AMA VICTORIA

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12 September 2007

Ms Isabelle Arnaud
Director, Adjudication
Australian Competition and Consumer Commission
GPO Box 3131
CANBERRA ACT 2601

Dear Isabelle

Notification for Latrobe Regional Hospital

Please find enclosed the Form GA and additional information in relation to the notification being lodged by AMA Victoria on behalf of Participants (Doctors) for collective bargaining arrangements with Latrobe Regional Hospital.

In addition, we enclose the Authority to Act forms for each Participant which provide proof in accordance with Section A, 2(b) of Form GA of agreement by Participants to the lodgement of the notification of their behalf.

Also enclosed is a cheque to the value of $1,000, which is to cover the lodgement fee for the notification.

We look forward to receiving a response from the ACCC in relation to this notification.

Yours sincerely,

David Goldberg
Solicitor/Senior Advisor
AMA Victoria

Form GA

Commonwealth of Australia

Trade Practices Act 1974 — subsection 93AB (1)

NOTIFICATION OF COLLECTIVE BARGAINING

This form is to be completed by applicants proposing to engage in collective bargaining arrangements.

In lodging this form, applicants must include all information, including supporting evidence that they wish the Commission take into account in assessing their notification.

Where there is insufficient space on this form to furnish the required information, the information is to be shown on separate sheets, numbered consecutively and signed by or on behalf of the applicant.

Protection provided by the notification extends only to the collective bargaining arrangements described in the form.

To the Australian Competition and Consumer Commission:

Notification is hereby given under subsection 93AB (1) of the *Trade Practices Act 1974*:

- to make, or propose to make, a contract containing a provision of the kind referred to in paragraph 45 (2)(a) of the *Trade Practices Act 1974*; or
- to give effect to a provision of a contract where the provision is of the kind referred to in paragraph 45 (2)(b) of the *Trade Practices Act 1974*.
  (Strike out if not applicable)

PLEASE FOLLOW DIRECTIONS ON BACK OF THIS FORM

Section A – general information

1. Applicant

(a) Name of the applicant:
(refer to Direction 1)

CB00004

Australian Medical Association (Vic) Pty Ltd ("Applicant")

(b) Description of business carried on by the applicant:
(refer to Direction 2)

The Applicant is the leading professional association representing the medical profession

(c) Is the representative of the applicant lodging the notice a trade union, an officer of a trade union or a person acting on the direction of a trade union?
(refer to Direction 3)

No

(d) Address in Australia for service of documents on the applicant:

293 Royal Parade, PARKVILLE, VIC, 3052

2. Lodged on behalf of

(a) Provide names and addresses of all persons on whose behalf the notification is lodged and who propose to participate in the collective bargaining arrangements:
(refer to Direction 4)

Ameen Medical Pty Ltd, PO Box 9251, TRARALGON VIC (Dr Nabil Ameen)
Dr Gordon Arthur, 138 Princes Highway, TRARALGON VIC
Dr David Birks, 130 Moe South Road, MOE VIC
Dr Tanja Bohl, PO Box 420, MOE VIC
Dr J P Brougham, 37 Breed St, TRARALGON, VIC
P F Burke Pty Ltd, PO Box 84, NEWBOROUGH VIC (Dr Peter F Burke)
Dr Gerald Busch, PO Box 467, WONTHAGGI VIC
Dr David K H Chan, PO Box 1825, TRARALGON VIC
Dr Jacques Coetzee, 2 Walnut Road, TRAFALGAR VIC
Robert J Dawson Pty Ltd, 35 Melaleuca Way, Traralgon 3844, (Dr Robert Dawson)
Dr Roger Fitzgerald, 37 Breed Street, TRARALGON, VIC
Dr Norbert Fuessel, PO Box 384, SALE VIC
Dr Midhat Ghali
Dr Andrew Green, 1 Treehaven Place, SOMERVILLE VIC
Dr Steve T Grigoleit, PO Box 934, MOE VIC
Dr Grant J Harrison, PO Box 228, TRAFALGAR VIC
Dr Chris Kimber, 2 Bristol Court, GLEN IRIS VIC
RWL Ocular Services Pty Ltd, 157-159 Kay St, TRARALGON 3844 (Dr Robert W Lazell)
Dr Sean T Leahy, 20 Kay Street, TRARALGON VIC
Dr Peter Lewis, 50 Radovick Street, KORUMBURRA VIC
Dr Pradeep Madhok, 10 Princely Terrace, TEMPLESTOWE VIC
Dr Edward A Marrow, 16 Bridges Avenue, TRARALGON VIC
Dr Charles Mashonganyika, 5 Ellenbrae Court, TRARALGON VIC
Dr David A Ogilvy, PO Box 368, TRARALGON VIC
Dr George Owen
Peter Rehfisch Pty Ltd , 485 Thomspsons Road, HAZELWOOD SOUTH 3844 (Dr Peter Rehfisch)
MH Sanderson Incorporated Pty Ltd, PO Box 583, MOE 3825 (Dr Michael H Sanderson)
Dr John Scarlett, PO Box 424, TRARALGON VIC
Peter Smith Nominees Pty Ltd, 148 Princess Hwy Traralgon 3844 (Dr Peter John Smith)
Dr Brendan J Steele, Suite 3, 35 Grey Street, TRARALGON VIC
Dr Neville Steer, 37 Breed Street, TRARALGON VIC
Dr Joseph Tam, PO 1982, TRARALGON VIC
Dr Malcolm Thomas
RG Thorne Pty Ltd, 17 Hickox Street, Traralgon 3844 (Dr Robert G Thorne)
Dr Mark Troski, 411/100 Victoria Parade, EAST MELBOURNE VIC
Dr Glenn Watson, 277 Somerville Road, YARRAVILLE VIC
Jillian R Wih Pty Ltd, 11 Eldale Ave Greesborough 3088 (Dr Jillian Whitney)
Dr Philip Worboys, 97 Station Rd, FOSTER, VIC
Dr Ming Yii, PO Box 855, Mount Waverly, VIC
(together, the "Participants")

