Australian Competition & Consumer Commission

Determination

Application for revocation and substitution of authorisation A90795

lodged by

The Royal Australian College of General Practitioners

in respect of intra-practice price setting arrangements and hospital agreements

Date: **23 May 2007**

Commissioners:

Samuel
Sylvan
King
Martin
McNeill
Willett

Authorisation no.: A91024

Public Register no.: C2006/2259

Summary

The ACCC grants authorisation to the Royal Australian College of General Practitioners (RACGP) for intra-practice price setting arrangements and hospital agreements for a period of 4 years. The arrangements apply to general practitioners and other medical practitioners in general practice in associateships and partnerships, who operate as a team, where they share patient records, have common facilities, a common trading name and common policies and procedures.

The authorisation process

The Australian Competition and Consumer Commission (ACCC) can grant immunity from the application of the competition provisions of the *Trade Practices Act 1974* (the Act) if it is satisfied that the benefit to the public from the conduct outweighs any public detriment. The ACCC conducts a public consultation process to assist it to determine whether a proposed arrangement results in a net public benefit.

The application

On 13 December 2006 the Royal Australian College of General Practitioners (RACGP) lodged an application for revocation of authorisation A90795 and its substitution with authorisation A91024. The application was lodged on behalf of general practitioners (GPs) and other medical practitioners (OMPs) in general practice.

The RACGP is seeking authorisation for GPs and OMPs within a single practice operating in particular business structures to agree on:

- fees charged to patients;
- fees that any locums the GPs engage, either individually or jointly, will charge patients for their services; and
- fees that the GPs charge to a hospital as Visiting Medical Officers (VMOs) (hospital agreements).

With regard to hospital agreements, the RACGP is seeking consistency at the national level for GPs and OMPs in the relevant business structures to be able to negotiate VMO arrangements with public hospitals.

Background

On 19 December 2002 the ACCC granted authorisation, subject to conditions, for intra-practice price setting by GPs operating within particular business structures. Hospital agreements were not a part of the conduct previously authorised. The previous authorisation lapsed on 10 January 2007.

Assessment of public benefits and detriments

Intra-practice price setting

Public Detriment

The ACCC considers that while there is potential anti-competitive detriment that could result from intra-practice price setting this detriment is likely to be limited. The ACCC notes that the arrangements are confined to agreement on price within practices operating under certain business structures, therefore competition between practices will not be affected.

Public Benefit

The ACCC considers that intra-practice price setting arrangements are likely to result in some public benefits, mainly through:

- continuity and consistency of patient care; and
- the ability for a team practice to discuss all aspects of their operations.

On balance, the ACCC is satisfied that the public benefits likely to arise from the intra-practice price setting arrangements will outweigh the likely public detriments.

Hospital agreements

Public detriment

The ACCC considers that collective negotiations among relevant GP VMOs and public hospitals are likely to result in limited public detriments. The ACCC notes that the arrangements are limited by:

- applying only to GPs operating in one practice;
- the proposed arrangements are voluntary; and
- the RACGP has not sought authorisation for boycott activity, meaning GPs cannot collectively agree to withdraw their services as part of the arrangements.

Public benefit

With regard to the hospital agreements, the ACCC is satisfied that the proposed arrangements are likely to generate some public benefits, mainly:

- potential future efficiency gains;
- improve the working relationships of doctors and the culture of team work in relevant business practice structures and in their work as VMOs in hospitals; and
- assist with the recruitment and retention of GPs in rural Australia by enabling relevant practices to offer negotiated hospital packages to prospective and resident GPs.

On balance, the ACCC considers the public benefit likely to arise from hospital agreements would outweigh the public detriment.

Length of authorisation

The ACCC generally considers it appropriate to grant authorisation for a limited period of time, so as to allow an authorisation to be reviewed in the light of any changed circumstances.

Consistent with the previous authorisation, the ACCC grants authorisation to the intra-practice price setting arrangements and hospital agreements as sought by the applicant, for a period of 4 years.

Contents

List of abbreviations and definitions

ACCC	Australian Competition and Consumer Commission
AMWAC	Australian Medical Workforce Advisory Committee
Associateship	Associateships allow GPs to share facilities, often managed by a service company, while maintaining their own status as independent businesses. The level of integration within an associateship may vary.
GP	General Practitioner
Hospital Agreements	A component of the application relating to collective negotiations between certain VMOs and public hospitals
MBS	Medicare Benefits Schedule
NRF	National Rural Faculty
OMPs	The RACGP defines OMPs as medical practitioners who are not vocationally registered, are not Fellows of RACGP and who render Group A2 Other Non-referred Attendance Items in the Medicare Benefits Schedule (MBS). OMPs include a group of Medical Practitioners who were in general practice prior to the introduction of vocational registration, and who have not become vocationally registered. OMPs also include international (rather than Australian) medical graduates, who are working in general practice, and who have not been assessed for Fellowship of the RACGP.
Partnership	A partnership is the formal legal relationships existing between GPs where they have agreed that their rights and obligations with respect to each other shall derive from partnership legislation in each State and Territory. Partnerships may include one or more incorporated entities.
PIP	Practice Incentives Program
RACGP	The Royal Australian College of General Practitioners
RDAA	Rural Doctors Association of Australia
RDAV	Rural Doctors Association of Victoria
VMO	Visiting Medical Officers
Unit Trust	A unit trust exists where the trustee is the legal owner of the practice and GPs provide medical services on behalf of the trustee. Usually the trustee is incorporated and the GPs are directors and employees of the company. They are also unit holders in the trust.

1. Introduction

Authorisation

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 conduct, thereby encouraging competition and efficiency in business, resulting in a greater choice for consumers in price, quality and service.

1.2 The Act, however, allows the ACCC to grant immunity from legal action in certain circumstances for conduct that might otherwise raise concerns under the competition provisions of the Act. One way in which parties may obtain immunity is to apply to the ACCC for what is known as an 'authorisation'. The ACCC may 'authorise' businesses to engage in such conduct where it is satisfied that the public benefit from the conduct outweighs any public detriment.

1.3 The ACCC conducts a public consultation process when it receives an application for authorisation. The ACCC invites interested parties to lodge submissions outlining whether they support the application or not, and their reasons for this.

1.4 After considering submissions, the ACCC issues a draft determination proposing to either grant the application or deny the application.

1.5 Once a draft determination is released, the applicant or any interested party may request that the ACCC hold a conference. A conference provides all parties with the opportunity to put oral submissions to the ACCC in response to the draft determination. The ACCC will also invite the applicant and interested parties to lodge written submissions commenting on the draft.

1.6 The ACCC then reconsiders the application taking into account the comments made at the conference (if one is requested) and any further submissions received and issues a final determination. Should the public benefit outweigh the public detriment, the ACCC may grant authorisation. If not, authorisation may be denied. However, in some cases it may still be possible to grant authorisation where conditions can be imposed which sufficiently increase the benefit to the public or reduce the public detriment.

The application

1.7 On 13 December 2006 the RACGP lodged an application for revocation of authorisation A90795 and its substitution with authorisation A91024.

1.8 The RACGP is seeking authorisation for GPs and OMPs operating in a single practice within particular business structures to agree on:

- fees charged to patients;
- fees that any locums the GPs engage, either individually or jointly, will charge patients for their services; and
- fees that the GPs charge to a hospital as Visiting Medical Officers (VMOs) (hospital agreements).

Interim authorisation

1.9 On 13 December 2006 the RACGP applied for interim authorisation for the arrangements while the ACCC considers the substantive application for authorisation.

1.10 The RACGP submitted that interruption of the previous authorisation (A90795) without interim arrangements may create uncertainty amongst GPs, bring about interruption of continuity of care, impact on safety and quality of patient care in a negative way and result in detriment to patient health outcomes.

1.11 On 20 December 2006 the ACCC granted interim authorisation to the parts of the substitute authorisation currently covered by authorisation A90795; that is, allowing certain GP practices to agree on fees charged to patients. The ACCC considered that this would preserve the status quo while the substantive application is considered.

1.12 The ACCC denied the request for interim authorisation for the arrangements regarding hospital agreements. The ACCC considered it inappropriate to grant interim authorisation before this conduct had been adequately considered by the ACCC.

1.13 The ACCC revisited the RACGP's request for interim authorisation in the draft determination and decided to grant interim authorisation to both the intra-practice price setting arrangements and the proposed hospital agreements as sought by the RACGP.

Chronology

1.14 Table 1.1 provides a chronology of significant dates in the consideration of this application.

Table 1.1: Chronology of application for revocation and substitution A91024

DATE	ACTION
13 December 2006	Application for revocation and substitution lodged with the ACCC, including an application for interim authorisation.
20 December 2006	The ACCC granted interim authorisation to the parts of the substitute authorisation covered by authorisation A90795 (i.e allowing certain GP practices to agree on fees charged to patients).
19 January 2007	ACCC received further information from RACGP in support of its application.
25 January 2007	Closing date for submissions from interested parties. Submissions were received until 19 February 2007. A late submission was received on 10 April 2007.
2 February 2007	ACCC received RACGP's response to interested party submissions.
9 March 2007	ACCC received RACGP's response to further interested party submissions.
11 April 2007	Draft determination issued.
4 May 2007	Closing date for submissions from interested parties in response to the draft determination.
23 May 2007	Final determination issued.

2. Background to the application

The Applicant[1]

2.1 The Royal Australian College of General Practitioners (RACGP) was incorporated in 1958. It is the peak professional organisation representing the interests of general practitioners (GPs) and other medical practitioners (OMPs) working in general practice in Australia.

2.2 The RACGP is the largest medical college in Australasia, with approximately 14,500 members. Nearly 100% of all general practice registrars are members of the RACGP.

2.3 At the state and territory levels, the RACGP has been organised into faculties. Each faculty has its own infrastructure and faculty board consisting of elected members and provides RACGP services to local communities. RACGP faculties currently operate in Queensland, New South Wales (including the Australian Capital Territory), Victoria, South Australia (a joint faculty with the Northern Territory), Western Australia and Tasmania.[2]

2.4 The RACGP also has a National Rural Faculty (NRF), which provides special training and education needs for rural GPs. There are currently over 4,500 members of the NRF which is the largest rural membership of any medical organisation in Australia.[3]

2.5 The RACGP's mission is to achieve and maintain the highest quality primary health care in urban and rural Australia by supporting GPs and promoting standards for general practice. The RACGP is involved in the setting of standards for the profession, education policy, award of the Fellowship of the RACGP, research, advocacy on political, strategic, corporate and business issues and member services.[4]

2.6 The RACGP runs Australia's largest medical college examinations and provides professional development and education to nearly 22,500 of Australia's medical practitioners.

Previous Authorisation

2.7 On 19 December 2002 the ACCC granted authorisation to the RACGP for a framework arrangement which provided that GPs may enter an agreement to maintain, set, or control the fees charged to patients where that practice is:

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[1] The majority of the information in this section is sourced from the RACGP's supporting submission to the ACCC of 13 December 2006.
[2] "RACGP Faculties", available at www.racgp.org.au
[3] National Rural Faculty, available at www.racgp.org.au.
[4] RACGP application (A91024) for revocation and substitution of authorisation A90795.

- An associateship where two or more GPs:
  - are co-located or operate as a central practice with satellite practices; and
  - which has a common service entity. Each of the GPs must either: have an interest in the service entity; have an agreement with the service entity; or be employed or otherwise engaged by the service entity to provide medical services on the service entity's behalf; and
  - the service entity is responsible for managing and/or maintaining a common reception, common fee collection, commo bank account, common trading name, common medical records and, except for branch practices, common policy and procedures
- A partnership of two or more GPs where at least one of the partners is a body corporate.

2.8 The authorisation was granted subject to conditions and expired on 10 January 2007.

Industry Background

General Practice Sector

2.9 General practice is the provision of primary, continuing, whole-patient medical care to individuals, families and their communities.[5] General practice is the first point of contact for the majority of people seeking health care, and often the first point of referral to other doctors, healthcare professionals and community services.[6]

2.10 General practice in Australia operates predominantly through private medical practices.[7]

General Practitioner Services

2.11 The RACGP defines general practitioners as "Fellows of the RACGP who have vocational recognition as Australian general practitioners."[8] The majority of GPs in Australia are fellows of the RACGP.

2.12 The RACGP indicated that fellowship of the RACGP is the required standard for doctors wishing to practise as an unsupervised GP in Australia. Fellowship may be granted to parties who have undertaken suitable

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[5] Definition of General Practice and General Practitioner, RACGP website, www.racgp.org.au
[6] Ibid.
[7] Australia Medical Association, "General Practice/Rural Medicine Training", June 2005, www.ama.com.au.
[8] RACGP application A91024 for revocation and substitution of authorisation A90795, p 5.

experience/training in general practice and demonstrated their competence by successfully completing the college examination or practice-based assessment.[9]

2.13 Fellowship of the RACGP entitles GPs to be eligible under the *Health Insurance Act 1973* to become vocationally registered with Medicare Australia. Vocationally registered GPs are entitled to access a higher Medicare Schedule for the provision of medical services. Vocationally registered GPs are required to maintain this registration by undertaking professional development activities in accordance with the Quality Assurance and Continuing Professional Development Program run by the RACGP.[10]

2.14 Other medical practitioners (OMPs) who are not Vocationally Registered and are not Fellows of the RACGP can also provide general practice services. OMPs include a group of medical practitioners who were in general practice prior to the introduction of vocational registration, and who have not become vocationally registered. OMPs also include overseas trained doctors who are working in general practice, and who have not been assessed for Fellowship of the RACGP.

