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29 January 2007

Mr Scott Gregson
General Manager
Adjudication Branch
Australian Competition and Consumer Commission
PO Box 1199
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Dear Mr Gregson

Royal Australian College of General Practitioners: Authorisation No A91024
Application for Revocation and Substitution

Thank you for your letter of 20 December 2006 seeking comment from the Australian Medical Association (AMA) in respect of the submission by the Royal Australian College of General Practitioners (RACGP) for the revocation of ACCC authorisation A90795 and the substitution of a new authorisation (A91024).

The AMA supports the application for a new authorisation to the extent that the new authorisation mirrors the scope of the original authorisation A90795 – that is, the AMA supports authorisation of the first two of the three types of conduct listed in your letter:

- General Practitioners (GPs) and other medical practitioners (OMPs) working in certain business structures agreeing on patient fees; and
- GPs and OMPs working in the above businesses agreeing on fees that any locums will charge patients for their services.

The AMA is unable, at this point, to support an extension of the original authorisation to cover the third type of conduct – that is, GPs and OMPs working in these business structures agreeing on fees that they charge as VMOs to a hospital (hospital agreements).

Fees within Practices

The AMA agrees with the submission by the RACGP that the original authorisation provides benefits for the consumers of health services, as well as for GPs themselves.

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General Practice (and indeed medical services generally) differ from other types of service in 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. Patients also want to establish a rapport with their GP which cannot be built on a single consultation. 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.

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, where their usual treating doctor is unavailable. This therefore increases the ease of a patient's access to other doctors, and improves the quality of the service each patient receives.

The AMA agrees with the RACGP that differential fee structures may create a barrier to appropriate health care in socially isolated and disadvantaged communities. Given existing workforce shortages 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. These arrangements facilitate flexible working hours, including leave, for doctors, while ensuring that a responsive service is still available for patients.

The demand for medical services, unlike other market forces, is not something which can be structured around the availability of the provider. There is a clear public benefit in patients being able to have some certainty and predictability around the price of seeking health care, and none in patients being encouraged to swap practitioners for each episode of care on the basis of price. The existing authorisation supports GPs in the provision of continuous, team-based, informed and high quality care, enabling, for example, co-operative arrangements for the provision of after-hours services in communities in which that service could not otherwise be provided. The ability to enter into such arrangements has an important impact on the capacity of communities to retain general practitioners by alleviating what is, more often than not, an unacceptable workload both in and after hours.

The AMA, however, takes this opportunity to observe that these very arguments in support of the RACGP's authorisation have far wider application, and underscore our position that medical services are in the main fundamentally different from the types of services that the *Trade Practices Act* is designed to regulate. The concepts of "market" and "competition" as they are constructed in the Act are simply not useful or relevant when applied to doctor-patient relationships, and an obvious example of this is the way in which the provisions around fee-setting pose a significant impediment to the consumer's ability to access quality team-based care.

Furthermore, the AMA argues – as we did in response to the application for the original authorisation – that there remains no public benefit from doctors having to submit to the additional red tape of the administrative requirements contained in the conditions which attach to the authorisation in its current form.

These conditions represent yet another unnecessary administrative burden upon GPs and are clearly inconsistent with the government's stated intention of reducing the amount of red tape regulating medical practice.

"Hospital Agreements"

Finally, we note that the RACGP is seeking to extend the scope of the original authorisation to include collective setting of fees for general practitioners working as Visiting Medical Officers (VMOs) at local hospitals.

The AMA is unable, at this point, to support this aspect of the application, given that the RACGP has provided no evidence or argument of substance in support of the proposal. The AMA cannot see a public benefit in authorising this conduct only in respect of a limited group of general practitioners, noting that GPs make up a relatively small proportion of the VMO population.

The AMA is also aware that changes to the *Trade Practices Act* allowing the notification of proposed collective bargaining arrangements commenced on 1 January 2007. While the practicality and limits of the notification process are yet to be properly tested, 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.

In the absence of any evidence from the RACGP in support of a blanket authorisation for this conduct, the AMA considers that it would be better to wait and see how the amended notification process operates in practice. If problems with the notification process emerge, our very strong preference would be to have these issues addressed directly for the potential benefit of all VMOs, not just that small group covered by the proposed RACGP authorisation.

Thank you for the opportunity to comment on this application. Should you have any further inquiries please contact Ms Sarah Byrne, our Director of Legal Services and Policy.

Yours faithfully

Dr E Robyn Mason
Secretary General

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