(b) Provide proof of the consent of each of the persons listed at 2 (a) above agreeing to the lodgement of the notification on their behalf:
(refer to Direction 5)

Refer enclosed "Authority to Act", Appendix E

(c) Provide the following information relating to a notification:

(i) Does this notification relate to a notification previously lodged with the Australian Competition and Consumer Commission and for which a concessional fee is claimed?

No

(ii) details of the first-mentioned notification, including but not limited to:

(A) the name of the applicant; and

(B) the date the notification was said to be lodged; and

(C) if known or applicable — the registration number allocated to that collective bargaining notification.

Section B – collective bargaining arrangements

3. Proposed collective bargaining arrangements

(a) Provide: the name and address of the target; the name, position and telephone contact details of an appropriate contact at the target; and a description of the business carried on by the target:
(refer to direction 6)

Target: Address: Latrobe Regional Hospital, PO Box 424, Traralgon, Latrobe City, VIC 3844 Contact: Mr Felix Pintado, CEO, (03) 5173 8000 Description: The Target is a is a 257-bed hospital and part of the Victorian Public Hospital Service. It offers a comprehensive range of medical services including elective surgery, maternity, pharmacy, rehabilitation, aged care, cancer care and mental health care.

(b) Provide a description of the goods or services which the participants of the collective bargaining arrangements (listed at 2 (a) above) propose to supply to or acquire from the target:

The Participants propose to supply to the Target the full range of medical services offered by the Target to patients.

(c) Do the participants of the proposed collective bargaining arrangements (see 2 (a) above) reasonably expect to make one or more contracts with the target about the supply to or acquisition from the target of one or more of the goods or services (listed at 3 (b) above)?
(refer to direction 7)

Yes

(d) In relation to (c) above, provide details of the basis upon which that expectation is held including details of past contracts with the target:

The expectation that the Participants will enter into at least one contract with the Target is based on previous experience and a long history of contractual relations, negotiations and discussions between the Participants and the Target.

(e) Do the participants of the collective bargaining arrangements (listed at 2 (a) above) reasonably expect that contractual payments between the target and each participant will not exceed $3 million (or any other amount prescribed by regulation) in any 12 month period, and on what basis?
(refer to direction 8)

The Participants reasonably expect that the contractual payments between the Target and each Participant will not exceed $3 million in any 12 month period. In reaching this view, the Participants rely on the fact they each provides and intends to continue providing a specific range of limited services to the Target. Those services, substantially similar to the services detailed in Section A, 1(b) of this Form GA, have never given rise to contractual payments between the Target and any Participant exceeding (or nearing) $3 million in any 12 month period. Further, the Participants believe that those services will not exceed $3 million in any 12 month period for the duration of this Application.

(f) In relation to (e) above provide an estimation of the contractual payments expected between the target and each participant in relation to the goods and services (listed at 2 (a) above):

See 3(e) above.

(g) Provide a description of the collective bargaining arrangements proposed including, but not limited to:

(i) the process by which participants propose to undertake collective bargaining with the target; and

(ii) the type of terms and conditions expected to be negotiated in collective bargaining arrangements (for example: price; non-price conditions of supply such as contract periods etc); and

(iii) details of any dispute resolution procedure (if any) proposed between participants throughout the collective bargaining process; and

(iv) details of any dispute resolution procedure (if any) proposed between participants and the target throughout the collective bargaining process; and

(v) details of any dispute resolution procedure (if any) proposed to deal with disputes throughout the term of contracts entered into with the target; and

(vi) details of proposed commencement and duration of contracts to be negotiated with the target:
(refer to direction 9)

Refer Appendix A

(h) Identify any parts of the proposed collective arrangements described in 3 (g) which relate to possible price agreements:

One of the powers being sought in this application is the power for medical practitioners to collectively agree fees/pricing when engaged as medical practitioners to the Target.

(i) Identify any parts of the proposed collective arrangements described in 3 (g) which relate to a possible or proposed exclusionary provision(s), including but not limited to:

(i) the nature of the proposed or possible exclusionary provision(s) (for example an agreement to withhold supply of the relevant goods or services to the target); and

(ii) the circumstances in which the collective bargaining participants would engage in the exclusionary provision(s), including but not limited to:

(A) details of the events that would trigger any such activity; and

(B) details of the process that would be followed in undertaking any such activity; and

(C) details of any proposed period of notice to be given to the target prior to the commencement of such activity; and

(D) details of any dispute resolution procedure to be applied or offered to the target prior to the commencement of such activity:

(refer to direction 10)

The Applicants are not seeking powers which relate to possible or proposed exclusionary provisions.