2.15 GPs predominantly provide surgery consultations in private practice, however they also conduct home visits (locum services), nursing home visits and hospital visits as visiting medical officers (VMOs).[11] The table below outlines the type of services provided by GPs and the rate of the provision of such services in 2000.

[9] The RACGP Fellowship Guide 2006, available at www.racgp.org.au**,** p. 2.
[10] Australian Government: Department of Health and Ageing, "General Practice in Australia: 2004", p 604.
[11] Australian Government: Department of Health and Ageing, "General Practice in Australia: 2004", Chapter 4.

Table 1: Distribution of GP services across Australia, 2000

Service	**Metropolitan**[12]	**Large rural**[13]	**Small rural**[14]
Variable	Rate per 100 encounters	Rate Per 100 Encounters	Rate Per 100 Encounters
Direct Consultations	96.8	94.8	94.7
Home visits	2.2	0.8	1.1
Hospital	0.3	0.8	1.1
Nursing home	1.0	0.7	0.5
Indirect consultations	3.3	4.9	5.3
- prescription	1.7	5.2	3.1
- referral	0.5	3.0	0.6
- certificate	0.1	0.6	0.2
- other	1.1	0.2	1.6

Source: Australian Institute of Health and Welfare, 2001.

Distribution of GPs across Australia

2.16 In 2005-06 there were 25,146 general practitioners providing medical services in Australia.[15] On average there were 6.1 GP practice locations per 10,000 population. In the 2005–06 financial year, approximately 90 million unreferred attendances were paid by Medicare at an average rate of 4.5 GP visits per person.[16] This equates to approximately 250,000 GP visits per day, every day of the year.

2.17 The table below outlines the number of GPs practising in Australia, by region, in 2002.

[12] Urban centre populations greater than 100,000.
[13] Large rural centres and remote centres with populations ranging between 5,000 and 99,000.
[14] Small rural centres and remote areas with populations ranging between less than 5,000 and 24,999.
[15] Department of Health and Ageing, Division of General Practice Workforce Data, 1995-96 to 2005-06, available at www.health.gov.au
[16] Medicare Australia, 2006. Medicare Benefits Schedule (MBS) Statistics reports, available at http://www.medicareaustralia.gov.au/providers/health_statistics/statistical_reporting/medicare.htm.

Table 2: Number of GPs (headcount) practising in Australian states/territories, 2002.[17]

State/Territory	Major City	Inner Regional	Outer Regional	Remote	Very Remote	Not stated	Total
NSW	6, 133	1,361	406	26	4	156	**8,065**
Vic	4,579	1,006	190	6	-	249	**6,030**
Qld	2,095	804	478	55	39	90	**3,560**
WA	1,555	184	163	100	72	58	**2,132**
SA	1,491	208	188	39	13	74	**2,013**
Tas	-	449	138	10	3	13	**613**
ACT	443	-	-	-	-	-	**443**
NT	-	-	159	83	51	13	**306**
Australia	16, 292	4,015	1,721	318	182	653	**23,182**
percentage	70.3	17.3	7.4	1.4	0.8	2.8	**100**
% population	66.3	20.8	10.3	1.7	0.9	-	**100**

Source: Australian Institute of Health and Welfare, 2004

2.18 As outlined above, approximately 70% of GPs operating in Australia in 2002 practiced in metropolitan regions, with significant reduction in representation in more rural and remote areas of Australia. The RACGP submits that there are significant medical workforce shortages and continued problems associated with recruitment and low retention of GPs in rural and remote Australia.[18]

General Practice in Rural and Remote Areas

2.19 In November 2002 there were 4,074 registered GPs practising in rural and remote locations in Australia. Approximately 60% of doctors providing medical services in rural and regional Australia were GPs.[19]

2.20 GPs operating in rural and remote areas often undertake a broader range of clinical work than their urban counterparts, including emergency care and population health activities. This is often due to geographic and professional

[17] The GP headcount is the number of general practitioners for whom at least one Medicare service was processed during the year. Headcount figures should be used with caution as they overstate the number of active general practitioners. They include doctors who worked for only part of the year, and many doctors who provide only a small number of services.
[18] Letter from the RACGP to the ACCC, 19 January 2007, p. 3.
[19] *The Review of the Impact of Part IV of the Trade Practices Act 1974 on the recruitment and retention of medical practitioners in rural and regional Australia*, 2002, p. 25.

isolation and the lack of nearby supporting medical specialists.[20] The Rural Doctors Association of Victoria (RDAV) indicated that the presence of a GP serviced hospital implies isolation and the necessity to supply advanced medical services to the local community by local doctors.[21]

2.21 GPs may also develop procedural skills in areas such as anaesthetics, obstetrics and general surgery to compensate for the limited availability of specialist consultants in remote regions. The RDAV indicated that in rural Victoria communities are serviced by generalist medical practitioners with emergency and procedural capabilities working both in local hospitals and in their own general practices.[22] Data from the Australian Medical Workforce Advisory Committee (AMWAC) indicated that in 2003, 22.1% of the rural and remote general practice workforce practised in at least one procedural field.[23]

Financing General Practice

2.22 General Practice is a private professional industry which is heavily publicly subsidised. Australian government payments constitute the largest fraction of general practice financing and of GP incomes as a component of this.

2.23 The Australian Government provides most of the funding for the services provided by GPs through Medicare benefits. Medicare allows patients to receive free or subsidised treatment from GPs. The Medicare Benefits Schedule (MBS) sets out the schedule of fees for medical services and procedures covered under the scheme.[24] Where a GP directly bills the government, the patient pays nothing and the GP is reimbursed 85% of the schedule fee; this procedure is known as 'bulk billing.' If a GP privately bills a patient, the patient can claim 85% of the schedule fee for that service from Medicare, and will be liable to pay any charge that exceeds that amount.

2.24 Government financing is also provided through programs such as the Practice Incentives Program (PIP). The PIP is administered by Medicare Australia on behalf of the Department of Health and Ageing. The PIP is part of a blended payment approach for general practice. Payments made through the program are in addition to other income earned by the general practitioners and the practice, such as patient payments and Medicare rebates.[25] It aims to recognise and provide financial incentives to general practices that provide comprehensive quality care and that are working towards meeting the RACGP Standards for General Practices.[26]

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[20] Australian Medical Workforce Advisory Committee, (AMWAC) "The General Practice Workforce in Australia: supply and requirements to 2013" Report 2005.2 (2005), p 97.
[21] Rural Doctors Association of Victoria, submission to the ACCC, 16 April 2007, p 2.
[22] Ibid.
[23] Ibid, p. 32.
[24] Department of Health and Ageing, General Practice in Australia 2004
[25] Medicare Australia, Practice Incentives Program, available at http://www.medicareaustralia.gov.au/
[26] Ibid.

2.25 PIP payments are mainly dependent on practice size, in terms of patients seen, rather than on the number of consultations performed. In February 2002 government developed a subsidy within the PIP for the employment of nurses in general practice, particularly in rural and remote Australia.[27]

Average out of pocket cost of GP services

2.26 The average patient contribution for non-hospital patient billed services has increased by 52.4% over the last decade, from $15.46 per service in 1995 to $23.57 in 2005. Compared with the average annual increase in the period 1995 to 2005 of 4.3%, the real increase from 2004 to 2005 was 2.8%.[28] Schedule fee expenditure per head (adjusted) on GP attendances declined from $175.63 in 1995-1996 to $163.70 in 2002-03.[29]

Government Initiatives in Rural Areas

2.27 The Federal government has introduced many programs to increase GP numbers in rural areas of Australia. In the 1996-97 budget, a major initiative of the Federal government was the General Practice Rural Incentives Program (GPRIP). Its objective was to attract and retain GPs in rural and remote communities in Australia.

2.28 In January 2003, the Australian government commenced the 'More doctors for outer metropolitan areas' program. Its two main recruitment strategies are relocation incentives and training placements. The target for June 2006 was the recruitment of between 200 and 250 doctors. [30]

2.29 In February 2004, the 'MedicarePlus for other medical practitioners' program started, providing access to the higher A1 Medicare rebate for GPs who are not vocationally registered if they work in areas of workforce shortage, including outer metropolitan areas.

General Practice Business Structures

2.30 In recent years there has been a trend away from solo practices, towards group structures.

2.31 In 2002, a large proportion of GPs (51.3%) reported working in a large practice of four or more GPs.[31] This represented a 30% increase in GPs practising in these type of working arrangements since 1997. Among the states and territories, New South Wales had the largest proportion of solo practitioners (22.5%) and South Australia had the largest proportion of practices with five or more practitioners (52.7%). Overall, only 15.9% of the workforce worked in a solo practice.[32] The RDAV indicated that in rural

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[27] RACGP application for Authorisation A91024, supporting submission, p 13.
[28] AMWAC, p. 155.
[29] Richardson et al 2005, p 44 (cited in AMWAC, 2005)
[30] AMWAC, "Executive Summary", p. xxxvi.
[31] AMWAC, p. 139.
[32] AMWAC, p. 140.

Victoria there are currently a total of 37 solo practices and 105 group practices.[33]

2.32 In January 2007, the RACGP conducted a survey of its members seeking information about the business models they use.[34] A significant proportion of respondents (87.1%) reported working in a group practice; only 10.3% reported working as solo practitioners.[35]

2.33 The RACGP submits that one of the characteristics of general practice is the diversity of business models being used around Australia. These include incorporated companies with more than one shareholder or director, corporate GP services, unit trusts, partnerships, associateships, and business models combining two or more of the above practice structures with a range of working and contractual arrangements among practice owners and other GPs.[36]

2.34 The results of the RACGP survey are outlined in Table 3 below.

Table 3: General practice business structures – RACGP Survey

Business Structure	**Percentage of general practitioners using structure**
Company	36
Associateship	16
Unit trust (and other trust)	12
Sole trader	8
Partnerships	13
corporate	4
Not sure	11

2.35 The RACGP cautioned about the interpretation of the survey. The RACGP indicated that based on the data collected, it is difficult to determine the number of GPs operating in particular business structures.

[33] Rural Doctors Association of Victoria, submission to the ACCC, 16 April 2007, p 2.
[34] The RACGP submits that the survey was widely advertised amongst its members, however it cannot confirm how many GPs it actually reached. The RACGP cannot confirm the representativeness of the survey (Record of meeting between the ACCC and the RACGP, 15 February 2007)
[35] RACGP, "Price Setting Survey: Summary Report", January 2007, p.8
[36] RACGP, "Price Setting Survey: Summary Report", January 2007, p. 14.

2.36 The ACCC understands that some of the respondents to the survey which answered that they operate under a "company" structure, may in fact be GPs who are individually incorporated, but work in a practice that operates in an "associateship" structure. The RACGP has indicated that the term 'company' may fall into two categories, service entities and company structure, and that it is difficult to determine from the data collected the comparative size of companies and structures using a service entity. When using a service entity, the GPs generally operate in an associateship structure.[37] Consequently, it is likely that there would be a greater proportion of associateships than is reflected in the above table.

2.37 The RACGP submits that overall the findings of the survey indicate that

- both the diversity and complexity of business models used by GPs continue to grow.
- associateships continue to be one of the most commonly used medical business structures in Australia.

2.38 The RDAV indicated that in rural Victoria there are currently a total of 37 solo practices and 105 group practices. The RDAV indicated that business structures such as associateships are becoming the norm in general practice because they allow flexibility and variation in work hours for doctors who want to work part time and doctors joining such practices can enter at minimum capital cost. The RDAV indicated that young doctors in particular want flexible working hours, limited costs and inconvenience when entering general practice.[38]

2.39 There has been an increase in corporatisation of general practice in recent years. Corporatisation occurs when GPs assign a portion of their gross income to a company in return for management and support services and a goodwill payment.[39] The choice to contract with a 'corporate' for the provisions of services is often made, in part, to reduce the burden of practice management.[40]

2.40 AMWAC notes that the exact number of practices that have been corporatised is difficult to gauge, partly because of definitional issues and partly because of the private company nature of some practices. However, the number of GPs working in this type of arrangement was estimated to be 2,500, or approximately 10% of the practising population, in 2001.[41]

2.41 The RACGP has indicated that most corporate practices have been structured as associateships.

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[37] Record of meeting between the ACCC and the RACGP, 15 February 2007
[38] Record of meeting between the ACCC and the Rural Doctors Association of Victoria, 8 May 2007.
[39] Australian Institute of Health and Welfare, Australia's Health 2002, Chapter 5: "Health resources and use of services," p. 241.
[40] RACGP letter to the ACCC, March 21 2007.
[41] Corporate structure (news review) *Australian Doctor 2001*; 27 April 29-31.

Visiting Medical Officers (VMOs)

2.42 VMOs are medical practitioners appointed by a hospital board to provide medical services for hospital (public) patients on an honorary, sessionally paid, or fee for service basis.[42] These services may be provided as in-patient or after-hours services.

