider that the most relevant area of competition is within the Gippsland region. The ACCC notes that a number of services of LRH require the presence of doctors located within the region. Whilst a percentage of doctors come on a regular basis from Melbourne, the ACCC notes that there are limitations within the Melbourne metropolitan market that result in a smaller pool of doctors being available to service LRH. The ACCC is of the view that the pool of doctors potentially available in the greater Melbourne metropolitan area is large, however this does not accurately represent that pool of doctors who are willing or able to service LRH.

Specialist medical services markets

3.18. The AMA submits that as about 20% of general practitioners in the region are appointed to LRH, other general practitioners in the Region offer substitute to doctors in the Group.

3.19. VHIA submits that there is a market for particular medical specialities as well as a market for general practitioners. Such GPs are medical practitioners providing general medical services to the public in general practice outside of hospitals.

3.20. LRH refuted the AMA Victoria claim that the 80% of GPs in the region would be a substitute for the Group. Most GPs appointed at the hospital are anaesthetists or obstetricians. LRH stated that if GPs do not have these relevant skills and training, they are not substitutes.

3.21. AHHA notes that the medical market is fragmented. The market for general practitioners cannot be a substitute for specialised medical practitioners such as anaesthetists, surgeons and obstetricians.

3.22. DHS considers that there are a number of distinct markets for different craft groups. There is only limited potential for substitution between doctors in different craft groups (for example between general practitioner obstetricians/anaesthetists and specialist obstetricians or anaesthetists).

3.23. 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 GP proceduralists and specialists.

3.24. However, the ACCC considers that GPs who only provide primary care and do not have specialist skills constitute a distinct market from specialist services. They do not supply services to hospitals and cannot be substitute for the doctors at LRH. They are not part of the relevant area of competition for the assessment of the notification.

3.25. The AMA Victoria submits that there are various substitutes for the Group:

- Locums
- Commercial recruiters of medical practitioners

- Federal Government funded Medical Specialist Outreach Assistance Program
- Additional health services supplied to LRH from other rural, regional and metropolitan hospitals
- Day procedure centres
- Critically ill transferred to Melbourne hospitals

3.26. DHS, VHIA and AHHA have submitted the above do not provide adequate substitutes to specialist medical practitioners who reside in the area.

3.27. The ACCC considers that these alternatives may only be used in limited circumstances. The ACCC considers that a base hospital such as LRH would not be able to rely on these to provide the full range of on-going specialist medical services it requires.

The future with or without test

3.28. 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 arrangements.

3.29. The AMA Victoria submits that the most appropriate counterfactual in these circumstances will be that the market will continue to operate in substantially the same way it does currently. That is, doctors will be required to negotiate individually with a hospital.

3.30. 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 group of doctors would not be able to collectively negotiate the terms and conditions of engagement with LRH.

Effect on competition

Submissions before the draft objection notice

Applicant's submission

3.31. AMA Victoria submits that the impact of the notified arrangements on pricing to the hospital will be minimal, as the notified conduct is voluntary for both medical practitioners and LRH. AMA Victoria notes that medical practitioners within the Group can opt-in and opt-out of the process.

3.32. The AMA Victoria submits that the budgetary restriction of LRH is by far the biggest determinative factor of wages for medical practitioners. AMA Victoria contends that whether negotiation is on a collective or individual basis is irrelevant to this chief determinative factor, except that there are

monetary savings for a hospital when dealing with medical practitioners as a collective.

3.33. The AMA Victoria submitted that evidence and historical practice strongly suggest that collective bargaining engaged in by medical practitioners has not resulted in higher comparative remuneration than medical practitioners who negotiate independently. The AMA Victoria noted that medical specialists who provide services to rural hospitals on a fee-for-service basis currently receive substantially higher remuneration than metropolitan medical specialists employed under collective employment agreement.

Department of Human Services

3.34. DHS questions the manner in which the notified arrangement will operate, and concludes that there are two possible ways it may proceed:

- discrete negotiations will be conducted for each particular craft group, or
- negotiations will be conducted collectively for all craft groups, for example to set a common percentage rate of the CMBS specified amount, and/or to obtain a percentage price increase that will apply for all craft groups.