Section C – public detriments

4. Market definition

Provide a description of the market(s) in which the goods or services described at 3 (b) are supplied or acquired and other affected markets including: significant suppliers and acquirers; substitutes available for the relevant goods or services; any restriction on the supply or acquisition of the relevant goods or services (for example geographic or legal restrictions):
(refer to direction 11)

Refer Appendix B

5. Public detriments

(a) What will be the likely effect of the notified conduct on the prices of the goods or services described at 3 (b) above and the prices of goods or services in other affected markets? In answering this question please provide facts and information to support the claims made:

Refer Appendix C

(b) What other detriments may result from the notified conduct? In answering this question please provide facts and information to support the claims made:

All potential detriments are discussed at 5(a) and Section D of this Form GA.

Section D – public benefits

6. Public benefit claims

(a) Provide details of the public benefits resulting or likely to result from the proposed arrangement. In answering this question please provide facts and information to support the claims made:

Refer Appendix D

Section E - authority

7. Contact details

(a) Name, contact telephone number and address of person authorised by the notifying parties to provide additional information in relation to this application: *(refer to direction 12)*

David Goldberg AMA Victoria 293 Royal Parade PARKVILLE VIC 3052 Phone: (03) 9280 8731

Dated: _____

Signed by/on behalf of the applicant

_____
(Signature)

_____
(Full Name)

_____
(Organisation)

_____
(Position in Organisation)

DIRECTIONS

1. Where the notice is given by or on behalf of a corporation, the name of the corporation is to be inserted in item 1 (a), not the name of the person signing the application and the application is to be signed by a person authorised by the corporation to do so.

2. Describe that part of the applicant's business relating to the subject matter of the contract, arrangement or understanding in respect of which notification is given.

3. A collective bargaining notification can not be lodged by a trade union or a trade union representative.

4. Where the applicant will be a participant in the collective bargaining arrangements (rather than a representative of participants) the name of the applicant must also be included. Where those persons are corporations, list the corporation's name and address.

5. The applicant, in lodging a notification on behalf of others, must obtain their consent to do so and provide proof of that consent.

6. Where the target is a corporation, provide the corporate name.

7. The collective bargaining notification process is only available to parties that reasonably expect to make one or more contracts with the target about the supply or acquisition of goods or services the subject of the notification.

8. The value of the contract to be collectively negotiated between the target and each participant is not to exceed $3 million (or such other amount as is prescribed by the regulations) per participant in any twelve month period.

9. To the extent that the collective bargaining arrangements have been reduced to writing, provide a true copy of the arrangement. To the extent that the collective bargaining arrangements have not been reduced to writing, provide a full and correct description of the key terms that have not been reduced to writing.

10. In simple terms an exclusionary provision exists where the proposed contract, arrangement or understanding is made by businesses (at least two of whom are competitors) for the purpose of preventing, restricting or limiting the supply of services to particular persons or classes of persons by all or any of the parties to the contract, arrangement or understanding.

    In the context of collective bargaining, an exclusionary provision(s) may include contracts, arrangements or understandings (whether currently in existence or to be made or arrived at during the term of the notification) between collective bargaining participants to limit or restrict their dealings with the target including contracts arrangements or understandings to:

    (a) withhold the supply of goods or services from the target; or

    (b) refuse or decline to acquire the goods or services of the target;

    whether such conduct was absolute, limited or subject to certain terms or conditions. This is sometimes referred to as a collective boycott.

11. Provide details of the market(s) likely to be affected by the notified conduct, in particular having regard to goods or services that may be substitutes for the good or service that is the subject matter of the notification.

12. The notification must be signed by a person authorised by the applicant to do so.

Appendix A

This Appendix relates to Section B, 3(g) of Form GA.

The collective bargaining arrangement proposed is as follows:

1. Participants will nominate a group of up to seven medical practitioners who are each members of the collective ("**Reference Group**") to form a steering committee for negotiations.
2. Participants to be entitled to meet to collectively discuss (both with the AMA Victoria and without the AMA Victoria's involvement):
    i. Pricing
    ii. Rostering
        - The weekly, fortnightly or monthly hours for which participant are rostered to attend the Target
    iii. Provision of Out of Hours service
        - Hours in addition to rostered hours, including on-call (where a doctor is on standby to attend the Target outside the hours for which the doctor is rostered) and recall (where a Target requires an on-call doctor to attend the Target outside the hours for which the doctor is rostered)
    iv. Other conditions of engagement
        - Including employment terms relating to attendance by participants at meetings convened by the Target, Continuing Medical Education and facilities to which participants will have access.
3. AMA Victoria to negotiate with the Target with a view to finalising an Agreement as between the Participants and Target.
4. AMA Victoria, upon receiving approval of the Participants, to enter into agreement with the Target for three years.
5. The types of terms and conditions expected to be negotiated in collective bargaining negotiations include:
    i. Pricing
    ii. Rostering
    iii. Provision of Out of Hours service
    iv. Any other condition of engagement

    Please refer to Point 2 above for a detailed explanation of the terms and conditions referred to in this Point 5.