2.43 The proportion of GPs working as VMOs is much greater in rural and remote Australia than in urban areas. VMOs do operate in metropolitan regions, however only a small number of GPs provide services in these areas.[43] Available data indicates that on a national basis GPs spend only a small fraction of their time (2.7%) as VMOs in hospitals.[44]

2.44 Victorian data indicates that in 2006, there were a total of 401 GPs engaged as VMOs, with 80 in metropolitan areas and 321 in rural and regional areas.[45] According to the RDAV's database as at April 2007, there were a total of 93 hospitals and 525 medical practitioners in rural locations of Victoria. The RDAV indicated that, except in larger locations where a smaller proportion of GPs work in hospitals, most of those GPs will be VMOs. The RDAV stated that the number of GPs practising as VMOs in rural Victorian locations may not exceed 450.[46]

2.45 NSW Health data from 2004/05 shows that 19% of all VMOs appointed to NSW public hospitals were VMO GPs. In rural NSW Area Health Services, however, they comprised a larger component of the VMO workforce, ranging from 25% to 50% of the total VMO workforce.[47]

GP appointment to public hospitals

2.46 In order to be granted VMO rights, a doctor must be appointed by the Area Health Service, or hospital. The doctor will generally be approved to provide specified medical services at a nominated hospital(s). The services provided by a GP depend on their individual skill mix. These services can include the provision of accident and emergency services, in-patient care and in some instances procedural activities such as anaesthetics, basic surgery or non-complex obstetrics.

2.47 Generally, GPs appointed as VMOs to a hospital are independent contractors (with the exception of Queensland, and in some instances, Victoria). The current appointment processes for VMOs varies between states and territories, and between hospitals in the same state or territory. The ACCC

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[42] 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**.**

[43] Record of meeting between the ACCC and the RACGP, 15 February 2007.

[44] Letter from the RACGP to the ACCC, 19 January 2007.

[45] Department of Human Services, Victoria, 2006 Annual Report.

[46] Rural Doctors Association of Victoria, submission to the ACCC, 16 April 2007, p 4.

[47] NSW Health, Submission to the ACCC, 9 February 2007, p. 1.

understands that in many states/territories standard VMO agreements are set at the state level.

2.48 In South Australia, the state department of health determines the fees for all GPs practising as VMOs in rural areas of the state.[48]

2.49 In Western Australia, VMO arrangements allow for a contract with corporate medical practices (where registered as such by the WA Medical Board) or individuals only. Fees are usually set by the state department of health, but there is flexibility in regard to after hours, service types, etc.[49]

2.50 In NSW, standard rates and conditions for fee-for-service and sessional VMO service contracts are established by NSW Health, following consultation with the Australian Medical Association (NSW), or with the Rural Doctors Association (NSW).[50]

2.51 In Victoria rural hospitals negotiate directly with GPs regarding their appointment as VMOs. The Department of Human Services Victoria states that Victorian public hospitals are statutory corporations with their own boards of governance and for many years they have negotiated contracts of engagement with GP/VMOs at the local level.[51] Victorian VMO appointments are predominantly sessional.

2.52 ACT Health submits that the ACT public hospital system is not supported by the GP workforce to any significant degree.[52]

2.53 The ACCC understands that VMOs in Tasmania operate in limited locations, predominantly under state set arrangements and in the Northern Territory VMOs operate mainly under salaried positions in hospitals.[53]

Labour Hire Organisations

2.54 To address workforce shortages that are particularly acute in rural and remote areas, hospitals are increasingly turning to Labour Hire Organisations for the supply of GPs.[54] The ACCC understands that at the request of a hospital, a labour hire organisation will supply the requisite services, usually through overseas recruitment. The ACCC understands that the practitioners providing these services have a contract with the organisation, not the hospital.

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[48] Department of Health, Government of South Australia, Submission to the ACCC, 5 February 2007.
[49] Department of Health, Government of Western Australia, Submission to the ACCC, 7 February 2007.
[50] NSW Health, Submission to the ACCC, 9 February 2007.
[51] Department of Human Services, Victoria, Submission to the ACCC, 20 February 2007.
[52] ACT Health, Submission to the ACCC, 10 January 2007.
[53] Rural Doctors Association of Victoria, submission to the ACCC, p 7. The RDAV indicated that this information was obtained from an email survey it conducted with Rural Doctors Association Presidents.
[54] Department of Human Services, Victoria, Submission to the ACCC, 20 February 2007.

The Public Hospital System

2.55 In June 2005, there were 760 public hospitals across Australia, compared with 749 in 2000-01.[55] They vary in size, in their range of services, their degree of specialisation, and the extent to which they engage in teaching and research.

2.56 The majority of public hospitals are in regional areas and major cities. The table below outlines the geographic distribution of public hospitals across Australia.

Table 4: Public Hospitals – number of public hospitals by remoteness area, Australia, 2004-05

Region	Number of hospitals
Major cities	176
Inner regional	194
Outer regional	224
Remote	94
Very remote	72

Source: Department of Health and Ageing, *The state of our public* hospitals, June 2006 report

2.57 There was an average of 55,112 beds in public hospitals during 2004-05, representing 68% of all beds in the hospital sector (public and private hospitals combined). Public hospital beds have increased from 2.7 beds per 1,000 population in 2000-01 to 2.8 beds in 2004-05.[56]

2.58 The ACCC understands that the number of beds immediately available for use is a basic measure of a hospital's capacity to provide care, particularly for patients needing to stay overnight. However, it does not measure capacity to provide care through all same day procedures, hospital in the home, emergency departments, and outpatient services.

2.59 Tables 5 and 6 below outline the average number of beds available in public hospitals per state/territory and the regional distribution of public hospital beds.

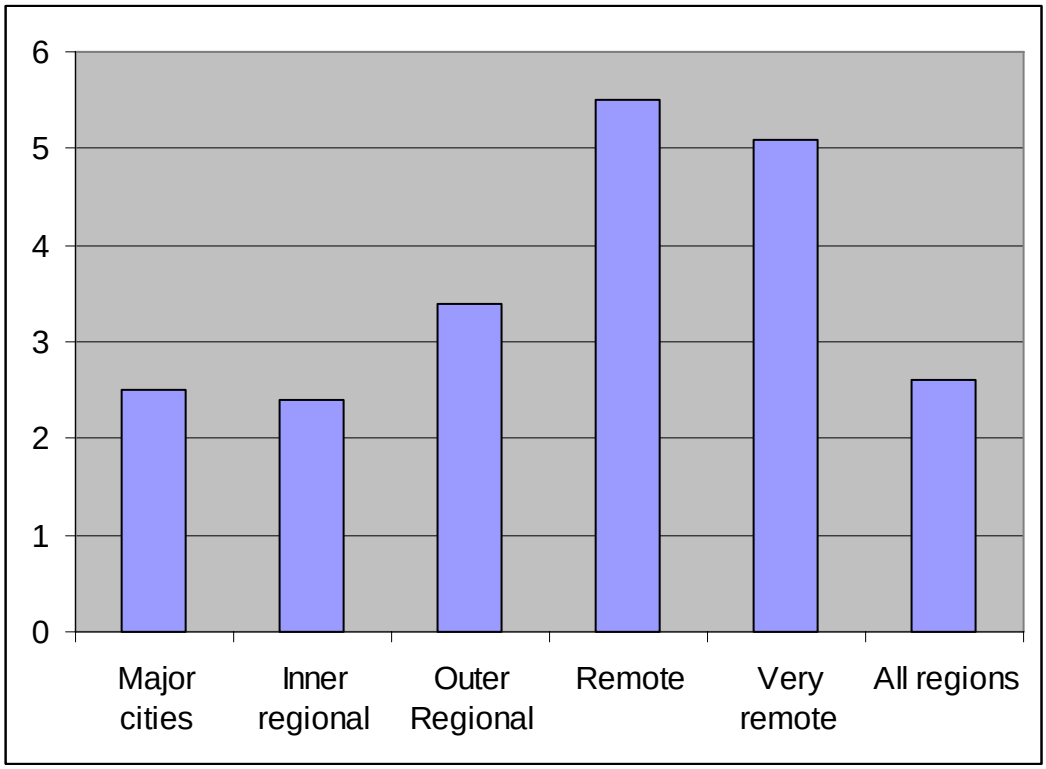
[55] Department of Health and Ageing, "The state of our public hospitals: June 2006 report", p.8.
[56] Australian Bureau of Statistics, "Health Care Delivery and Financing", Year Book Australia, 2007.

Table 5: Public Hospitals – number of average available beds per 1,000 weighted population, states and territories, 2004-05 (1998-99)

	2004-05	**1998-99**
Northern Territory	3.7	4.2
South Australia	2.9	3.2
New South Wales	2.9	2.9
Queensland	2.5	3.2
Western Australia	2.5	3.1
Tasmania	2.5	2.4
Victoria	2.3	2.5
Australian Capital Territory	2.2	2.7

Source: Department of Health and Ageing, *The state of our public hospitals*, June 2006 report.

Table 6: Regional distribution of public hospital beds per 1,000 people, 2003-04



Source: Department of Health and Ageing, *The state of our public hospitals*, June 2005 report.

Expenditure on public hospitals

2.60 An estimated $78.6 billion was spent on health care in Australia in 2003-04, the latest year for which full year expenditure figures are available.[57] Of this amount, $20.3 billion was spent in public hospitals, with the Australian Government contribution totalling $9.2 billion; state, territory and local governments $9.6 billion and private sources $1.5 billion.

2.61 Under the Australian Health Care Agreements, the Australian Government provides grants to the states and territories to help them provide free public hospital services to public patients.

2.62 There has been a substantial increase in the recurrent expenditure for public hospitals in all states and territories. In 2004-05 public hospital recurrent expenditure equalled $600 per person, up from $552 in 2003-04.[58]

[57] Department of Health and Ageing, "The state of our public hospitals: June 2006 report", p. 12.
[58] Ibid, p. 8.

3. The application for authorisation

3.1 The RACGP seeks revocation of authorisation A90795 and its substitution with authorisation A91024.

3.2 The RACGP seeks authorisation for a framework agreement to allow general practitioners (GPs) and OMPs operating within specific business structures to:

- set, control or maintain fees charged to patients;
- agree on the fees that any locums they engage either individually or jointly will charge patients for their services; and
- agree on the fees they charge as visiting medical officers (VMOs) to a hospital (hospital agreements)

3.3 The RACGP's application covers GPs and OMPs within one practice, in the following business structures:

- A partnership of two or more GPs (and OMPs), where at least one of the partners is a body corporate; or
- An associateship of two or more GPs (and OMPs):
  - who are co-located or operate as a branch practice; and
  - which has a common service entity, in which each of the GPs must either have an interest in the service entity; have contracted with the service entity; or be employed or otherwise engaged by the service entity to provide medical services on the service entity's behalf; and
  - the service entity is responsible for managing and/or maintaining a common reception, common fee collection, common bank account, common trading name, common medical records and, except for branch practices, common policy and procedures.

3.4 With regard to hospital agreements, the RACGP submits that it is seeking consistency at the national level for GPs to be able to negotiate VMO arrangements. The RACGP envisages that in practical terms the proposed conduct will involve a representative from a relevant GP practice reaching an agreement with the hospital board to provide medical services to the hospital on a fee for service basis and on other workplace relations issues such as:[59]

[59] RACGP letter of 19 January 2007 to the ACCC, providing further information regarding application A91024.

- a common fee structure
- an after hours and weekend roster
- an arrangement to provide the delivery of specific services, for example:
    - anaesthetics
    - obstetrics
    - surgery

3.5 Consistent with the previous authorisation (A90795), the RACGP seeks authorisation for the above-mentioned arrangements on behalf of all future and current GPs (and OMPs) in Australia.

3.6 Further, consistent with the previous authorisation, the RACGP seeks the application for re-authorisation to extend to contracts, arrangements or understandings in similar terms to the conduct proposed to be authorised.

3.7 In addition, the RACGP is seeking re-authorisation for the arrangements under the State and Territory Competition Codes.

4. Submissions received by the ACCC

4.1 The RACGP provided a supporting submission with its application for authorisation and has since provided further information in response to ACCC queries and interested party submissions.

4.2 The ACCC also sought submissions from a broad range of interested parties potentially affected by the application, including state and federal health departments, consumer groups, medical associations, community and health services bodies, hospital associations, and other relevant health entities.

4.3 The ACCC received public submissions from:

- ACT Health
- Queensland Health
- Health Services Commissioner Victoria
- Australia Medical Association
- Department of Health South Australia
- Department of Health Western Australia
- NSW Health
- Department of Human Services Victoria
- Health Complaints Commissioner Tasmania
- Rural Doctors Association of Victoria
- Rural Doctors Association of Australia

4.4 A summary of the views of the RACGP and interested parties are outlined below. Copies of public submissions are available from the ACCC website (**www.accc.gov.au**) by following the 'Public Registers' and 'Authorisations Public Registers' links.

The RACGP's supporting submission

4.5 Generally, the RACGP submits that authorisation of intra-practice price setting among GPs in particular business structures brings benefits to patients and GPs.

4.6 The RACGP submits that the price setting arrangements promote a culture of safety, quality and teamwork, while preventing the inefficiencies, costs and risks of further fragmentation of care. The RACGP submits that primary care is associated with better health outcomes and reduction in health disparities among Australians from various socio-economic and cultural groups.

4.7 The RACGP considers that intra-practice price setting is one of a number of activities that GPs need to be able to undertake in an open and transparent way, as part of a culture of teamwork and safety in their practices.

4.8 The RACGP commented that while it could be argued that since being authorised by the ACCC in 2002, the arrangements have contributed to an increase in the price of primary care, there is no evidence to support these theories.