3.35. DHS contends that both scenarios will have the effect of eliminating the competitive tension that currently exists between the medical practitioners in the distinct craft groups.

3.36. In the event that the first scenario put forward by DHS eventuates, DHS submits that competitive tension will be eliminated where discrete negotiations for terms and conditions are conducted for each craft group.

3.37. With regard to the second scenario, DHS considers that those craft groups containing a lower number of doctors servicing the region and/or providing essential emergency services have a substantial degree of bargaining power. Therefore, DHS contends that with collective negotiations their market power would be leveraged to achieve higher fees for those craft groups that have a higher number of doctors servicing the region and/or provide predominantly elective services than would otherwise result where terms and conditions are negotiated individually.

3.38. DHS further submits that a reduction in competitive tension will in turn lead to the following public detriments in either case:

- An increase in the price that LRH is required to pay for services provided by the Group.
- LRH being faced with the potential to lose all members of the Group if collective negotiations fail. Alternatively, under the first scenario put forward by DHS, LRH potentially faces losing complete craft groups if collective negotiations fail. Therefore, there is a risk that LRH would lose the services of a large proportion of its medical staff at one time. Given the absence of

adequate 'substitutes' for the services of doctors currently servicing LRH, this would result in a major health crisis in the region.

- LRH is being force to contract the elective services it currently offers to patients. As a result, DHS contends that patients will be forced to travel further to receive medical treatment and medical practitioners offering those services would have to look elsewhere for work.

3.39. DHS submits that while LRH has the ability to opt out of negotiations and negotiate with doctors individually, the proposed arrangement puts pressure on LRH to participate in collective negotiations.

3.40. DHS expresses concern that if LRH were to opt out of collective negotiations, it would not be able to exercise its ability to opt out with confidence that there would be no adverse consequences for its ability to secure adequate medical practitioners.

Australian Healthcare and Hospital Association

3.41. The AHHA is concerned that in the event collective negotiations break down or there are substantial disputes in relation to the performance of the collectively bargained agreement, the participating medical practitioners could collectively boycott the hospital, either completely or in relation to certain services such as out of hours service or rostering. If this were to happen, the AHHA is concerned that medical services in the Region would be disrupted, or in the worst case stopped. The AHHA believes that this will have a 'catastrophic' effect, and is clearly a substantial public detriment.

3.42. The AHHA notes that the collective bargaining group represents a significant number of medical practitioners appointed as independent contractors to LRH. The AHHA submits that the hospital is likely to be left with a shortfall of medical practitioners if disputes arise either during or after the negotiation of the contract due to the composition and coverage of the group.

3.43. The AHHA is also concerned that the size and negotiating power of the collective would be so great that the hospital would be unable to fund the required medical services within tight budgetary constraints.

3.44. The AHHA submits that the strongest determining factor in public hospitals contracting with medical practitioners is budgetary restraints.

3.45. The AHHA submits that if payments to medical practitioners are forced to increase as a result of this notification process, then the hospital will be required to consider other options, including closure or amalgamation. In both of these circumstances, AHHA contends that services will have to be reduced or ceased, or LHR will be forced to operate with fewer medical practitioners, which may result in longer waiting lists.

3.46. The AHHA considers that public hospitals are 'completely dependant' on medical practitioner support.

VHIA

3.47. The VHIA submits that to permit the Group to collectively bargain as contractors can only result in an increase in price that might be greater than if derived from individual negotiations.

3.48. Further, the VHIA argues that fee for service doctors already command higher wages, and will therefore command additional power when involved in collective bargaining, with the outcome inevitably being even further increases in price.

3.49. The VHIA disputes the AMA assertion that collective bargaining is likely to lead to enhanced patient access to services.

3.50. VHIA contends that there is no doubt that the relationship between the hospital and its medical staff should be close and productive. However, it cannot be argued that such a relationship through collective bargaining will enhance service delivery.

3.51. VHIA submits that the major mitigating factor in the application is the admission by the AMA that the budgetary restriction of the target is by far the biggest determinative factor of payment for medical practitioners. If this is the case then VHIA considers that collective bargaining will save money because, instead of dealing with multiples, the target is dealing with one collective.