6. **Dispute Resolution Procedure**
    a. As between participants throughout the collective bargaining process

    Disputes between Participants will be resolved by:
    i. Referring the matter to the Reference Group for discussion

ii. Failing resolution at 6(a)(i), or in the case where the Reference Group is an inappropriate forum for discussion of the dispute (such as if the dispute involves a member or members of the Reference Group), the matter will be referred to AMA Victoria for mediation.

AMA Victoria notes that any Participant is entitled to opt out of collective negotiations should they choose to do so for any reason, including being unhappy with the resolution of a dispute between participants in the collective bargaining process.

b. As between participants and the Target throughout the collective bargaining process

AMA Victoria proposes that disputes between Participants and the Target will be resolved using the below Dispute Resolution Procedure.

i. Notice of Dispute will be served on the other party detailing the grounds for dispute and invoking the Dispute Resolution Procedure.
ii. If the dispute is between the Participants' Representative and the Target, the matter will be referred for discussions in good faith between the Target and Reference Group.

Should the dispute fail to be resolved by the above Dispute Resolution Procedure, we note that this arrangement is voluntary and each party and Participant has the right to withdraw individually and voluntarily from the collective process.

c. To deal with disputes throughout the term of the Agreement

Disputes throughout the term of the Agreement shall be:

i. Determined using the Dispute Resolution Procedure;
ii. Determined by consent to refer to arbitration should the dispute fail to be resolved by the Dispute Resolution Procedure; and
iii. Limited to the terms of the Agreement.

7. Opt out: It is important to note that the conduct being proposed is enhanced through the choice of both independent contractors to hospitals in rural and regional Victoria ("***Doctors***") and the Target to opt into and out of the process during the process.

Appendix B

This Appendix relates to Section C, 4 of Form GA.

In describing the market below, AMA Victoria is mindful of the broad approach taken by the Trade Practices Tribunal[1] and the general and accepted approach of the High Court of Australia in *Queensland Wire Industries*[2].

In the application of a broad definition of market, it is certainly open to the ACCC to determine that the market is in fact the market of provision of medical services in Victoria. Supporting this view is that many doctors travel throughout Victoria (whether engaging in fly-in fly-out practice or otherwise), and many hospitals in Victoria recruit doctors from across Victoria, Australia and the world.

The Participants are medical practitioners who provide the services described at 3(b) of this Form GA as Doctors to the Target. Doctors contracted to public hospitals are Specialists and general practitioners ("**GPs**") who develop specialist expertise (for example in obstetrics, minor surgery, emergency medicine and anaesthesia), and also private consultants.

There are a number of major factors to consider in relation to the nature of the service Doctors provide to rural and regional public hospitals:

1. Doctors in rural and regional areas generally provide service to public hospitals out of a sense of professional and ethical obligation. Although it is not disputed that there are professional and personal benefits arising from Doctors working in public hospitals, Doctors generally view such work as a public service, as the opportunity cost of providing that service is great. Specifically, Doctors generally receive less income for the time they spend treating public patients in public hospitals compared to that same time being devoted to their private practice. This is especially so in rural practice. Therefore, the service Doctors provide to their communities and patients should be viewed as partially "pro bono".
2. There is currently very little competition between Doctors in rural and regional areas due to high demand for medical practitioners in rural and regional communities. This view is neither likely nor projected to change in the short to medium term.
3. Medical practitioners providing services to public hospitals are required to operate together as a team in many respects. For example, peer review by one medical practitioner on other practitioners' practices is a positive requirement of many Doctor agreements, and in fact often forms a part of public hospital policy and accreditation procedure. This peer review is an example of a beneficial yet potentially powerful anti-competitive mechanism, in that a peer can influence his or her competitor's ability to perform certain procedures or operations.

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[1] E.g. Re *Tooth & Co Ltd* ATPR 40-113
Queensland Wire Industries Pty Ltd v *BHP* (1989) 167 CLR 177

4. It is well documented that rural and regional areas are under-resourced in relation to medical services. This has significant impact of rural and regional Doctors.

    a. *On-call care to the community*

    The demand on rural and regional Doctors to provide after hours and 24 hour on-call service to their communities is relentless. Medical practitioners are frequently required to be ready, willing and able to work on weekends, overnight and during personal and family time. Female medical practitioners in rural and regional areas often return to work under two weeks after giving birth due to the patient need for their services. An older medical workforce is providing the bulk of services in rural and regional areas (see Point 9 below), thus the impact of uncontrolled on-call demand cannot be under-estimated.

    b. *Time spent as Doctors to hospitals has a detrimental impact on private practice*

    It is a market reality in rural and regional areas that Doctors to public hospitals often provide their services at both personal and private patient expense. As rural and regional public hospitals are over-burdened, so to are the private practices of rural and regional GPs and specialists. Time spent providing service to hospitals is time which is either out of hours or time which would otherwise be spent with private patients, who obviously also have medical needs.

    Further, the imposition of on-call impacts medical practitioners' private practice, in that they are frequently required to attend public hospital patients in the middle of the night or on weekends, and return to private practice hours later, having had little time to rest.

5. Doctors in rural and regional areas often have a continual, personal and enduring relationship to their patients. That is, the patients they treat privately are very frequently the same patients they admit to, and treat in, hospital.
6. General Practitioners "who are usually private practitioners are an essential component of the small rural hospital workforce. The sustainability of rural hospitals and rural general practices are inevitably tied[3]." Further, General Practitioner "workforce shortages have significant impact on the delivery of rural hospital services"[4].