4.9 With regard to the proposed collective bargaining arrangements between GP VMOs and public hospitals, the RACGP submits that the arrangements will benefit GPs and the Australian public. Specifically, the RACGP submits that the following benefits will result from the proposed collective arrangements:

- Increasing time available for clinical activity
- Reducing stress of uncertainty in GP practices
- Improving working relationships among GPs in relevant practices
- Promoting a culture of teamwork
- Improving the retention of GPs in rural areas
- Preventing the risks of further health disparities/inequalities among marginalised Australians
- Enhancing patient access to primary care and specific services (i.e. anaesthetics, obstetrics and surgery)

4.10 The RACGP submits that the only potential detriment would be for collective VMO negotiations to increase costs to the public hospitals, however the RACGP does not consider this would eventuate.[60]

4.11 A more detailed outline of the RACGP's submissions on the public benefits and detriments that it considers will flow from the proposed arrangements is discussed in section 6.

Interested party submissions

ACT Health

4.12 ACT Health considers that it is in the public interest to provide predictable consistent billing arrangements in general practice.

4.13 ACT Health submits that it has been advised that the 2002 authorisation was welcomed by eligible practices as it provided a stable business environment and removed concern of possible investigation by the ACCC. ACT Health considers that a new authorisation would further contribute to stability in

[60] RACGP letter of 19 January 2007 to the ACCC, providing further information regarding application A91024.

general practice businesses and support consistent and predictable fees for patients.

4.14 ACT Health noted that GP fees in the ACT do not appear to have increased as a result of the authorisation.

4.15 ACT Health submits that the ACT public hospital system is not supported by the GP workforce to any significant degree, therefore the authorisation relating to hospital agreements will have no impact in the ACT.

Queensland Health

4.16 Qld Health supports the RACGP's application for authorisation for intra-practice price setting arrangements.

4.17 Qld Health considers the authorisation to be in the public interest as it supports general practitioner partnership structures in the primary health care industry.

4.18 Qld Health submits that there are sufficient checks and balances within the health insurance system to ensure that GPs are not over servicing or engaged in inappropriate practices.

Health Services Commissioner Victoria

4.19 The Commissioner submits that it has not been presented with evidence that prices for medical practices have risen as a result of the previous authorisation, nor that negative consequences have resulted from the authorisation.

4.20 The Commissioner submits that there have been some benefits from the previous authorisation in that a common fee is useful information for consumers.

4.21 With regard to hospital agreements, the Commissioner understands that there is a very low percentage of negotiations concerning doctors and hospital fees and that this usually occurs in rural areas on a subcontracting basis. The Commissioner supports the application for authorisation and can see no public benefits in impeding these arrangements.

Australian Medical Association

4.22 The AMA supports the application for authorisation to the extent it mirrors the scope of the original authorisation.

4.23 The AMA agrees with the RACGP that the original authorisation provides benefits for consumers of health services and GPs. The AMA agrees that differential fee structures may create barriers to health care in socially isolated and disadvantaged communities. The AMA considers there is a clear public benefit in patients having some certainty and predictability around the price of health care. The AMA submits that the existing authorisation

supports GPs in the provision of continuous, team-based, informed and high quality care.

4.24 The AMA considers that there is no need for the conditions attached to the authorisation in its current form.

4.25 The AMA submitted that it does not, at this point, support the extension of the original authorisation to include collective setting of fees for general practitioners working as VMOs at hospitals. The AMA submits that it cannot see a public benefit in authorising this conduct as it affects only a limited group of GPs.

Department of Health South Australia

4.26 The Department of Health South Australia supports the application for re-authorisation. The department considers that intra-practice price setting is of benefit to consumers and contributes to equitable access to these services.

4.27 The Department states that it determines VMO fees for all GPs in rural areas of the state; consequently, there is no opportunity for practices in SA to set their own fees for public hospital agreements.

Department of Health Western Australia

4.28 The Department of Health Western Australia is concerned about the authorisation of fee setting agreements by GPs providing services to public hospitals as VMOs.

NSW Health

4.29 NSW Health does not support the extension of the authorisation to cover agreement between GPs and public hospitals in NSW. NSW Health considers there to be no public benefit arising from the proposed arrangements and therefore considers that authorisation of the collective arrangements should not be granted.

4.30 NSW Health notes that in NSW, it establishes standard rates and conditions for fee-for-service and sessional contracts. The contracts are varied by NSW Health from time to time following consultation with the AMA or the Rural Doctors Association (NSW).

4.31 NSW Health submits that price fixing arrangements within a general practice may have contributed to the increase in practice costs.

Department of Human Services Victoria

4.32 The Department of Human Services submits that Victoria's position is unique nationally in that rural public hospitals negotiate directly with GPs. The department outlines the situation in Victoria as follows:

- There are very few GPs engaged in metropolitan or large regional hospitals; GP/hospital arrangements are generally confined to rural hospitals
- Victorian public hospitals are statutory corporations with their own boards of governance. They have negotiated contracts of engagement with GP VMOs at a local level for many years
- Any reduction in competition for public hospital medical services in rural areas will have a significant effect on the Victorian health care system that would not be experienced in other jurisdictions

4.33 The Department considers that current VMO arrangements work well and submits there is no evidence that a public benefit would arise if fee setting were authorised.

4.34 The Department considers that the negotiation of fair and equitable fees and other contractual conditions by rural public hospitals, with resulting public benefit, is assisted by a negotiating framework which maximises the number of competitive alternatives available in local areas.

4.35 The Department supports the maintenance of the status quo with respect to GP/hospital relationships, and considers that the application for authorisation of fee setting by GPs for VMO services to public hospitals should be rejected.

Health Complaints Commissioner Tasmania

4.36 The Health Complaints Commissioner submits that it supports the RACGP's application for revocation and substitution.

Rural Doctors Association of Victoria[61]

4.37 The Rural Doctors Association of Victoria (RDAV) supports the authorisation of intra-practice price setting arrangements by GPs in certain business structures and authorisation of those GPs to collectively negotiate with public hospitals on the terms and conditions of their VMO contracts.

4.38 The RDAV submits that since 1985 community access to local medical services in Victoria has progressively reduced in smaller towns. In particular there has been a loss of obstetrics and theatre facilities, reduced number of days in residence by doctors, doctors participating in on-call rosters with other often distant towns, loss of speciality visiting services, loss of local

[61] Rural Doctors Association of Victoria, submission to the ACCC of 9 April 2007.

doctors, loss of acute beds, and reduction to aged care facilities. The RDAV submits that there are currently 5 rural communities in Victoria that are known to be without resident doctors and an additional 21 that have lost their acute beds since 1991.

4.39 The RDAV submits that the loss of obstetrics is a major loss to any population catchment and medium sized towns in Victoria are also now starting to be affected by this issue. The RDAV submits that in Victoria 37 towns still have obstetrics and caesar capability, with 12 that have marginal capability. The RDAV states that on current trends most of these towns will lose this capability over the next 5-10 years as doctors start to retire.

4.40 The RDAV submits that larger rural Victorian towns[62] have considerable dependence on generalist doctors and that closure of services in medium sized towns will alter equations in larger towns. The RDAV submits that the closure of small town services has put a lot of workload pressure on medium sized towns, with patients presenting to medical services later and sicker.

4.41 The RDAV submits that Victorian rural practices are having great difficulties finding doctors capable of conducting necessary hospital work. The RDAV submits that this has been compounded by greatly improved Medicare reimbursements, making hospital VMO services uncompetitive with community medicine. The RDAV submits that the number of Australian graduate recruitments to rural Victoria has also fallen steadily off in the last 15 years and there is growing dependency on doctors from overseas.

4.42 The RDAV submits that rural recruitment is the responsibility of doctors themselves, except in some locations where hospitals now also operate the community practice. The RDAV states that hospitals go to great lengths to find doctors. The RDAV submits that the Rural Workforce Agency of Victoria assists by finding doctors, but it seems to have less success recently than labour hire organisations operating in the region. The RDAV notes that labour hire organisations operate in limited regions in Victoria.

4.43 The RDAV submits that the high demands of rural practice work, especially the need to juggle after-hours on-call services, with often just as urgent day-time practice based work, can take a high toll on individual doctors. The RDAV states that adequate rural manpower and resources are not available to ensure safe working hours, especially with an ageing, diminishing, workforce, with increasing commitments to education and training and greater statutory demands for continuing professional development.

4.44 The RDAV submits that the evidence shows that given appropriate resourcing and support rural doctors can be very effective in providing outcomes comparable to metropolitan health services, particularly regarding urgent medicine and obstetrics. The RDAV submits that to maintain rural hospital services, it is necessary to provide a remuneration structure which is competitive with other sectors of medical practice.

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[62] Such towns include Hamilton, Horsham, Wodonga, Traralgon, Sale and Waragul.

4.45 The RDAV considers the application to be in the public interest for the following reasons:

- There is major and continuing rundown of Victorian rural hospital services, which results in a lack of access to basic hospital services for many Victorian rural communities. The RDAV submits that this has a negative impact on the health and well being of rural residents and the rural economy as a whole. The RDAV submits that the principal contributor to this issue is the diminishing supply and retention of appropriately skilled rural medical practitioners in rural regions.

- Equitable rural hospital VMO payments are essential for recruitment and retention of doctors. VMO payments have become uncompetitive with HIC funded community practices. These low fee levels work against recruitment and retention of GPs in rural areas.

- Individual negotiations in Victoria place a substantial impost on both doctors and hospitals.

- Statutory obligations for rural doctors should be minimised so they can focus on their main function as clinicians.

- Authorisation of the arrangements will facilitate the role of rural practice entities in Victoria in the recruitment and retention of other appropriately qualified and skilled doctors, which will improve rural community access to local medical services.

- Authorisation of the arrangements will help accommodate a major trend in the younger workforce towards shorter and more flexible hours, with the creation of more GP associateships to facilitate the necessary practice structure arrangements.

Submissions in response to the draft determination

4.46 The ACCC received one substantive submission in response to the draft determination for application A91024.

Rural Doctors Association of Australia

4.47 The Rural Doctors Association of Australia (RDAA) supports the RACGP's application for authorisation and considers that a final determination should be issued by the ACCC in favour of the application.[63] The details of RDAA's submission have been included in section 6.

[63] Rural Doctors Association of Australia, submission to the ACCC of 4 May 2007.

5. The net public benefit test

5.1 Under section 91C of the Act, the ACCC may revoke an existing authorisation and grant another authorisation in substitution for the one revoked, at the request of the person to whom the authorisation was granted or another person on behalf of such a person.

5.2 In order for the ACCC to grant an application to revoke an existing authorisation and grant a substitute authorisation, the ACCC must consider the substitute authorisation in the same manner as the standard authorisation process (as outlined in Chapter 1).

5.3 Under section 91C(7) the ACCC must not make a determination revoking an authorisation and substituting another authorisation unless the ACCC is satisfied that the relevant statutory tests are met.

Application A91024

5.4 Application for re-authorisation A91024 was made to make and give effect to a contract or arrangement, or arrive at an understanding, a provision of which would have the purpose, or would have or might have the effect, of substantially lessening competition within the meaning of section 45 of the Act. The relevant tests for this application are found in sections 90(6) and 90(7) of the Act.

5.5 In respect of the making of and giving effect to the arrangements, sections 90(6) and 90(7) of the Act state that the ACCC shall not authorise a provision of a proposed contract, arrangement or understanding, other than an exclusionary provision, unless it is satisfied in all the circumstances that:

- the provision of the proposed contract, arrangement or understanding would result, or be likely to result, in a benefit to the public; and
- this benefit would outweigh the detriment to the public constituted by any lessening of competition that would result, or be likely to result, if the proposed contract or arrangement was made and the provision concerned was given effect to.

Application of the tests

5.6 The Tribunal has stated that the test under section 90(6) is limited to a consideration of those detriments arising from a lessening of competition.[64]

5.7 However, the Tribunal has previously stated that regarding the test under section 90(6):

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[64] *Australian Association of Pathology Practices Incorporated* [2004] ACompT 4; 7 April 2004. This view was supported in *VFF Chicken Meat Growers' Boycott Authorisation* [2006] AcompT9 at paragraph 67.

> [the] fact that the only public detriment to be taken into account is lessening of competition does not mean that other detriments are not to be weighed in the balance when a judgment is being made. Something relied upon as a benefit may have a beneficial, and also a detrimental, effect on society. Such detrimental effect as it has must be considered in order to determine the extent of its beneficial effect.[65]

5.8 Consequently, given the similarity of wording between sections 90(6) and 90(7), when applying these tests the ACCC can take most, if not all, detriments likely to result from the relevant conduct into account either by looking at the detriment side of the equation or when assessing the extent of the benefits.

Definition of public benefit and public detriment

5.9 Public benefit is not defined in the Act. However, the Tribunal has stated that the term should be given its widest possible meaning. In particular, it includes:

> …anything of value to the community generally, any contribution to the aims pursued by society including as one of its principle elements … the achievement of the economic goals of efficiency and progress.[66]

5.10 Public detriment is also not defined in the Act but the Tribunal has given the concept a wide ambit, including:

> …any impairment to the community generally, any harm or damage to the aims pursued by the society including as one of its principal elements the achievement of the goal of economic efficiency.[67]

Future with-and-without test

5.11 The ACCC applies the 'future with-and-without test' established by the Tribunal to identify and weigh the public benefit and public detriment generated by arrangements for which authorisation has been sought.[68]

5.12 Under this test, the ACCC compares the public benefit and anti-competitive detriment generated by arrangements in the future if the authorisation is granted with those generated if the authorisation is not granted. This requires the ACCC to predict how the relevant markets will react if authorisation is not granted. This prediction is referred to as the 'counterfactual'.