Department of Health and Ageing

3.52. DOHA notes that parts of the Gippsland region serviced by LRH are classed as districts of workforce shortage. DOHA has no information which would indicate that the supply of doctors to this region would be affected one way or the other by the use or otherwise of a collective negotiation.

Catholic Health Australia

3.53. CHA contends that for health services in regional areas to remain viable and to achieve their aim of responding to the health needs of individual communities, there must remain as much flexibility as possible in negotiating with and engaging medical practitioners. CHA submits that this will be significantly undermined if individual visiting private practitioners are able to negotiate as a collective group and hold health services, and as such communities, to ransom over conditions and remuneration for what is essentially their collective private practices.

3.54. CHA submits that many medical practitioners already have significant negotiating power in regional areas. They are able to ensure higher remuneration than what is typically available in metropolitan public health services where supply is much greater. Their conditions are also improved with regard to on-call and recall being minimal to non-existent. CHA considers that allowing collective bargaining risks creating a situation where attracting and recruiting new practitioners to already disadvantaged regional areas will be further compromised by:

- allowing small private practices to form local market monopolies;
- allowing 'ratcheting' of terms and conditions across the market (ie negotiating one increase in one area and then continuing to use this to build and increase future negotiations in other regions);
- restricting hospitals and health services to develop specific conditions for specialists who have different needs, including responding to the needs of new practitioners;
- restricting hospitals and health services ability to respond and negotiate on behalf of communities.

Submissions after the draft objection notice

AMA

3.55. Following the release of the draft objection notice, AMA Victoria submits that there is substantial commonality between the Applicants on all elements of the negotiations and contractual terms. Further, AMA Victoria contends that to the extent there is a lack of commonality between Applicants, this is between non-competitors, between whom price and non-price contractual discussions are already lawful.

DHS

3.56. DHS believes that there may be a greater degree of negotiation than the ACCC has suggested. DHS considers that this is evidenced by individual members within a craft group insisting on receiving the same fee for service as their colleagues at LRH.

3.57. DHS agrees with the views expressed in the ACCC's draft objection notice that there may be a high level of pressure placed on LRH to participate in negotiation due to the size of the group. 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 given significant weight.

3.58. DHS considers that each practitioner, as an incumbent supplier of services to LRH, has an enhanced degree of bargaining power because LRH is looking to retain their services. DHS submits that this is influenced by two factors:

- the medical practitioners are familiar with LRH and its systems and
- sourcing supply of such services from a new provider is challenging for LRH.

3.59. DHS argues that if a number of incumbent services providers are able to collectively negotiate, their collective level of bargaining power is magnified. In essence, DHS considers that LRH cannot afford to lose access to multiple suppliers simultaneously and therefore will become the weaker party in any collective negotiations.

3.60. 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 considers 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.

3.61. 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.

3.62. DHS submits that there is an increased risk of tacit boycott activity, and would itself be an anti-competitive effect of allowing the proposed collective negotiation.

ACCC Assessment

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

3.64. 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. However, the extent of the detriment and the impact on competition of the collective agreement will depend upon the specific circumstances involved.

3.65. The ACCC has previously 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 negotiations between individual members of the group and the proposed counterparties is low
- participation in the collective bargaining arrangements is voluntary
- there are restrictions on the coverage or composition of the group
- there is no boycott activity.

3.66. The ACCC noted interested parties' concerns with the proposed conduct, namely that the price paid for VMO services may increase significantly as a result of the Group's increased bargaining power, and that if negotiations were to break down or prices were to increase, hospital services could be jeopardised.

3.67. The ACCC noted that LRH currently offers different pricing (as a percentage of the CMBS) for each craft group; whilst specialists within a craft group are offered the same pricing. This reflects the relevant market position of the various craft groups, in terms of how critical they are to the hospital and the difficulty in attracting such groups to the hospital.

3.68. Concerns have been raised that the collective bargaining will eliminate the competitive tension that currently exists between medical practitioners in a distinct craft group. However, the ACCC noted that despite this competitive tension there seems to be little difference in pricing paid between practitioners within a craft group reflecting different efficiency, productivity or experience.