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[3] *Planning for 2012; Victorian Rural General Practice Workforce*, Rural Workforce Agency, Victoria, 2004, p42

[4] *Planning for 2012; Victorian Rural General Practice Workforce*, Rural Workforce Agency, Victoria, 2004, p42

7. Rural general practitioners play "a key role in the delivery of rural hospital services. Of all rural GPs, 35 per cent have procedural skills in obstetrics, general anaesthetics and surgery[5]."
8. "It is clear from the data that rural and regional hospitals have much more difficulty recruiting and retaining medical staff than their urban counterparts. This is due to a number of factors, including a smaller number of doctors willing to work in rural areas, higher workloads and fewer staff to cover them, less specialised services...[6]". Further, "lack of training opportunities also adversely affected a rural hospital's chances of attracting staff[7]".
9. Older general practitioners in rural areas carry a greater proportion of the workload. Where on average a rural GP works 51.6 hours per week, rural GPs over 55 years of age work on average 56.0 hours per week.[8]
10. The medical workforce generally takes a collaborative approach to patient care. This collaboration lies at the heart of quality health care and delivers better outcomes to patients.
11. The provision of medical services is inherently different from most other industries and professions. Competition is naturally stifled by the operation of state, federal and private insurance. Insurance and public hospital free service operates to underwrite all or a significant portion of the cost to a patient of medical consultations and interventions. Therefore, the difference in fees between competitor doctors is minimised, as is that competitive differentiator. This creates a disincentive for consumers to "shop around" on the basis of the price of medical services. Price therefore becomes significantly less of a factor in the medical services market than other markets. Rather, the doctor/patient relationship is characterised by trust[9].
12. There are many examples in the medical services market where the consequences of what could be potentially deemed anti-competitive behaviour have a clear and undisputed public interest (see point 7 above). For example, as Janes contends,[10] "there has been insufficient attention paid by either governments or regulatory bodies to the existence of "cluster" markets in the health sector. A "cluster" market is a market comprised of a group of related products or services which are supplied together, generally by one provider. For example, anaesthetic services are support services used in conjunction with other specialised services. To require the "unbundling" of these products or services could lead to transaction

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[5] *Planning for 2012; Victorian Rural General Practice Workforce*, Rural Workforce Agency, Victoria, 2004, p43

[6] Australian Medical Workforce Advisory Committee (2004), *The Public Hospital Workforce in Australia,* AMWAC Report 2004.3, Sydney, p56

[7] Australian Medical Workforce Advisory Committee (2004), *The Public Hospital Workforce in Australia,* AMWAC Report 2004.3, Sydney, p57

[8] *Planning for 2012; Victorian Rural General Practice Workforce*, Rural Workforce Agency, Victoria, 2004, p43

[9] *Competition policy: Consequences of restrictive trade practices and price-fixing provisions for medical practitioners in Australia and New Zealand,* Hanne Janes, (2006) 13 JLM 439

[10] *Competition policy: Consequences of restrictive trade practices and price-fixing provisions for medical practitioners in Australia and New Zealand,* Hanne Janes, (2006) 13 JLM 439

costs being incurred by consumers or diseconomies of scope for suppliers, which would then be reflected in the relative prices of bundled and unbundled services."

Specific Market Characteristics

I. Region

While we submit that the relevant market for the purpose of this notification is Victoria, it is informative to explore the local region in which the Target operations. That region is most effectively categorised at the South Gippsland region ("**Region**"). The Region is approximately 160 kilometres from Melbourne; approximately one hour, 45 minutes by car.

There are approximately 40 specialists and 220 general practitioners working in the Region. All Specialists in the Region work at hospitals in the Region, and approximately 20% of all general practitioners are appointed as Visiting Medical Officers in the Region.

The Gippsland Health Alliance, of which the Target is a member, provides a list of acute and primary care providers in the Region (and more broadly than the Region as defined)[11]. Many of these care givers offer specialised or limited services which are not particularly illuminating for the purpose of inclusion in this notification.

The relevant hospitals in the Region that patients could choose to attend instead of attending the Target are:

- Maryvale Private Hospital[12] ("**Maryvale**")

Maryvale is a private hospital offering a number of services including general surgery and day procedures. It is situated approximately 20 minutes drive from the Target. Maryvale has 45 acute beds. They are split approximately 25 medical, 20 surgical.

- Gippsland Southern Health Service[13] ("**Leongatha**")

Leongatha provides a comprehensive range of Specialist General, Acute, Aged and Residential, Allied Health and Community Services. It is situated approximately 60 minutes drive from the Target. Leongatha has 31 acute beds. The beds are allocated on a somewhat flexible basis. The best estimate Leongatha could provide is that they have 6 maternity beds, and 25 beds split between medical and surgical patients, depending on demand at any given time.

- Central Gippsland Health Service[14] ("**Sale**")

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[11] http://www.gha.net.au/
[12] http://www.maryvaleph.com.au/
[13] http://www.gha.net.au/gshs/
[14] http://www.salecommunity.com/hospital.html

Sale offers a comprehensive range of health services, including obstetrics and paediatrics. It is situated approximately 50 minutes drive from the Target. Sale has 62 acute beds. Sale was not in a position to provide a breakdown of its acute bed allocations.