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[65] Re Association of Consulting Engineers, Australia (1981) ATPR 40-2-2 at 42788. See also: *Media Council case* (1978) ATPR 40-058 at 17606; and *Application of Southern Cross Beverages Pty. Ltd., Cadbury Schweppes Pty Ltd and Amatil Ltd for review* (1981) ATPR 40-200 at 42,763, 42766.

[66] Re 7-Eleven Stores (1994) ATPR 41-357 at 42,677. See also Queensland Co-operative Milling Association Ltd (1976) ATPR 40-012 at 17,242.

[67] Re 7-Eleven Stores (1994) ATPR 41-357 at 42,683.

[68] Australian Performing Rights Association (1999) ATPR 41-701 at 42,936. See also for example: Australian Association of Pathology Practices Incorporated (2004) ATPR 41-985 at 48,556; Re Media Council of Australia (No.2) (1987) ATPR 40-774 at 48,419.

Length of authorisation

5.13 The ACCC can grant authorisation for a limited period of time.[69]

Conditions

5.14 The Act also allows the ACCC to grant authorisation subject to conditions which the ACCC considers necessary in order to satisfy the net public benefit test.[70]

Future and other parties

5.15 Applications to make or give effect to contracts, arrangements or understandings that might substantially lessen competition or constitute exclusionary provisions may be expressed to extend to:

- persons who become party to the contract, arrangement or understanding at some time in the future[71]
- persons named in the authorisation as being a party or a proposed party to the contract, arrangement or understanding.[72]

69 Section 91(1).
70 Section 91(3).
71 Section 88(10).
72 Section 88(6).

6. ACCC evaluation

6.1 The ACCC's evaluation of the arrangements is in accordance with the net public benefit test outlined in Chapter 5 of this draft determination. As required by the test, it is necessary for the ACCC to assess the likely public benefits and detriments flowing from the proposed arrangements.

The market

6.2 The first step in assessing the effect of the conduct for which authorisation is sought is to consider the relevant market(s) affected by that conduct.

6.3 The RACGP has not made a submission regarding the relevant market(s) which may be affected by the application.

6.4 The application concerns the provision of two types of services by GPs operating in particular business structures:

- the provision of primary medical services to the public; and
- the provision of medical services to public hospitals, as VMOs.

6.5 The ACCC considers that the relevant areas of competition would be the provision of primary medical services in a fairly localised geographic region. These services are provided by medical practitioners in practices operating under a range of business structures. To a small extent, public hospitals may also provide primary care.

6.6 In general, the ACCC considers that consumers are unlikely to travel long distances to seek substitute primary medical services from a service provider. Consumers are most likely to seek these services within a localised and convenient geographic radius. The ACCC considers that localised geographic markets for the provision of primary medical services are relevant areas of competition for this assessment.

6.7 The other relevant area of competition would be the provision of medical services to public hospitals. These services would most likely be provided by GPs as well as specialists operating in the relevant region. The ACCC notes that the proportion of GP VMOs (compared with specialist VMOs) increases in rural and remote areas.

6.8 With regard to the geographic region for the provision of VMO services, the ACCC considers that public hospitals are likely to seek VMO services from doctors practising in a localised geographic radius from the hospital. The breadth of this region is likely to differ depending on the remoteness of the area.

6.9 The ACCC notes comments by the RACGP that GP VMOs operate predominantly in rural areas, and while GPs do operate in some metropolitan regions, only a small number of GPs provide VMO services in those regions.

The ACCC considers that localised geographic markets, predominantly in rural Australia, are likely to be relevant areas of competition for this assessment.

6.10 The ACCC also notes comments by the Department of Human Services Victoria that in rural Victoria labour hire organisations are increasingly becoming significant players in the medical workforce.[73] The ACCC understands that when local avenues of supply have been exhausted public hospitals seek the services of labour hire organisations. The ACCC understands that labour hire organisations recruit predominantly overseas trained doctors.

6.11 The ACCC understands that while rural public hospitals may recruit GPs from outside their local area (including from labour hire organisations), those hospitals generally source GPs from local regions. The ACCC also notes comments by the RDAV that rural towns are in competition with each other in attracting GPs to their town. The RDAV indicates that each town competes with each other as to who can provide the better package for GPs.[74]

6.12 Overall, the ACCC does not consider it necessary to precisely define the markets in this instance, as the outcome of the assessment would not be affected.

The counterfactual

6.13 As noted in Chapter 5 of this draft determination, in order to identify and measure the public benefit and public detriment generated by conduct, the ACCC applies the 'future with-and-without test'. This involves a counterfactual of identifying the conduct likely to occur if authorisation is not granted.

6.14 With regard to intra-practice price setting arrangements, the ACCC considers that the most likely counterfactual is a situation where GPs in one practice, operating in particular business structures, would price their services individually, without the ability to agree on a common fee structure for the services they provide to patients.

6.15 Similarly, with regard to the hospital agreements, the most likely counterfactual would be a continuation of the present situation where GPs within one practice operating within the relevant business structures who are appointed as VMOs to hospitals would not be able to collectively negotiate with those hospitals on the fees they charge and other terms and conditions.

[73] Department of Human Services Victoria, submission to the ACCC of 19 February 2007, p 2.
[74] Record of meeting between ACCC and the Rural Doctors Association of Victoria, 8 May 2007.

Intra-practice price setting

Anti-competitive detriment

The RACGP

6.16 The RACGP submits that the Medicare data on patient average contribution per service supports the RACGP's position that the 2002 authorisation has no negative impact on costs, and therefore access and equity of general practice services.

6.17 The RACGP acknowledges that there is a range of factors that affect the price of general practice services and the rate of bulk billing (which can be seen as one marker of price sensitivity), including:

- the cost of providing general practice care, including those related to locality, overheads, and those related to the professional services component of general practice
- the level of government subsidy for general practice care (generally the Medicare rebate)
- the presence of e-commerce (as there is an anecdotally reported view that there is a 'pent-up' desire to move to private billing which is constrained by the absence of e-billing options in general practice, which may lead to some increases in patient fees should e-commerce become more widespread)
- the cost of medical indemnity insurance (which has stabilised in the four year period since the first authorisation)

6.18 The RACGP submits that it has been unable to find evidence of any cost increases that could be attributed to the 2002 authorisation. The RACGP states that literature searches and consultations with stakeholders suggest that there is no evidence of any negative impact of the 2002 ACCC authorisation on patient fees.

6.19 The RACGP submits further that the potential detriments to GPs from authorisation of the conduct are limited by the fact that relevant GPs are not compelled to engage in intra-practice price setting; the arrangements are voluntary.

NSW Health

6.20 NSW Health does not agree with the RACGP's analysis of the Medicare data, and submits that other measures need to be taken into account. NSW Health submits that those measures suggest that access to general practice services has not been enhanced since 2001/02 in terms of service provision despite growth in outlays and fees charged. However, NSW Health submits that it would be difficult to attribute these outcomes solely to the 2002 authorisation.

6.21 NSW Health submits that since 2002 the Australian Government has introduced the Medicare Safety Net (which NSW Health considers to have been inflationary), as well as a range of bulk billing initiatives. NSW Health considers that practice costs have increased.

6.22 NSW Health submits that the price fixing arrangements may have had the potential to contribute to these outcomes because they may:

- decrease consumer choice due to lack of competitive pricing by clinicians within a practice
- mean that quality of service is not price responsive; consumers will pay the same price for any doctor at a practice regardless of whether that clinician provides a service of quality
- distort price signals within a practice

6.23 NSW Health submits that GP fees should be realistic and not force some patients, who are unable to afford GP fees, to seek treatment in a public hospital Emergency Department.

Rural Doctors Association of Australia

6.24 The RDAA submits that since the ACCC's authorisation in 2002 the costs of primary care to consumers through general practice have fallen relative to the total cost of providing GP services. The RDAA submits that Medicare data indicates that since 2002:

- There has been an increase in the number of consultations that have been bulkbilled from 67.8% in 2002/03 to 75.6 in 2005/06, and 77.1% in the December quarter 2006. When bulk billed, patients do not have to pay a contribution and are not incurring expenses when they see a GP or OMP.

- The percentage of items billed that were in observance of the schedule fee has increased from 74.5% in 2002/03 to 76.8% in December 2006.

- The average patient contribution per service has risen from $5.70 in 2002/03 to $6.10 in 2005/06. The RDAA submits that this represents an average increase of ~2% per year which is well below the growth in practice costs and cost of wage increases.[75]

ACCC's view

6.25 Generally, the ACCC considers that agreements between competitors which influence the pricing decisions of market participants have the potential to result in allocative inefficiencies. That is, they can move prices away from levels that would be set in a competitive market. This can result in higher prices for consumers and send market signals which direct resources away from their most efficient use.

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[75] Rural Doctors Association of Australia, submission to the ACCC of 4 May 2007.

6.26 The ACCC considers that, in the present case, while there is potential for anti-competitive detriment to result from intra-practice price setting, any potential detriment is likely to be limited.

6.27 The ACCC notes that the arrangements are confined to agreement on price within practices operating under certain business structures. The conduct only applies to GPs who operate in associateships and incorporated partnerships; where the GPs work as a team, sharing patient records, common facilities, a common trading name, and common policies and procedures. Other group practices can already agree on the fee they charge as they constitute one legal entity; for example, companies with doctors as shareholders or directors.

6.28 One key feature of the team approach of these practices is that they share patient records, which means that the GPs would see each other's patients therefore ensuring continuity of care. In that regard, the extent of competition between GPs in those practices absent authorisation would likely to be more limited.

6.29 The ACCC considers that while there is potential for relevant GPs to set their fees higher than would be the case without authorisation as a result of the relevant conduct, those GPs are likely to be constrained, to some extent, by other GP practices in localised markets. The ACCC considers that this constraint is likely to be greater in metropolitan regions where there is a larger number of GP practices.

6.30 The ACCC notes that there are differing views among interested parties regarding the costs of general practice services since 2002. However the ACCC notes comments by the RACGP that while prices for GP services have increased since the 2002 authorisation, there are many factors which influence such prices and therefore it is difficult to isolate cost increases from the authorisation, from other factors. In particular, there does not appear to be evidence that the increase in average out-of-pocket expenses for GP services since 2001/02 was linked to authorisation A90795.

6.31 The ACCC notes that the intra-practice price setting arrangements are voluntary, meaning that GPs in particular business structures are not compelled to engage in intra-practice price setting. In addition, where GPs do choose to engage in the intra-practice price setting arrangements, the ACCC notes that importantly the authorisation does not prevent GPs from individually discounting or bulk billing their patients if they choose to do so.

ACCC conclusion on public detriments

6.32 The ACCC considers that while there is potential anti-competitive detriment that could result from intra-practice price setting, this detriment is likely to be limited.

Public benefit

6.33 The RACGP submits that intra-practice price-setting by GPs operating in the business structures the subject of this application will deliver public benefits, including:

- increasing the safety culture of general practice
- continuity and consistency of patient care
- reducing stress of uncertainty in GP practices
- efficiencies

Increasing the safety culture of general practice

6.34 The RACGP submits that promoting a culture of safety has become a pillar of the patient safety movement, with a transformation in organisational culture being sought. The RACGP submits that good teamwork in health care has several positive effects, including fewer and shorter delays, increases in morale, job satisfaction and efficiency, and its use in error-management and reduction.

6.35 The RACGP submits that it is important for GPs to be able to discuss all aspects of general practice. The RACGP considers that having aspects of their practice "off-limits" for discussion runs a risk of undermining the culture of open communication that is central to patient safety. The RACGP submits that authorisation of the relevant intra-practice price setting arrangements will assist this.

Department of Health Western Australia

6.36 The Dept of Health Western Australia agrees with the RACGP that allowing individuals within a single practice to set common prices benefits patients as it encourages a team approach by GPs within a practice.

ACCC's view

6.37 The ACCC considers that the ability of GPs operating in the relevant business structures to agree on the price they charge patients is consistent with the team approach already adopted by those practices without authorisation. The ACCC understands that while GPs the subject of the application operate in independent legal entities, in practice they act as one unit sharing patient records, common facilities, a common trading name, and common policies and procedures. Agreeing on the price they charge patients is consistent with this approach.

6.38 Therefore the ACCC considers that GPs operating in the relevant business structures are likely to benefit to some extent by being able to discuss all aspects of general practice, in a team-based environment.

6.39 The ACCC accepts that there are benefits to GPs and consumers (including error management and reduction) from an open, team-based structure in general practice. The ACCC considers that most of these benefits would already be generated by the team structures and policies adopted by the relevant GPs, without authorisation. However, the ACCC accepts that there is some benefit from the proposed arrangement as fee setting will not risk undermining the team approach of the practice.

Continuity and consistency of patient care

6.40 The RACGP submits that if the proposed conduct is authorised GPs will be able to provide greater continuity of patient care. The RACGP submits that fee structures that differed depending on the GP could create real barriers to a patient attending a practice; for example, a patient may be able to afford to see one doctor, but not another.