3.69. Concerns have also been raised that collective negotiations for all craft groups will have a devastating impact on the pricing structure by eliminating the pricing differential between groups and therefore increasing overall cost. The ACCC noted that whilst there is generally little competition between craft groups, the differential in pricing reflects to some extent their different competitive position with regard to the hospital.

3.70. The ACCC noted clarification from the AMA Victoria that there is no restriction in the proposed collective bargaining for payment rates to vary between craft groups and potentially between individuals. However, even if a differential were to remain, the concern is that the increased bargaining position of the Group would lead to an overall increase in pricing paid to all practitioners, leading to increased cost to the hospital or a rationalisation of its existing services, to the detriment of the community.

3.71. The AMA Victoria argued that evidence of historical practice strongly suggests that collective bargaining engaged by medical practitioners has not resulted in higher comparative remuneration than medical practitioners who negotiate independently.

3.72. The ACCC noted that the evidence provided by the AMA appears to relate to two very different categories of specialists, on the one hand specialists employed in metropolitan public hospitals and on the other specialists providing services on a fee-for-service basis to rural hospitals. The ACCC understands there is a significant price differential between metropolitan doctors who are employees and 'fee for service' practitioners in rural areas. The ACCC therefore did not consider the pricing comparison provided by the AMA to be meaningful or indicative of any likely pricing outcome of the proposed collective bargaining at LRH.

Budgetary constraints

3.73. The ACCC continues to accept that public hospitals operate within the constraint of the State health budget. The ACCC considers that this would limit to some extent any fee increase that may result from the proposed collective bargaining at LRH. However, this does not eliminate the possibility that LRH may require some additional funding from the State health budget to cover fee increases.

3.74. That being said, the ACCC notes that the AMA has conceded the importance of LRH's budgetary restriction as the biggest determinative factor for the remuneration of medical practitioners.

Current level of negotiations and bargaining position

3.75. The ACCC considers that 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.

3.76. LRH indicated that whilst each doctor has an individual contract and may attempt to negotiate with LRH, it has not in the past shifted from its initial offer to doctors, as LRH is constrained by its budget. However, DHS noted that negotiation between doctors and LRH does occur, and this is evidenced by individual members within a craft group insisting on receiving the same fee for service as their colleagues at LRH.

3.77. The AMA has suggested that the hospital has the ability to put pressure on individual doctors to sign a contract. However, VHIA rejected this.

3.78. The ACCC noted generally specialists within a particular craft groups do not compete across craft groups. However, a regional base hospital such as LRH needs the bundle of services supplied by a range of craft group in order to operate.

3.79. The ACCC noted that LRH is in an area of workforce shortage. LRH noted that there are shortages for all specialties. AMA Victoria also made reference to DHS, "Rural Directions," which states that Gippsland is at a particular disadvantage even compared to other rural regions. Interested parties have noted that public hospitals are dependent on medical practitioners to operate. The ACCC also notes that regional hospitals are the major specialist service providers for their regions.

3.80. Whilst doctors in regional and rural areas, such as the Latrobe Valley area, are in high demand, the ACCC considered that this may be balanced with the relative power LRH may possess after doctors have relocated to the local area. However, doctors can, and do, leave if they are dissatisfied with the hospital.

3.81. Moreover the ACCC notes submissions to workforce shortage and the current bargaining position of VMOs. Unlike many collective bargaining arrangements considered by the ACCC, there does not appear to be strong evidence of significant disparities in bargaining positions of VMOs and LRH.

Coverage or composition of the group

3.82. 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.

3.83. In this instance, the ACCC noted that the Group represents a significant proportion of LRH's medical workforce. As noted by LRH, the hospital would not be able to function without the doctors in the Group. As noted above, there is little adequate substitute for the services of the medical practitioners currently serving the hospital.

3.84. The ACCC notes DHS comments 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. DHS considers that in this instance the size and composition of the group is such that allowing them to collectively negotiate with LRH would have a significant anti-competitive effect.

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

3.86. While the ACCC considers that there is limited direct competition between craft groups, LRH needs all craft groups to operate. In these circumstances the size and coverage of the Group has the potential to lessen competition.