- West Gippsland Healthcare Group[15] ("**Warragul**")

Warragul provides acute medical and surgical, obstetric, emergency, community and aged care services. It is situated approximately 60 minutes drive from the Target. Warragul has 77 acute beds. Warragul has 26 surgical beds, 6 paediatric beds, 17 maternity beds, 23 medical beds and 5 high dependency beds.

- Bairnsdale Regional Health Service[16] ("**Bairnsdale**")

Bairnsdale provides acute care, aged care , community and home based health services.

II. Target characteristics

The Target is a 158 acute bed public hospital located in Traralgon West. It offers a full suite of services including elective surgery, maternity, rehabilitation, aged care, cancer care and mental health.

The breakdown of acute beds at the Target is as follows:

Orthopaedics	20
Paediatrics	10
Maternity	26
Acute Medical & Surgical	26
Short Stay Unit - between 4 and 24 hours	4
Medical	26
Intensive Care	10
Day Surgery	18
Oncology	7
Renal Dialysis	7
Medical	4

The Target is a teaching hospital affiliated with the Monash University School of Rural Health, which is located on the Target's main campus. The Target cares for an immediate population of nearly 70,000 in the Latrobe Valley and, in conjunction with the region's other healthcare providers, over 240,000 across Gippsland[17].

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[15] http://www.gha.net.au/wghg/
[16] http://www.brhs.com.au
[17] http://www.lrh.com.au/corpinfo.html

Approximately sixty medical practitioners (specialists and general) are appointed to work as independent contractors at the Target.

Substitutes in the market

Substitutes to Doctors in the relevant market include:

1. Additional general practitioners in the Region

   Approximately 20% of general practitioners in the Region are appointed to the Target. Therefore, other general practitioners offer a market substitute.

2. Locums

   Locum services are regularly used by rural and regional hospitals to cover roster and resourcing shortfalls. Increasingly, locums are being relied upon as an integral part of the rural and regional medical workforce.

   This is the case in the Region, with locums regularly employed to work at the Target and in the Region.

3. Commercial recruiters of medical practitioners

   Commercial providers of medical services can be prevailed upon by hospitals in order to contractually oblige that commercial provider to ensure certain medical services are provided to the hospital.

4. Employees

   A further substitute in the market is the option for a Target to employ medical practitioners as employees to the hospital on a full-time, part-time or casual basis.

5. Federal Government funded Medical Specialist Outreach Assistance Program ("**MSOAP**") doctors

   The MSOAP is a national program funded by the Australian Government's Rural Health Strategy under the Rural Specialist Support Program. This program enables funding for specialists to supply services to rural hospitals on a "fly-in, fly-out" basis.

6. Health Services

   Victoria's public hospitals operate as a network with over 80 additional public hospitals. Further, health services are advanced by a significant number of private hospitals in the district.

Metropolitan hospitals regularly provide medical practitioners to rural and regional public hospitals to cover shortfalls in resources or expertise. Many rural and regional hospital medical practitioners (residents, registrars) are supplied by major teaching hospitals.

Similarly, there are countless examples of metropolitan hospitals providing specialist services to rural and regional areas. For example, many rural ophthalmic services are provided by the Royal Victorian Eye and Ear Hospital. Similarly, paediatric services are often provided through the Royal Children's Hospital, and cancer services provided through the Peter MacCallum Cancer Centre.

7. Day procedure centres

Day procedure centres provide another alternative to public hospital treatment.

8. Critically ill transferred to Melbourne hospitals

Notwithstanding the distance of the Target from Melbourne, critically ill patients are sometimes and can continue to be transferred to Melbourne's tertiary hospitals for treatment.

Appendix C

This Appendix relates to Section C, 5(a) of Form GA.

The consumer impact of the notified arrangements on pricing will be minimal. Certainly, due to the nature of the market, specifically Point 11, Appendix B, there is unlikely to be a pricing impact on consumers.

In relation to the affect of the notified conduct on pricing with regard to hospitals, AMA Victoria similarly submits that the impact would be minimal. Evidence and historical practice strongly suggest that collective bargaining engaged in by medical practitioners has not resulted in higher comparative remuneration than medical practitioners who negotiate independently. Rather, the benefit of collective negotiation has generally been in relation to non-price components of the relevant arrangements, mainly efficiency.

There are many examples to the support the above assertion. Medical Specialists employed in metropolitan and regional hospitals under collective employment agreements are paid a salary of up to $123 per hour. An initial consultation with a Medical Specialist in a rural hospital at 100% CMBS (Medicare) rates is $133.35, and it is reasonable to estimate that a rural Medical Specialist could conduct three such initial consultations per hour. This results in rural Medical Specialists receiving substantially higher remuneration in such circumstances than metropolitan Medical Specialists who negotiate as a collective.

Further, AMA Victoria submits that the budgetary restriction of a Target is by far the biggest determinative factor of wages for medical practitioners. Whether negotiation is on a collective or individual basis is irrelevant to this chief determinative factor, except that there are monetary savings for a hospital when dealing with medical practitioners as a collective.

Limitations on public detriment:

Limitations with respect to collective bargaining

1. Negotiating with Doctors as individuals

   An option available to the Target is to negotiate with Doctors individually, notwithstanding the right for Doctors to negotiate collectively with a Target. The ability for both Doctors and the Target to opt out of collective bargaining, or negotiate individually contemporaneously with collective negotiation is a major inhibiting factor limiting public detriment.