6.41 The RACGP submits that many patients generally prefer to see another doctor in the same practice if their regular doctor is unavailable, and an inability to agree on a common fee structure could create barriers to achieving continuity of care. The RACGP submits that if a patient is in need of medical attention, and their usual doctor is not on duty, the structures in place within the vast majority of general practices enable the patient to be treated by another GP. This provides the patient with continuity of care. The RACGP submits that practice coordination has been associated with improved patient outcomes, including better cancer screening, chronic disease management and patient satisfaction.

6.42 The RACGP submits that different fee structures may create a barrier to patients attending a practice and thus maintaining continuity of care. The RACGP submits that such barriers may limit access to quality care and compromise equitable health outcomes for patients who are marginalised structurally, socially, economically, linguistically or culturally. For example, patients who are:

- Underprivileged
- Elderly and frail
- Rural residents and residents in geographically remote areas
- People from culturally and linguistically diverse communities
- Indigenous Australians
- People with disabilities

Australian Medical Association

6.43 The AMA submits that there is a clear public benefit in patients being able to have some certainty and predictability around the price of seeking healthcare, and none in patients being encouraged to swap practitioners for each episode of care on the basis of price.

6.44 The AMA submits that the existing authorisation supports GPs in the provision of continuous, team-based, informed and high quality care. The AMA submits that the authorisation enables, for example, co-operative arrangements for the provision of after-hours services in communities in which that service could not otherwise be provided. The AMA submits that the ability to enter into such arrangements has an important impact on the capacity of communities to retain general practitioners by alleviating an unacceptable workload both in and after hours.

6.45 The AMA submits that consumers generally look to build a long-term relationship with their doctor on the understanding that past medical history is a very significant factor in ongoing medical treatment. The AMA submits that many patients are seeking ongoing care for chronic or recurring conditions, and are not seeking to access isolated episodes of medical care from different practitioners depending on who is offering the lowest fee on the day.

6.46 The AMA submits that within a medical practice, GPs who are independent legal entities may reach agreement on the range of fees to be charged because this enables patients easily to identify the costs when consulting other doctors within the practice; for example, when their usual treating doctor is unavailable. The AMA submits that this increases the ease of a patient's access to other doctors, and improves the quality of the service each patient receives.

6.47 The AMA agrees with the RACGP that differential fee structures may create a barrier to appropriate health care in socially isolated and disadvantaged communities. The AMA submits that existing workforce shortages mean it is already difficult for such communities to attract medical practitioners, and it is especially important for those who are there to be encouraged to work together to ensure that patients are looked after. The AMA submits that these arrangements facilitate flexible working hours, including leave, for doctors, while ensuring that a responsive service is still available for patients.

ACT Health

6.48 ACT Health submits that there has been a reduction in the number of solo practices and an increase in the number of group practices since 2002, and as a result patients are less likely to see the same doctor on every visit to the general practice, a fact that is increased by the part-time GP workforce. ACT Health submits that in this context, it is important that fees are consistent within practices to ensure that patients who may see a different GP do not experience any change in fee. ACT Health submits that it is in the public interest to provide predictable, consistent billing arrangements within the health unit of a general practice.

6.49 ACT Health submits that there has been an increased in the last four years in the item numbers that GPs can access under the MBS, and differing charges within the general practice for each item number would be additionally confusing to the patient.

Department of Health South Australia

6.50 The Dept of Health South Australia submits that the proposed conduct is of benefit to the consumers of general practice and contributes to equitable access to these services.

Queensland Health

6.51 Qld Health submits that the proposed conduct is appropriate as it is in the public interest to support general practitioner partnership structures in the primary health care industry. Qld Health submits that GPs are an essential part of the provision of health care in Australia without which the public hospital system would be grossly overburdened.

Health Services Commissioner Victoria

6.52 The Health Services Commissioner Victoria submits that it often receives calls from users of medical services who are confused about pricing structures. The Commissioner states that people are often puzzled as to why one practitioner can charge more than another, whereas their expectation is that there would be set fees for all doctors.

6.53 The Commissioner submits that there have been some benefits from the previous authorisation in that a common fee is useful information for consumers.

ACCC's view

6.54 The ACCC considers that consumers may experience some benefit from consistent, predictable pricing among GPs operating within one practice. Whilst those GPs operate under separate legal entities, they work as a team, sharing patient records, common facilities, a common trading name and common policies and procedures. Therefore they would appear to consumers to be one business. It would be consistent with that perception if GPs operating in such practices have the ability to charge a common price. The ACCC notes comments by the Health Services Commissioner Victoria that it often receives calls from users of medical services who are confused about pricing structures in GP practices, in particular as to why one practitioner can charge more than another, whereas the expectation is that there would be set fees for all doctors.

6.55 The ACCC also notes comments by the RACGP that if their regular doctor is unavailable, many patients prefer to see a doctor within the same practice. The ACCC understands that is important to ensure continuity of care. The ACCC considers that consistent pricing for GPs services in the one practice may enable those consumers who are price sensitive to continue their care within the one practice, in the event their regular doctor is not available. More generally, consistency of fees within a practice can assist with ensuring predictability of costs for consumers who attend that practice.

Reducing stress of uncertainty for GPs

RACGP

6.56 The RACGP submits that the proposed collective arrangements are likely to benefit GPs by reducing uncertainty in GP practices.

6.57 The RACGP submits that an environment without authorisation provides an environment of perceived uncertainty for GPs. The RACGP submits that general practice research has shown that the experience of stress of GPs arose mainly from 'job context' rather than from 'job content'. The RACGP states that this research showed that the third most stressful aspect of their work were issues such as government pressure and that fear of litigation was one of the most stressful events. The RACGP submits that the research shows that without authorisation there may be consistent concern among GPs about a major investigation by the ACCC.

NSW Health

6.58 NSW Health submits that any person or business who is subject to the anti-competitive provisions of the Trade Practices Act could seek immunity if the stress of potential prosecution may be detrimental to the public. NSW Health submits that this reasoning should be rejected.

ACCC's view

6.59 The ACCC notes that the relevant GPs cannot engage in the proposed conduct without authorisation. Therefore there is unlikely to be stress from the fear of litigation that would be alleviated by authorisation of intra-practice price setting arrangements. Consequently, the ACCC does not accept this benefit claim.

6.60 However, the ACCC acknowledges that doctors in group practices work under diverse and complex, overlapping business structures. In these circumstances, the ACCC considers that authorisation would provide certainty that all doctors working in group practices where they operate as a team can agree on the fee they charge patients, if they choose to, irrespective of their legal structure. The ACCC notes that under other group business structures GPs can collectively agree on the price they charge patients. The authorisation may assist doctors to choose the business structure that best suit their needs without differing application of the Act. The ACCC notes comments by the RACGP that practice structures are largely determined by liability issues. The ACCC accepts this may provide a small benefit, in the context of intra-practice fee setting having limited detriment.

Efficiencies

RACGP

6.61 The RACGP submits that the price setting arrangements among relevant GPs prevent the inefficiencies, costs and risks of further fragmentation of care.

ACCC's view

6.62 The ACCC considers that GPs operating in relevant business structures are likely to experience some efficiency savings in administrative functions from agreeing on one price structure, as opposed to pricing their services individually. The ACCC accepts that GPs may accrue some benefit in this regard.

ACCC conclusion on public benefit

6.63 The ACCC accepts that there is some public benefit flowing from the intra-practice price setting.

Balance of public benefit and detriment

6.64 Overall, the ACCC is satisfied that the proposed intra-practice price setting arrangements are likely to result in some public benefits, mainly through:

- continuity and consistency of patient care
- the ability for a team practice to discuss all aspects of their operations

6.65 The ACCC is of the view that there are likely to be limited anti-competitive detriments arising from intra-practice price setting arrangements.

6.66 On balance, the ACCC is satisfied that the public benefits likely to arise from the arrangements will outweigh the likely public detriments.

Hospital agreements

Public detriment

6.67 Collective bargaining refers to an arrangement under which two or more competitors in an industry come together to negotiate terms and conditions, which can include price, with a supplier or customer.

6.68 In general terms, collective agreements to negotiate terms and conditions for independent businesses covered by that agreement are likely to lessen competition relative to a situation where each business individually negotiates its own terms and conditions. The extent of the detriment and the impact on competition of the collective agreement will depend upon specific circumstances involved.

Increased costs to public hospitals

The RACGP

6.69 The RACGP submits that the only potential detriment would be for collective VMO negotiations to increase costs to the public hospitals, however the RACGP does not consider this would eventuate.[76]

The Department of Human Services Victoria

6.70 The Department of Human Services Victoria submits that its rural public hospitals negotiate directly with GPs for the provision of VMO services. The department submits that many GPs have shown restraint to date in their negotiations with rural public hospitals, in circumstances where the hospitals have had reducing alternatives available for the supply of medical services. However, the department considers that such restraint is a direct consequence of the localised nature of negotiations and may not continue under increasingly difficult market circumstances or different negotiating structures.

6.71 The department submits that severe shortages of GPs nationally and the rapidly changing structure of general practice have placed hospitals in a particularly poor negotiating position for GP services. As a consequence, these factors have contributed to the increasing costs of hospital medical services, particularly in small rural public hospitals. The department considers that further concentration of competition will lead to increased costs for medical services in rural public hospitals.

6.72 The department submits that there is no compelling argument for change to current processes for the creation of hospital agreements, particularly in an environment where the competitive alternatives are already low and reducing.

6.73 The department is concerned that rural hospitals are becoming increasingly dependent on a single corporate provider of GP services. The department submits that approximately 15 Victorian rural public hospitals now depend on a single corporate provider.

6.74 The department considers that supply of GP services in rural regions is already reduced and that if the authorisation is granted supply would contract further. The department is concerned that authorisation of the relevant conduct will result in no competition at all in many markets in which rural hospitals must negotiate for the provision of medical services.

6.75 The department considers that the negotiation of fair and equitable fees and other contractual conditions by rural public hospitals, with resulting public benefit, is assisted by a negotiating framework which maximises the number of competitive alternatives available in local areas.

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[76] RACGP letter of 19 January 2007 to the ACCC, providing further information regarding application A91024.

Department of Health Western Australia

6.76 The Department of Health Western Australia is concerned about the inclusion of hospital agreements in the conduct proposed to be authorised.

6.77 The department considers that if authorisation is confined to GPs within a single practice the detriment, if any, would be minor in the metropolitan and larger rural centres. However, the department submits that in regional and rural areas, where all GPs who provide VMO services are more likely to be part of the same practice (often the only GP practice in the town), there is far greater potential for a single agreed price framework to be anti-competitive.

Department of Health South Australia

6.78 The Department of Health South Australia submits that in South Australia it determines VMO fees for all GPs in rural areas of the State. Therefore there is no opportunity for practices to set their own fees for public hospital work.

ACT Health

6.79 ACT Health submits that the ACT public health system is not supported by the GP workforce to any significant degree and therefore authorisation relating to hospital agreements has no impact in the ACT.

Rural Doctors Association of Australia

6.80 The RDAA submits that the proposed hospital agreements are unlikely to result in any significant cost increases to hospitals.

6.81 The RDAA considers it unlikely that any cost increases that may eventuate over the authorisation period could be attributed alone to the proposed arrangements and would more likely relate to real cost increases in practices and reduced workforce supply. [77]

ACCC's view

6.82 The ACCC notes concerns raised by interested parties that severe shortages of GPs and the rapidly changing structure of general practice have contributed to increased costs for public hospitals, and that any additional concentration of competition in relevant markets may increase costs further for the public health system. While the ACCC appreciates these concerns, it considers that the proposed arrangements are unlikely to significantly impact on those issues further.

6.83 The proposed collective arrangements are limited in several respects. The arrangements are limited to GPs operating in one practice, in particular business structures. Those practices that supply VMO services to public hospitals may be structured in a variety of ways, including sole traders, corporate practices, unit trusts, partnerships (with at least one corporate

[77] Rural Doctors Association of Australia, submission to the ACCC of 4 May 2007.

partner or with no corporate partner) or associateships. The collective arrangements will only affect those GPs operating in practices that are structured as associateships or incorporated partnerships where the GPs are working as a team, sharing patient records, common facilities, a common trading name and common policies and procedures. GPs operating in other business structures will not fall within the scope of this application and therefore their relationship with hospitals will not be affected by the proposed arrangements.

6.84 The bargaining groups are limited to each GP practice. The ACCC understands that in many circumstances a single bargaining group will not cover all the GPs supplying VMO services to a particular hospital. The ACCC also understands that there may be situations where not all GPs from a single practice are appointed to a hospital.

6.85 Further, the proposed arrangements are voluntary. Hospitals will remain free to enter or not into collective negotiations with groups of GPs that fall within the scope of this application. A hospital can choose to continue to negotiate individually with the GPs concerned. Groups of GPs in the relevant practices cannot force hospitals to enter into collective negotiations with them.

6.86 The ACCC notes that the RACGP has not sought authorisation for collective boycott activity, meaning that GPs cannot collectively agree to withdraw their services from a hospital if, for example, the hospital refuses to enter into collective negotiations with the GPs or the GPs are not satisfied with the outcome of the negotiations. While there are circumstances in which the ability to boycott may itself generate a net public benefit, more generally, collective boycotts can significantly increase any anti-competitive effects of collective bargaining arrangements.