3.87. In the past, the ACCC has looked to areas of residual competition. For instance, in the recent Royal Australian College of General Practitioners application for authorisation the bargaining groups were limited to each GP practice. In that case, the ACCC considered that GPs were likely to be constrained, to some extent, by other GP practices in localised markets.[8]

3.88. In this case, the ACCC continues to be concerned that the size and composition of the Group represents a significant portion of the doctors readily available to LRH. While the ACCC notes AMA Victoria's contention that the relevant market includes medical practitioners from metropolitan Melbourne, the ACCC considers that the pool of medical practitioners ultimately available to service LRH in this broad market is limited.

Voluntary participation

3.89. The ACCC notes that the proposed arrangements are voluntary for the doctors and the hospital.

3.90. The VHIA expressed concern that the capacity to "opt out" during collective bargaining negotiations introduces an inherent instability in the proposed process that may be at odds with LRH's interests. However, the ACCC considered that this is likely to limit the potential anti-competitive detriment.

3.91. In addition, DHS expressed concern that the proposed arrangement puts pressure on LRH to participate in collective negotiations. DHS contended that if LRH were to opt out of collective negotiation, it could not exercise its ability to opt out with confidence that there would be no adverse consequences for its ability to secure adequate medical practitioners.

3.92. The ACCC previously noted that doctors remain free to decide individually to terminate their engagement with the hospital if they are dissatisfied with the terms and conditions offered by LRH, in either collective or individual negotiations.

[8] Authorisation A90795, 28 May 2007.

3.93. That said, the ACCC notes interested party views 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. For the hospital, there would appear to be a greater risk that if negotiation fails, this would be a trigger for a large number of individual doctor decisions to withdraw services.

Boycott activity

3.94. Interested parties have raised concerns that any break down in negotiations between the Group and LRH may result in a collective boycott.

3.95. As the AMA Victoria has not applied for collective boycott, the notified conduct does not provide for doctors to engage in collective boycott activity. The extent to which any such conduct occurred, the ACCC would investigate.

Public benefits

3.96. The AMA Victoria submitted that the proposed collective bargaining arrangement will result in substantial public benefits. These benefits can be broadly described as:

- improved collaboration between doctors in the Group
- input into contracts
- cost savings in negotiating contracts
- enhanced relationship between LRH and the Group
- recruitment and retention of doctors

Collaboration

Interested parties submissions

3.97. The AMA Victoria submits that collective negotiations will promote collaboration among doctors. AMA Victoria submits that medical practitioners providing services to public hospitals are required to operate together as a team in many respects. The AMA Victoria contends that collaboration in the medical profession leads to better outcomes for patients and the public.

3.98. The AMA Victoria contends that collaboration amongst medical practitioners will provide an open and inclusive forum in which medical practitioners can discuss common issues in a collegiate and facilitated manner. Collaboration is facilitated by collective negotiation of contractual terms which provide doctors with a framework for discussing these issues.

3.99. The AMA Victoria submits that many doctors are often uncertain about which topics they are permitted to collectively discuss freely. As such, the AMA Victoria is of the view that this notification would create certainty for doctors and will allow doctors to cease acting in an overly conservative manner with

regard to communicating with their colleagues. This openness will facilitate greater teamwork and helps doctors address common issues in the health system on a daily basis. AMA Victoria notes that these issues lie at the heart of better patient outcomes, because they include matters such as quality assurance, responsible and adequate rostering, and resource allocation.

3.100. The AMA Victoria submits that individual contract negotiations with hospitals are the antithesis of how modern hospitals and health care need to be organised. The AMA Victoria submits that 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.

3.101. Further, AMA Victoria notes that as a result of LRH being under resourced for the population it is expected to serve, the workforce at its disposal must be utilised to best advantage. Therefore, the AMA considers that establishing a common view of medical practitioner and hospital obligations would provide a good platform for this to occur.

3.102. The Rural Doctors Association of Victoria (RDAV) submits that it supports arrangements which foster team harmony within and between visiting doctors and hospital staff and create a flow on effect into clinical operation and governance. RDAV submits that individual contract agreements fragment rather than foster such team arrangements.

3.103. VHIA considers that there is little doubt collaborative approaches by doctors can aid and abet better care for patients. However, VHIA considers that to extend the benefits of collaboration in the clinical field to collective bargaining on the price applicable to procedures and consultations is far fetched.