2. Voluntariness of notified conduct

AMA Victoria notes that, in accordance with the proposed collective bargaining arrangements (at Appendix A), the notified conduct is voluntary for both medical

practitioners and a Target. That is, a medical practitioner must opt-in as a party to collective bargaining, and may opt-out during the process.

Similarly, a Target may choose whether or not to negotiate with Doctors as a collective. The hospital has various other options and substitutes in place of dealing with a collective bargaining group.

3. Internal constraints on Doctors in the bargaining process

The pre-existing relationship rural and regional medical practitioners often have with patients is a crucial factor mitigating any potential detriments of allowing Doctors the power of collective bargaining. That is, notwithstanding how aggrieved a Doctor may feel with regard to the conduct or bargaining position of the Target, Doctors are always reluctant to engage in conduct which will negatively impact on their patients, reputation and standing in the community and their private practice.

4. External constraints on bargaining

A further constraint limiting the detriment of the proposed conduct is that Doctors have ethical and professional obligations with regard to patient care. Doctors are under an ethical obligation to provide assistance in any emergency situation[18]. The Medical Practitioners Board of Victoria periodically issues "Good Medical Practice – Guidelines on professional conduct" ("**Guidelines**"), which includes such obligations as "putting patients first" and Doctor "duty to protect all patients". Doctors are answerable to the Medical Practitioners Board for breaches of these Guidelines. These Guidelines act as an external monitor on Doctor behaviour towards the Target, patients and the general public.

[18] Refer to Medical Practitioners Board of Victoria policy at http://www.medicalboardvic.org.au/content.php?sec=34

Appendix D

This Appendix relates to Section C, 6 of Form GA.

The arrangement proposed in this Form GA brings with it substantial benefit to the public, patients and medical practitioners.

The ACCC has recently, in its Draft Determination to the Application for revocation and substitution of authorisation A90795 (11 April 2007)[19], accepted that certain "price setting arrangements and hospital agreements" are in the public benefit.

Collaboration

Collective negotiations promote collaboration by involving Doctors in the process of discussing their terms of engagement with a hospital. As described in Appendix B, collaboration in the medical profession leads to better outcomes for patients and the public. Better patient outcomes are indisputably of benefit to the public.

The Royal College of General Practitioners ("**RACGP**"), in its submissions in relation to A91024, provides examples of where collaboration between doctors has been actively promoted by the Australian Government (including National GP Collaboratives Program, PIP). AMA Victoria supports these submissions. Further, RACGP provides international evidence illustrating the better health outcomes attained through a collaborative approach. This data is relied upon in this application.

An additional public benefit of collaboration amongst medical practitioners is that it provides an open and inclusive forum in which medical practitioners can discuss common issues in a collegiate and facilitated manner. This type of discourse creates an environment of mutual responsibility, which has the effect of promoting retention of medical practitioners in rural areas. A salient example of this is the ability of a hospital (or, in fact, medical practitioners amongst themselves) to collectively discuss quality issues. There is a clear public benefit in this discourse being facilitated by collective negotiation of contractual terms thereby providing Doctors with a framework for discussing these issues. Currently, consistent quality is an issue which is not being addressed sufficiently in rural and regional areas[20].

The current state of the law creates an environment of confusion for medical practitioners. Doctors are often uncertain about which topics they are permitted to collectively discuss freely. For example, there is much confusion as to whether peer review constitutes a restrictive trade practice. In addition, some partners and some associates in a rural medical practice cannot collectively discuss remuneration, employees, yet partners and non-competing medical practitioners can freely discuss such matters. This notification would create certainty by diminishing the often artificial

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[19] Authorisation number A91024

[20] Australian Medical Workforce Advisory Committee (2004), *The Public Hospital Workforce in Australia,* AMWAC Report 2004.3, Sydney, p57

distinctions between categories of medical practitioners. That certainty is in the public benefit because it allows Doctors to cease acting in an overly conservative manner with regard to communicating with their colleagues. This openness facilitates greater teamwork and helps Doctors address common issues in the health system on a daily basis. These issues lie at the heart of better patient outcomes, because they include matters such as quality assurance, responsible and adequate rostering, and resource allocation.

Overall, collective negotiation can empower medical practitioners through the candour of the negotiation process. Considering the fundamental link between the number of GPs in the area and the ability of the Target to provide services in the area, initiative such as collective negotiation will ultimately lead to enhanced patient access to both primary care and specific services (e.g. anaesthesia, obstetrics and emergency surgery).

Often medical practitioners are attracted to rural and regional areas through discussion with their colleagues. Empowerment of medical practitioners in the area creates an environment which is more attractive to other medical practitioners. The inability to discuss engagement terms makes attracting medical practitioners even more difficult. Improvement in the attractiveness of medical practice in rural and regional areas is a major challenge[21] and clearly in the public interest.