6.87 GPs who provide VMO services to hospitals can always decide individually to no longer supply those services. In the absence of collective boycott, the ACCC considers that the proposed arrangements are unlikely to increase any leverage the GPs may have in negotiations with a hospital.

6.88 Some concerns have been raised that the proposed arrangements will force public hospitals to increase their fees for VMO services, and as a result increase costs to the public health system.

6.89 The ACCC considers that any increase in costs from the arrangements is likely to be limited. As noted above, the bargaining group remains small and in many cases will not represent all the GPs supplying VMO services to a particular hospital. Without the ability to collectively boycott their services, GP VMOs will be unlikely to have an increased leverage in collective negotiations with a public hospital. In addition, the hospital will not be compelled to accept the terms and conditions negotiated by a group of GPs nor enter into collective negotiations.

6.90 The ACCC notes that any potential detriment from the proposed arrangements is also likely to be constrained by the fact that public hospitals operate within the constraint of State health budget. The ACCC considers

that this would limit any fee increase that may result from the proposed collective negotiations.

6.91 The ACCC understands that in most states/territories (excluding Victoria) VMO hospital agreements are set at the state level, leaving limited opportunity for GPs to negotiate with public hospitals at the local level. Therefore, it would appear that there may be limited opportunity for GPs within the relevant business structures to enter into collective negotiations with their local public hospitals, thereby further limiting the potential for the proposed arrangements to result in anti-competitive detriment, including increased costs to the public health system.

6.92 Additional concerns have been raised that GPs could individually withdraw their services from a hospital if that hospital chooses not to enter into collective negotiations with the GPs, thus forcing the price up for VMO services. As noted above, doctors can individually decide to withdraw their services from a hospital with, or without the proposed arrangements. As such, this is not a detriment arising from the conduct sought to be authorised.

Inefficiencies

NSW Health

6.93 NSW Health submits that under the Australian Health Care Agreement all States and Territories receive fixed funding for the provision of public hospital services. The determination of the fee arrangements that apply to VMOs (not just VMO GPs) in NSW takes place within these budgetary constraints. NSW Health considers that to allow VMOs to negotiate on a collective basis may produce inefficiencies and inconsistencies in the remuneration of VMO GPs within the NSW public health system.

ACCC's view

6.94 With regard to the concern that the proposed collective arrangements will produce inefficiencies in the remuneration of GP VMOs in NSW, the ACCC considers that this outcome is unlikely to result. The ACCC understands that in NSW standard terms and conditions for fee-for-service and sessional service contracts are established by NSW Health and are applicable to all VMOs appointed on this basis. Section 88 of the *Health Services Act 1997 (NSW)* mandates the use of standard service contracts for sessional or fee for service arrangements, where they have been established.

6.95 It would appear that where standard contracts have been established by NSW Health, with or without the collective arrangements, NSW public hospitals are compelled to appoint VMOs on the terms and conditions determined by NSW Health.

6.96 Nothing in the proposed arrangements will compel hospitals to collectively negotiate with GPs in the relevant business structures. That is, NSW Health will not have to change its current arrangements. In that regard, NSW Health has indicated that there is no intention to depart from the position whereby

the types and terms of service contracts that area heath services may offer to VMOs are regulated by NSW Health. The ACCC considers it unlikely that the proposed arrangements will produce inefficiencies in the remuneration of GP VMOs in NSW in the near future, as the proposed arrangements would appear to have only very limited application to NSW.

6.97 In other state/territories, such as Western Australia and Victoria, where GPs have a greater ability to negotiate at the local level on the terms and conditions of VMO service contracts, it is likely that inconsistent terms and conditions already exist. The proposed collective arrangements are not likely to alter this position. Therefore, any inefficiencies associated with inconsistent terms and conditions in VMO contracts in those states is not likely to be a detriment arising from the collective arrangements the subject of this application.

Restriction of service provision, including specialty services

Department of Health Western Australia

6.98 The Department of Health Western Australia is concerned that price setting by all GPs in a regional or rural area might be used to anti-competitively influence not only fees but also the delivery of specific services such as anaesthesia, obstetrics or surgery at hospitals.

The RACGP

6.99 The RACGP submits that while it is not aware of any risks associated with collective fee setting activities among GPs, it does recognise possible risks of expanding negotiations beyond fee setting in an attempt to influence the scope and conditions of service provision. The RACGP submits that in theory such activities might cause public detriment by limiting patient access to certain services and at certain times (i.e. after hours services, etc).[78]

6.100 The RACGP submits that from its perspective, any attempt to influence the scope and conditions of service provision which might disadvantage patients by limiting access to services, create risk to patient safety and undermine the quality of services would be unethical. The RACGP considers that the likelihood of GPs involvement in unethical activities is highly improbable and would support the ACCC strategies aimed at preventing such activities.[79]

ACCC's view

6.101 The ACCC notes comments by the RACGP that it would be unethical for GPs to attempt to influence the scope and conditions of service provision which might disadvantage patients by limiting access to services, create risk to patient safety and undermine the quality of services.

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[78] RACGP letter to ACCC of 2 February 2007.
[79] Ibid.

6.102 The present application is to allow GPs in certain business structures to collectively negotiate with hospitals the terms and conditions, including price, for the supply of VMO services. It is not to restrict the supply of such services. If GPs were to agree to restrict or limit the supply of their services in any way, this would be likely to constitute collective boycott. Collective boycotts are prohibited by the Act.

6.103 As mentioned previously in this draft determination, the RACGP has not sought authorisation for collective boycott activity. Accordingly any collective agreement by GPs in one practice, operating in the relevant business structures, not to supply their services (including speciality services) to a public hospital would not be protected from legal action under the Act.

6.104 In light of the above, the ACCC considers that the proposed arrangements are unlikely to adversely affect the supply of VMO services, including specialty services, by GPs to public hospitals.

Labour hire organisations

The Department of Human Services Victoria

6.105 The Department is concerned that labour hire/corporate organisations are becoming increasingly significant players in the medical workforce, especially in rural areas and that if the relevant conduct is authorised it could open the door to market domination by such organisations.

The RACGP

6.106 The RACGP does not see that the authorisation would further 'open the door to market domination by labour hire/corporate organisations'. The RACGP considers that, if granted, the authorisation would allow GPs operating in the relevant business structures to negotiate together. It would not impede competition between practices, nor is it intended for a 'corporate' to negotiate a single fee schedule across competing practices.[80]

ACCC's view

6.107 The ACCC notes that the application does not apply to labour hire organisations; it is limited to collective negotiation by GPs operating in one practice, under certain business structures. Consequently, labour hire organisations will not receive a competitive benefit from the conduct sought to be authorised.

6.108 The ACCC understands that when doctors are supplied by labour hire organisations, the hospital has a contract with that organisation. Therefore labour hire organisation can already negotiate with hospitals in relation to all the doctors it contracts.

[80] RACGP letter to the ACCC of 7 March 2007.

Rosters

6.109 The ACCC notes comments by the RACGP in support of its application that at present VMOs are likely to breach the Act if they bargain collectively or agree with the local hospital for a particular after-hour roster. The RACGP envisages that the proposed arrangements would allow agreement between a practice representative and the hospital board on after hours and weekend rosters.[81]

6.110 The ACCC has consistently stated that a medical roster developed to facilitate patient access to medical services does not raise concerns under the Act.[82] Therefore an agreement between GP VMOs to supply their services to a particular hospital under such roster arrangements can occur without authorisation.

6.111 However, collective bargaining for a common fee to be charged by the relevant GPs under a roster arrangement would fall within the proposed arrangements.

ACCC conclusion on public detriments

6.112 Overall, the ACCC considers that collective negotiations among relevant GP VMOs and public hospitals are likely to result in limited public detriments.

Public benefit

Efficiencies

6.113 The RACGP submits that authorisation by the ACCC would enable more efficient utilisation of GPs valuable time (which is currently used for individual negotiations) for providing primary health care.

6.114 The RACGP submits that this is particularly valuable in the context of significant medical workforce shortages and continued problems associated with recruitment and low retention of GPs in rural and remote Australia. The RACGP submits that various initiatives have been implemented by key stakeholders including government, academic, public and private health sectors to address workforce deficiencies. However, despite all the effort, rural and remote areas in Australia are still medical workforce deficient.

NSW Health

6.115 NSW Health submits that individual GPs do not negotiate fee arrangements with area health services in NSW prior to their appointment as VMOs. Rather the types and terms of service contracts that area health services may offer to VMOs are regulated by NSW Health.

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[81] RACGP letter to ACCC of 19 January 2007
[82] ACCC publication, "Medical rosters": *ACCC Info Kit for the Medical Profession*, 2004.

6.116 NSW Health submits that depending on the nature of the appointment, GPs and area health services may directly negotiate certain other matters such as roster arrangements. However, NSW Health notes that the ACCC's position is that genuine rosters do not breach the anti-competitive conduct provisions of the Act and therefore there is nothing preventing GPs (whether from the same practice or not) who are appointed as VMOs at the same hospital from discussing roster arrangements amongst themselves.

The Australian Medical Association

6.117 The AMA submits that it is unable, at this point, to support collective negotiation for general practitioners working as VMOs at local hospitals. The AMA considers that the RACGP has not provided enough evidence or argument of substance in support of the proposal. The AMA cannot see a public benefit in authorising the conduct only in respect of a limited group of GPs, noting that GPs make up a relatively small proportion of the VMO population.

Rural Doctors Association of Australia

6.118 The RDAA considers that the Victorian situation would be improved by authorisation of the proposed hospital agreements as the hospitals would be able to negotiate with practice doctors, as a group, for the provision of the relevant services and this will ensure that coordinated and efficient arrangements are put in place.[83]

6.119 In addition, the RDAA considers that the arrangement are likely to result in decreased costs to public hospitals as more efficient and effective rostering arrangements may be put in place and the costs associated with negotiating contracts with multiple providers within a practice will be removed.[84]

Rural Doctors Association of Victoria

6.120 The RDAV submits that individual negotiations in Victoria place a substantial impost on both doctors and hospitals.[85]

ACCC's view

6.121 The ACCC understands that with or without the proposed collective arrangements GP VMOs will continue to be individually appointed by public hospitals. The ACCC understands that the terms and conditions of individual VMO appointments differ depending on the skill mix of the practitioner and therefore the services they can provide to the hospital. The ACCC understands that in most states/territories (excluding Victoria) VMO contracts contain standard terms and conditions which are set at the state level by the relevant departments of health.

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[83] Rural Doctors Association of Australia, submission to the ACCC of 4 May 2007.
[84] Ibid.
[85] Rural Doctors Association of Victoria, submission to the ACCC of 9 April 2007.

6.122 The ACCC understands that where standard terms and conditions have been established there may be some ability, in certain regions of certain states, for individual GPs to negotiate beyond those standard terms and conditions with their local hospital. The ACCC notes comments by the RACGP that while there may be room for GPs to negotiate at the local level in some regions, this may not be the case in other states. However, the ACCC understands that presently opportunities to negotiate individually would appear to be limited.

6.123 It would appear that in states/territories other than Victoria, there may be limited opportunities for GP VMOs to collectively negotiate with public hospitals under the proposed arrangements. Where collective bargaining opportunities do arise those GPs are likely to experience some efficiency benefits from having one representative negotiate with the hospital on their behalf.

6.124 In Victoria VMOs currently negotiate directly with public hospitals regarding the terms and conditions of their appointment as VMOs. The ACCC understands that the Victorian Government does not set standard terms and conditions for VMO arrangements. Therefore, it would appear that in that state there is likely to be greater opportunity for GPs operating in relevant business structures to collectively negotiate with public hospitals. Consequently in Victoria a larger group of GPs is likely to benefit from efficiencies generated by the proposed collective arrangements.

6.125 Enhanced input into contracts by providing doctors with a clear voice in negotiations may also contribute to efficiencies. The ACCC notes comments by the RDAA that the Victorian situation will be improved by authorisation of the proposed hospital agreements as hospitals will be able to negotiate with practice doctors, as a group, for the provision of VMO services, which will ensure that coordinated and efficient arrangements are put in place.[86]

6.126 Similarly, the ACCC notes comments by the RDAV that the proposed collective negotiations may allow GPs to reach more reasonable terms with hospitals, across common issues affecting VMOs. The RDAV submits that some doctors may have unrealistic expectations in negotiating with a hospital. Collective discussion of issues regarding VMO contracts among doctors in one practice may assist to determine the most reasonable terms to negotiate with a hospital, both in the interests of the hospital and the relevant doctors; thus making the process clearer and fairer.[87]

6.127 The ACCC further notes comments by the RACGP that situations in which a group of GPs would choose to collectively negotiate would also be limited and is likely to arise where the GPs are similarly appointed to a hospital (i.e. they have the same skill mix) and where other common issues regarding their appointment to a hospital arise following their original appointment process. The RACGP has indicated that opportunities to negotiate collectively may arise at the expiration of individual VMO contracts with hospitals, or prior to

[86] Rural Doctors Association of Australia, submission to the ACCC of 4 May 2007.
[87] Record of meeting between the ACCC and the Rural Doctors Association of Victoria, 8 May 2007.

the expiration individual VMO contracts. The proposed conduct would allow practitioners operating in relevant business structures and who share similar concerns to collectively raise these issues with the hospital board.