3.104. Further, VHIA contends that medical practitioners do not form a collegiate as such.

> They might be members of a profession, but they also compete in the market place. … Collegiality operates at a certain level, [but] not when it involves price for independent contractors.

3.105. DHS considers that there is no reason that the public benefit flowing from the collaboration among medical practitioners could not be achieved in the absence of collective negotiations. Therefore, DHS submits that this benefit is negligible and should not be taken into account.

ACCC assessment

3.106. The ACCC considers that there may be some public benefit through increased collaboration between the doctors in the Group and better team work from collective bargaining.

3.107. The proposed collective bargaining will enable the group to discuss all aspects of their engagement with LRH. The ability to discuss common terms and

conditions and to put a common voice on those issues may assist greater collaboration among the doctors.

3.108. That said, the ACCC agrees with DHS that many of the teamwork benefits can be achieved without transgressing competition laws, and less weight should be given accordingly.

Input into contracts

Interested parties submissions

3.109. AMA Victoria submits that collective negotiations will increase the likelihood of consistent and more comprehensive training and education in rural public hospitals, due mainly to the ability of doctors to collectively negotiate appropriate structures and recognition of continuing medical education.

3.110. AMA Victoria submits that the benefit from collective bargaining also relates to the making of rosters, and after-hours and on-call arrangements (hours of engagement). AMA Victoria submits that there is significant public benefit to flow from the enhancement of the hours of engagement system. AMA Victoria argues that by better defining the hours of engagement, medical practitioners will have a clearer understanding about when they are on-call and when other doctors are providing on-call and after hours service to the community, as well as when they are not on-call.

3.111. The AMA submits that the recognition of those issues through collective negotiation will enhance the attractiveness of rural medical practice, leading to a greater likelihood of increased recruitment and retention of medical practitioners in the area.

3.112. Following the release of the draft objection notice, AMA Victoria submits that there is substantial commonality between the Applicants on all elements of the negotiations and contractual terms.

3.113. AHHA considers that collective bargaining can lead to improvement in information.

3.114. VHIA does not concede that there are efficiencies to be gained by collective bargaining.[9]

ACCC assessment

3.115. In many cases, the ACCC has identified that individually, businesses have a limited degree of input into their contracts being offered take it or leave it terms and conditions. These circumstances do not always lead to the most efficient contract. The ACCC has often accepted that collective bargaining arrangements can provide participants with an opportunity for greater input into contracts and accordingly deliver the opportunity for more efficient contracts.

[9] VHIA submission to ACCC, 3 October 2007

3.116. In this case there does not appear to be strong evidence of significant disparities in bargaining positions of VMOs and LRH, unlike many other collective bargaining arrangements considered by the ACCC.

3.117. That being said, collective bargaining may provide a greater opportunity for common issues relevant to the doctors in the Group to be given consideration, and if both sides consider it appropriate, for contract terms and conditions to better reflect those issues. The AMA Victoria has identified in that regard specific common issues, such as appropriate structures and recognition of continuing medical education, rosters and hours of engagement system, the further development of clinical services at the hospital, the development of new models of care, and working in teams. The ACCC considers however, that common issues may be more limited due to the presence of different craft groups. In particular, the ACCC understands that the percentage above the CMBS to be paid and the payment of on-call services differ between craft groups.

3.118. The ACCC notes comments from a number of interested parties regarding the difficulties around rosters and on-call services.

3.119. The ACCC has consistently stated that a medical roster developed to facilitate patient access to medical services does not raise concerns under the Act.[10] As noted by interested parties, an agreement between the Group to supply their services to LRH under a roster arrangement can occur without this notification. However, agreement on the fees to be charged in that context would fall within the proposed arrangements.

3.120. The ACCC notes that collective negotiation arrangements are often proposed as a means of addressing or at least improving instances of information asymmetry. The ACCC notes comments by AHHA that collective bargaining may lead to improvement in information. However, the ACCC has not received information regarding the inadequacy or otherwise of the information currently provided to doctors, nor how the proposed collective bargaining process would improve this potential problem.

Transaction cost savings

Interested parties submissions

3.121. The AMA Victoria submits that the efficiency gains to be expected from allowing a rural Doctor workforce to collectively negotiate are extremely significant. AMA Victoria contends that those efficiency gains will be both cost related and time related.