Quality and Education

One of the major inhibiting factors to recruitment of medical practitioners in rural areas is the lack of educational opportunities and support (See point 8 of Appendix B) for less experienced medical practitioners. AMA Victoria submits that collective negotiations will increase the likelihood of consistent and more comprehensive training and education in rural public hospitals, due mainly to the ability of Doctors to collective negotiate appropriate structures and recognition of continuing medical education. Appropriate structures for continuing medical education includes negotiation of employment terms allocating to doctors specific time for professional development, attendance at conferences and possibly a sub-committee to identify the educational and developmental needs of Doctors and the Target. More effective and better recognised education and training enhances the attractiveness and the standard of rural medical practice. Enhancing the attractiveness of rural and regional medical practice will result in more medical practitioners choosing to practice in those areas, which will contribute to the effort to provide sufficient medical services to patients in rural and regional Victoria. Similarly, collective recognition of the community medical educational needs and the specific needs of each Doctor increases the knowledge and hence the standard of medical practice in rural and regional areas. This increased knowledge may result in additional medical services being offered to patients in the area and certainly brings increased medical expertise to the area.

Relationship with Hospital

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[21] *Planning for 2012; Victorian Rural General Practice Workforce*, Rural Workforce Agency, Victoria, 2004

As a consequence of the current bargaining framework (which AMA Victoria submits forms the counter-factual as detailed below), communication between the Target and the medical practitioners providing services to that hospital is sometimes strained. The fragmented dissemination of information to the collective breeds both uncertainty and suspicion. Further, medical practitioners suffer from inequality in their relative bargaining positions with the hospital. Medical practitioners are generally unskilled negotiators, and there exists potential for negotiations to become stalled, personal and emotion-charged. Further, compared to the hospital, medical practitioners have neither the time necessary to adequately self-represent nor the knowledge of the market. As such, there is significant and often realised potential for conflict and animosity between medical practitioners and hospitals.

Collective bargaining will therefore bring the benefit of rectifying the imbalance in negotiations and decreasing potential animosity and conflict between medical practitioners and hospitals.

Roster

As discussed with regard to education, training and quality issues, collaboration is a major benefit of collective bargaining. This public benefit relates also to the making of rosters and after-hours and on-call arrangements ("**Hours of Engagement**"). There is significant operational and public benefit to flow from the enhancement of the Hours of Engagement system. Most significantly, by better defining the Hours of Engagement, medical practitioners can have clarity about when they are on-call and when other Doctors are providing on-call and after hours service to the community. Just as importantly, a collective approach to defining the Hours of Engagement will allow a Doctor to know when he/she is **not** on-call. Currently, medical practitioners are often on-call indefinitely, which has enormous impact on their ability to disengage from work. The consequence of this status quo is that medical practitioners are often in a position of having to be "ready, willing and able" to be called in on extremely short notice. This impacts the personal and family life of medical practitioners, and ultimately their morale and the appeal of rural practice. It inhibits the ability of a medical practitioner to travel far from the Target, and places burden on all members of the household in which the medical practitioner lives. Collective discussion of Hours of Engagement, specifically which Doctors will provide roster, after hours and on-call support and *when* is in the public interest because it greatly assists the Doctors in reaching a balance between their private practice commitment to patients, the commitment to the Target and their private lives and ability to keep functioning day after day to the best of their ability.

For the above reasons, facilitating open discussion around Hours of Engagement brings additional public benefit of making rural practice more attractive to medical practitioners, leading to an enhanced likelihood of recruiting medical practitioner to rural areas and a greater likelihood of retention of medical practitioners in the area. This is especially so in light of the market reality that the medical workforce bearing the brunt of the medical resource shortage is an older workforce (as per Point 9, Appendix B).

Efficiency

As the ACCC accepted at 6.61 of A91024, it is likely there will be "some efficiency savings in administrative functions from agreeing on one price structure". AMA Victoria submits that this benefit is substantially greater in the context of this application.

Currently, Doctors must each individually negotiate their contracts of engagement. This laborious process repeats itself time and time again. AMA Victoria has extensive experience acting on behalf of Doctors in the current system. AMA Victoria estimates that, on average, each Doctor will spend approximately 8 – 9 hours of his or her time re-negotiating an existing (expiring) arrangement with a hospital, and significantly more time if the negotiation is for a new contract of engagement.

The efficiency gains to be expected from allowing, for example, a rural Doctor workforce to collectively negotiate are extremely significant. Those gains are both cost related and time related. The time being spent by medical practitioners engaged in this process would be time better spent treating patients, and the financial implications are similarly onerous.

Similarly, AMA Victoria estimates that a hospital engaged in the current process would spend at least an average of 12 hours of mainly CEO and senior executive time per Doctor.

Counter-factual

The ACCC must apply the "future-with-and-without test" to weigh the public benefit of this proposed arrangement against the public detriment (the "counter-factual"). AMA Victoria submits that the counter-factual in these circumstances will be that the market will continue to operate in substantially the same way it does currently. That is, Doctors will be required to negotiate individually with a hospital. Therefore, the current systemic inefficiencies would continue to operate.

Medical practitioners will continue to work collaboratively in private practice, including the provision to set intra-practice pricing (in some circumstances), whilst having to set up "Chinese walls" to protect certain information being made available to other medical practitioners with whom they work. A further disadvantage of the status quo remaining is that Doctors will be one of a diminishing class of medical practitioners unable to collectively negotiate with a hospital. Doctors who are hospital employees can negotiate collectively (or are subject to collectively negotiated terms of engagement). Further, medical practitioners in partnership arrangements and certain associateship arrangements can negotiate collectively (depending on the partnership/associateship structure).

Overall, for the market to continue operating in the same way is unsustainable in the medium to long term.