6.128 The ACCC also notes the comments by the AMA that only a limited group of GPs are concerned by the proposed arrangements and that GPs make up a relatively small proportion of the VMO population.

6.129 The ACCC accepts that the proposed arrangements have the potential to lead to some efficiency benefits but these would be limited by the fact that they are likely to only arise in relation to a small number of doctors.

Reducing stress of uncertainty in GP practices

6.130 The RACGP submits that the proposed collective arrangements are likely to benefit GPs by reducing uncertainty in GP practices.

6.131 The RACGP submits that an environment without authorisation provides an environment of perceived uncertainty for GPs. The RACGP submits that general practice research has shown that the experience of stress of GPs arose mainly from 'job context' rather than from 'job content'. The RACGP states that this research showed that the third most stressful aspect of their work were issues such as government pressure and that fear of litigation was one of the most stressful events. The RACGP submits that the research shows that without authorisation there may be consistent concern among GPs about a major investigation by the ACCC.

NSW Health

6.132 NSW Health submits that GPs currently have certainty in relation to their fee arrangements when working in NSW hospitals and that this certainty would be diminished if GPs were able to negotiate collectively.

6.133 NSW Health submits that any person or business who is subject to the anti-competitive conduct provisions of the Act could seek immunity if the 'stress' of potential prosecution for anti-competitive conduct may be detrimental to the public. NSW Health submits that this reasoning should be rejected.

ACCC's view

6.134 The ACCC notes that the relevant GPs cannot engage in the proposed conduct without authorisation. Therefore there is unlikely to be stress and uncertainty that would be alleviated by authorisation of the proposed conduct. Consequently, the ACCC does not accept this benefit claim.

Improving working relationships among GPs in a practice and promoting a culture of teamwork

6.135 The RACGP submits that the proposed collective arrangements will improve working relationships among GPs in practices the subject of this application and promote a culture of teamwork.

NSW Health

6.136 NSW Health submits that there is no evidence to support the claim that the proposed collective arrangements will improve working relationships among GPs in practices the subject of this application.

6.137 NSW Health submits that the appointment by area health services of GPs as VMOs is dependent upon the needs of the clinical service requirements of the area health services, and on the qualifications and skills of the applicants. In the event that two or more GPs from the same general practice were to be appointed as VMOs by the same area health service, it would be entirely coincidental.

6.138 NSW Health submits that there is no basis for suggesting that if each GP's dealings with their area health service were conducted on a collective, rather than an individual basis, working relationships between GPs within their general practice would be affected.

6.139 For the same reasons, NSW Health considers that there is no evidence to support the claim that the proposed collective arrangements will promote a culture of teamwork in practices affected by the arrangements.

Department of Health Western Australia

6.140 The Department of Health Western Australia submits that a significant argument in the RACGP's submission is that allowing individuals within a single practice to set common prices is beneficial to patients because it encourages a team approach by GPs within a practice. However, the department considers that when extended to the provision of VMO services to public hospitals, the potential benefits to individual patients are less clear.

Rural Doctors Association of Victoria

6.141 The RDAV submits that it is very important for doctors to work as a harmonious group. The RDAV submits that the ability to discuss common terms, conditions and issues of VMO contracts and to put a common voice on those issues to relevant hospitals will assist doctors working in relevant practices to work harmoniously together; it will give them a sense of a support network on VMO issues. The RDAV submits that strong, harmonious working groups of doctors are more inclined to stay in rural regions and they achieve better clinical outcomes.[88]

ACCC's view

6.142 The ACCC considers that there may be some benefit to the working relationships of doctors and the culture of team work in relevant business structures from the ability to collectively negotiate with public hospitals regarding VMO services.

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[88] Record of meeting between the ACCC and the RDAV, 8 May 2007.

6.143 The ACCC considers that as a result of the proposed arrangements GPs will be able to discuss all aspects of the delivery of primary care services within their group practice and will not be barred from discussing the terms and conditions of their VMO appointments to a public hospital. In addition, the ACCC considers that the ability to discuss common terms and conditions of VMO contracts and to put a common voice on those issues may assist relevant GPs to work harmoniously together. The ACCC considers there may be some benefit to doctors and their patients in this regard.

Retention of doctors

RACGP

6.144 The RACGP submits that authorisation of the proposed arrangements would positively influence morale, and subsequently the retention of GPs in rural and geographically remote areas of Australia, by reducing red tape and saving on transaction costs and time.

6.145 The RACGP submits that it is of grave concern that medical workforce shortages in rural Australia create health risks for Australian health consumers, in particular after hours and on the weekends. The RACGP submits that the proposed arrangements will prevent further risks of health disparities/inequalities among marginalised Australians.

6.146 The RACGP submits that patient access to specific services such as anaesthetics, obstetrics and surgery in rural hospitals is limited. The RACGP submits that the proposed arrangements will enhance patient access to specific services.

Department of Human Services Victoria

6.147 The Department of Human Services submits that there is no evidence of public benefit from authorisation of the proposed collective arrangements. The department submits that it is unaware of any evidence that the current requirement in Victoria for GPs to negotiate directly with hospitals has had an adverse affect on recruitment and retention of GPs in rural areas or impacts negatively on the relationship between rural hospitals and their GP VMOs.

6.148 The department considers that local negotiations have improved professional relationships in recent years. The department submits that it has been advised repeatedly that relationships between rural public hospitals and GPs at a local level are generally sound.

6.149 The department considers that in the context of the extreme shortage of medical professionals in rural Australia the current negotiating framework has been successful.

Rural Doctors Association of Australia

6.150 The RDAA submits that the current arrangements in Victoria are not working well; the RDAA states that large numbers of procedural doctors in

Victoria have indicated dissatisfaction and they have left, or intend to leave the hospital system in the next 5 years.

6.151 The RDAA considers that authorisation of the proposed conduct would result in public benefits as it would mean that more doctors would be more inclined to continue in their roles, or take up roles as VMOs.[89]

Rural Doctors Association of Victoria

6.152 The RDAV submits that authorisation of the proposed hospital agreements will have a direct impact on recruitment of doctors to rural regions, in particular young doctors. The RDAV submits that young doctors want flexible working hours and limited costs and inconvenience when entering into general practice. The RDAV submits that business structures such as associateships are becoming the norm in general practice because they allow flexibility and variation in work hours for doctors who want to work part time and doctors joining such practices can enter at minimum capital cost.

6.153 The RDAV submits that young doctors want an 'umbrella package' where everything is organised for them; they are not interested in the hassle and stress of negotiating with hospitals. The RDAV submits that the current application for authorisation allows doctors to collectively negotiate terms and conditions with hospitals and therefore offer those conditions to prospective doctors as part of a package.

6.154 The RDAV submits that individual negotiations between doctors and hospitals for VMO contracts is stressful, costly and can cause conflict in some instances. The RDAV submits that the feedback it receives from doctors indicates that they do not like the process of individual negotiation of their VMO contacts with hospitals. The RDAV indicated that if doctor involvement in the VMO negotiation process can be minimised this will assist to reduce the disincentives to join general practice and as a result assist with recruitment/retention of doctors in rural regions.

ACCC's view

6.155 The ACCC appreciates that medical workforce shortages in rural Australia are important issues. The ACCC considers that arrangements which would assist with the recruitment and retention of GPs can generate public benefits. The ACCC accepts that the proposed hospital arrangements may allow general practices, operating under relevant business structures, to offer a negotiated hospital packages to prospective and resident GPs, which in turn may assist with some recruitment/retention of GPs in those regions. The ACCC considers that if this outcome were to occur it would have a beneficial effect on the health of relevant rural communities. The ACCC considers that the proposed hospital agreements are likely to result in public benefit in this regard.

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[89] Rural Doctors Association of Australia, submission to the ACCC of 4 May 2007.

Collective bargaining notification process

The Australian Medical Association

6.156 The AMA notes recent changes to the Act allowing notification of collective bargaining arrangements. The AMA submits that the stated intent of these changes would encompass situations where a group of doctors in a practice sought to set VMO fees collectively with a local hospital. The AMA submits that in absence of any evidence from the RACGP to support a blanket authorisation of this conduct, it would be better to wait and see how the notification process operates in practice.

NSW Health

6.157 NSW Health notes that GPs who are appointed or seeking appointment as VMOs to NSW public hospitals are likely to fall within the recent amendments to the Act containing new collective bargaining and collective boycott provisions for small businesses. NSW Health considers that these provisions should allow individual GPs or groups of GPs (whether working in the same general practice or not) who wish to collectively negotiate with an area health service to seek immunity by lodging a collective bargaining notification with the ACCC. NSW Health submits that the availability of this mechanism is a further argument against granting the authorisation.

ACCC's view

6.158 The ACCC notes comments by the AMA and NSW Health. However, the ACCC considers that the processes under which parties seek legal immunity for conduct that may breach certain provisions of the Act is a decision that should be made by each party separately. The ACCC will assess each application for authorisation and notification on its merits.

ACCC conclusion on public benefits

6.159 Overall, the ACCC considers that the proposed arrangements are likely to generate some public benefits.

Balance of public benefit and detriment

6.160 The ACCC may only grant authorisation if it is satisfied that, in all the circumstances, the proposed conduct is likely to result in a public benefit that will outweigh any public detriment.

6.161 In the context of applying the net public benefit test at section 90(8)[90] of the Act, the Tribunal commented that:

> … something more than a negligible benefit is required before the power to grant authorisation can be exercised.[91]

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[90] The test at 90(8) of the Act is in essence that conduct is likely to result in such a benefit to the public that it should be allowed to take place.

6.162 The ACCC considers that the proposed hospital agreements are likely to result in limited public detriments.

6.163 The ACCC is satisfied that the proposed arrangements are likely to generate some public benefits, mainly:

- potential future efficiency gains;
- improve the working relationships of doctors and the culture of team work in relevant practices and in their work as VMOs in hospitals; and
- assist with the recruitment and retention of GPs in rural Australia by enabling relevant practices to offer negotiated hospital packages to prospective and resident GPs.

6.164 On balance, the ACCC considers the public benefit is likely to outweigh the public detriment.

Length of authorisation

6.165 The ACCC generally considers it appropriate to grant authorisation for a limited period of time, so as to allow an authorisation to be reviewed in light of any changed circumstances.

6.166 In this instance, the RACGP has not sought authorisation for a specified time period.

6.167 Consistent with the previous authorisation, the ACCC grants authorisation to the intra-practice price setting arrangements and the proposed hospital agreements as sought by the applicant, for a period of 4 years.

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[91] Re Application by Michael Jools, President of the NSW Taxi Drivers Association [2006] ACompT 5 at paragraph 22.

7. Determination

The application

7.1 On 13 December 2006, the Royal Australian College of General Practitioners (RACGP) lodged application A91024 with the Australian Competition and Consumer Commission (the ACCC). Pursuant to section 91C of the Act the application was lodged to revoke authorisation A90795 and substitute it with a new authorisation to:

- make a contract or arrangement, or arrive at an understanding, a provision of which would have the purpose, or would have or might have the effect, of substantially lessening competition within the meaning of section 45 of the Act and;
- to give effect to a provision of a contract, arrangement or understanding which provision has the purpose, or has or may have the effect, of substantially lessening competition within the meaning of section 45 of the Act.

7.2 In particular, the RACGP seeks authorisation for GPs and OMPs within a single practice operating in particular business structures to agree on:

- fees charged to patients;
- fees that any locums the GPs engage, either individually or jointly, will charge patients for their services; and
- fees that the GPs charge to a hospital as Visiting Medical Officers (hospital agreements)

The net public benefit test

7.3 For the reasons outlined in Chapter 6 of this determination, the ACCC considers that in all the circumstances the arrangements for which authorisation is sought are likely to result in a public benefit that would outweigh the detriment to the public constituted by any lessening of competition arising from the arrangements.

7.4 The ACCC therefore **grants** authorisation to application A91024 under the Act and the Competition Code of each state and territory.

Conduct for which the ACCC grants authorisation

7.5 The ACCC grants authorisation for intra-practice price setting arrangements and hospital agreements to GPs in associateships and partnerships, operating as a team where they share patient records, common facilities, a common trading name and common policies and procedures.

7.6 The ACCC notes that the intra-practice price setting arrangements and hospital agreements are voluntary. In particular, the ACCC notes that:

- hospitals will remain free to enter or not into collective negotiations with groups of GPs that fall within the scope of this application.
- GPs may choose not to be part of the bargaining groups
- the hospitals will remain free to continue with the current arrangements, negotiating individually with the relevant GP VMOs or negotiating new arrangements with bargaining groups
- under the intra-practice price setting arrangements, GPs will remain free to choose whether to agree on the fee they charge patients.

Conduct not authorised

7.7 Nothing in this determination permits the making of any contract, arrangement or understanding containing an exclusionary provision as defined in section 4D of the Act (otherwise known as a collective boycott).

7.8 In particular any collective agreement by GPs operating in the relevant business structures to restrict or limit the supply of their services in any way, or to withdraw those services from a public hospital would not be protected from legal action under the Act.

Date authorisation comes into effect

7.9 This determination is made on 23 May 2007. If no application for review of the determination is made to the Australian Competition Tribunal (the Tribunal), it will come into force on 14 June 2007. If an application for review is made to the Tribunal, the determination will come into effect:

- where the application is not withdrawn – on the day on which the Tribunal makes a determination on the review, or
- where the application is withdrawn – on the day on which the application is withdrawn.