3.122. The AMA Victoria estimates that, on average, each doctor will spend approximately 8-9 hours of his or her time re-negotiating an existing arrangement with a hospital, and significantly more time if the negotiation is for a new contract of engagement. The AMA Victoria submits that collective bargaining would also generate efficiency savings for the hospital.

[10] ACCC publication, "Medical rosters": *ACCC Info Kit for the Medical Profession*, 2004.

3.123. AHHA submits that collective bargaining will generate 'economies of scale' for the hospital by being able to negotiate with a number of medical practitioners at the same time and associated savings in administrative time and cost.

3.124. VHIA submits that as the AMA appears to accept that the budget of the target is the major determinant, collective bargaining will save money because the target is dealing with one collective instead of a large number of practitioners.

3.125. While DHS accepts the proposed arrangements may result in some efficiency savings in administrative functions, DHS considers AMA Victoria's assertion about average time spent re-negotiating contracts to be highly overstated. DHS disputes that any efficiency savings flowing from the proposed arrangement are 'extremely significant' as alleged by AMA Victoria.

ACCC assessment

3.126. Whilst the ACCC accepts that the proposed arrangement is likely to generate transaction cost savings, the ACCC considers that the savings will be more limited than claimed by the AMA Victoria because of the nature of contracting VMOs.

3.127. The ACCC understands that pay rates differ between craft groups. AMA Victoria submits that while there may be a "common conditions" section of the contract negotiated by the Group, there is an assumption that pay rates would be a matter that is likely to be tailored to individual craft groups and would be included in separate appendices.

3.128. AMA Victoria further submits that each contract may require individual tailoring in order to take into account the different requirements each medical practitioner has.

3.129. The ACCC considers that these differences between craft groups, and possible individual issues, are likely to make the collective bargaining process more complex and less timely, which would reduce to some extent the benefits from transaction cost savings.

Improved relationship with LRH

3.130. AMA Victoria submits that as a consequence of the current bargaining framework, communication between LRH and medical practitioners providing services is sometimes strained.

3.131. AMA Victoria contends that medical practitioners suffer from inequality in their relative bargaining positions with the hospital. AMA Victoria submits that medical practitioners are generally unskilled negotiators, and there exists potential for negotiations to become stalled, personal and emotion-charged. Further, compared to the hospital, AMA Victoria submits that medical practitioners have neither the time necessary to adequately self-represent nor the knowledge of the market to do so effectively. There is a significant

potential for conflict and animosity between medical practitioners and the hospital.

3.132. VHIA disputes the AMA Victoria assertion that strained relationships between medical practitioners and LRH are related to the inability of VMOs to collectively negotiate pay rates. Rather, VHIA contends that strain in relationships between VMOs and LRH are largely due to historical factors.

3.133. Further, VHIA contends that in the current negotiation process, such strain is limited to individuals and the hospitals. In a collective bargaining situation, VHIA submits that such strains would apply to the collective and hence could become problematic.

3.134. As previously noted, the ACCC considers that there does not appear to be strong evidence of significant disparities in bargaining positions between VMOs and LRH. That said, the ACCC considers that the doctors' possible improved input into contracts and less personal involvement in the contract negotiation with the hospital may in some circumstances contribute to improve the relationship with the hospital. This in turn may contribute to improving the retention of the medical practitioners to the area.

Retention and Recruitment of Doctors

3.135. Following the draft objection notice AMA Victoria submitted that a potential price rise as a result of collective negotiations will not necessarily result in a public detriment, and could in fact result in a public benefit.

3.136. AMA Victoria contends that a price rise may enhance the likelihood of doctor retention and greatly increase the attraction for doctors considering working at Latrobe Regional Hospital. Further, AMA Victoria argues that a price rise may attract more specialists and higher quality specialty care to the Gippsland region.

3.137. AMA Victoria contends that 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.

3.138. AMA Victoria argues that increasing the appeal of LRH to doctors will lead to greater access to medical services for the community of Gippsland. Further, AMA Victoria contends that an increase in access to medical services is commensurate with an increase in quality of such services.

3.139. The ACCC appreciates that medical workforce shortages in rural areas are important issues. The ACCC notes in that regard that LRH operates in a designated 'area of workforce shortage'. The ACCC considers that arrangements which would assist the retention of medical practitioners in this particular area can generate public benefit.

3.140. The ACCC notes AMA Victoria's assertion that an increase in pay rates to medical practitioners may actually result in a public benefit, as it will enable LRH to attract and retain a greater number of doctors, especially some of the

doctors on the fringe of the market. No evidence has been put to the ACCC that individual doctors are currently at such a disadvantage when negotiating individual contracts as to require the added bargaining power of a collective group to ensure competitive pay rates. The ACCC remains concerned that the increased bargaining position of the Group will lead to outcomes where the hospital may be forced to operate with fewer medical practitioners, or rationalise services.

Balance of public benefits and detriments

3.141. The proposed collective bargaining arrangement involves an agreement on price and is therefore subject to the test described in paragraph 2.37.

3.142. 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.

3.143. Having considered the information before it, the ACCC considers that the public benefit to result from the arrangement would be limited.

3.144. There is not a strong case as to such a disparity in bargaining position between doctors and the hospital such that collective bargaining is necessary to provide doctors with an efficient level of input into contracts. Hospitals are faced with workforce shortages and the need to engage specialists placing doctors in a reasonable bargaining position.

3.145. The presence of doctors from different craft groups, and less commonality of interests, further reduces the public interest justification

3.146. That said some benefits may arise in collective bargaining by addressing common issues and the potential for cost savings.

3.147. Against this limited public benefit case, the ACCC notes the size of the group constitutes a significant proportion of the specialists that would be available to undertake VMO services at the hospital.

3.148. Whilst the ACCC considers that the voluntary nature of the arrangements and the absence of collective boycott aspects would usually limit the detriment, the ACCC is concerned that the coverage and composition of the Group would lead to sufficient increases in doctor bargaining power to lead to potentially anti-competitive outcomes.

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

4. Objection Notice

4.1. For the reasons outlined in this notice, the ACCC is satisfied that the likely benefit to the public from collective bargaining notification CB00004 will not outweigh the likely detriment to the public from the notified conduct.

4.2. Accordingly, the ACCC gives notice under subsection 93AC(2) of the *Trade Practices Act 1974* (the Act) in respect of collective bargaining notification CB00004.

4.3. Collective bargaining notification CB00004 has not, and will not, come into force because the ACCC issued a draft notice in respect of the notification during the prescribed 28 day period, and has now issued a final notice revoking the notification.

Attachment A

The Group of Doctors

- Ameen Medical Pty Ltd (Dr Nabil Ameen)
- Dr Gordon Arthur
- Dr David Birks
- Dr Tanja Bohl
- Dr J P Brougham
- P F Burke Pty Ltd (Dr Peter F Burke)
- Dr Geral Busch
- Dr David K H Chan
- Dr Jacques Coetzee
- Robert J Dawson Pty Ltd (Dr Robert Dawson)
- Dr Roger Fitzgerald
- Dr Norber Fuessel
- Dr Midhat Ghali
- Dr Andrew Green
- Dr Steve T Grigoleit
- Dr Grant J Harrison
- Dr Chris Kimber
- RWL Ocular Services Pty Ltd (Dr Robert W Lazell)
- Dr Sean T Leahy
- Dr Peter Lewis
- Dr Pradeep Madhok
- Dr Edward A Marrow
- Dr Charles Mashonganyika
- Dr David A Ogilvy
- Dr Geroge Owen
- Peter Rehfisch Pty Ltd (Dr Peter Rehfisch)
- MH Sanderson Incorporated Pty Ltd (Dr Michael H Sanderson
- Dr John Scarlett
- Peter Smith Nominees Pty Ltd (Dr Peter John Smith)
- Dr Brendan J Steele
- Dr Neville Steer
- Dr Joseph Tam
- Dr Malcolm Thomas
- RG Thorne Pty Ltd (Dr Robert G Thorne)
- Dr Mark Troski
- Dr Glenn Watson
- Jillian R Wih Pty Ltd (Dr Jillian Whitney)
- Dr Philip Worboys
- Dr Ming Yii