VHIA

Victorian Hospitals' Industrial Association
Level 1, 499 St Kilda Road Melbourne VIC 3004 ABN 77 538 927 547
T 03 9861 4000 F 03 9867 8540 www.vhia.com.au

24 September 2007

Ms. Isabelle Arnaud
Director, Adjudication
Australian Competition &
Consumer Commission
GPO Box 520
Melbourne Victoria 3001

Dear Ms. Arnaud

Re: <u>Collective bargaining notification CB00004 lodged by the Australian Medical Association (Vic) Pty Ltd on 17 September 2007 – interested party consultation</u>

The VHIA has received your letter dated 17 September and received in this office on 18 September 2007.

Our submissions in response will address the following:

1. Comment on the various assertions made by the Applicant in its Notification Form & Appendix A; and
2. An assessment of the benefits and detriments raised by the Notification.

We note that the Applicant has amended the Notification as a result of our correspondence in relation to its proposed dispute settlement procedure throughout the collective bargaining process. (See: Appendix A 6 (b)).

We submit that the application lacks merit in so far as it is general and non-specific, confusing in its approach to the market and generally unsubstantiated. The application also discusses modes of employment as a possible outcome of the bargaining process which in our view is totally inappropriate in the context of this application. Should the practitioners wish to become employees, the process is through ASMOF not the AMA. Should they remain as contractors, the application can be considered on its merits.

Regardless of our considerable reservations, the Target is prepared to support this application in the context that the AMA recognizes, as attested to in their application, that the budgetary restriction of the Target is by far the biggest determinative factor of remuneration for medical practitioners.

We would happy to augment this submission by verbal submission or by way of explanation.

Yours sincerely
<u>VICTORIAN HOSPITALS' INDUSTRIAL ASSOCIATION</u>

I. M. Oostermeyer

VHIA

VICTORIAN HOSPITALS'
INDUSTRIAL ASSOCIATION

ABN 77 538 927 547

Level 1 499 St Kilda Road
Melbourne Vic 3004
Tel (03) 9861 4000
Fax (03) 9867 8540
Email vhia@vhia.com.au
Website www.vhia.com.au

SUBMISSION IN RESPONSE TO THE AMA APPLICATION

PART 1 Comments on Notification Form, Appendix A, and B

Comment on the responses - Notification Form

1. By way of introduction, the application is made in the name of the AMA (Vic) Pty Ltd. It is apparent from the legislation that trade unions or an officer of a trade union cannot make the application. For the record, the target raises the issue of the "degree of separation" between ASMOF and the Australian Medical Association. It is a matter for the record that certain officers of the AMA are also office holders of ASMOF, which is a registered trade union.

2. The target acknowledges that ASMOF can only act in accordance with its rules, which by definition are not independent contractors such as those listed in the application. Nevertheless, as far as collective bargaining is concerned, employees readily come to mind. It seems that the application and the legislation is in two minds, almost schizophrenic. Collective bargaining is about seeking strength in the collective, whereas independent contractors place themselves by choice in the market.

3. It is not apparent from the list of names on whose behalf the notification is lodged as to which craft groups the individual Medical Practitioners belong. As will be pointed out, it is not sufficient to state that they supply the full range of medical services to the target (See: Section B 3 (b)). The market position of different craft groups can be radically different.

4. This relates to the response provided in Section B 3 (h) as well. That is, medical practitioners have never collectively agreed to fees and prices across craft groups per se as distinct from within craft groups. This applies in particular to Specialists rather than General Practitioners. Medical Practitioners as such apart from GP's do not have a particular interest in the fee or price structure of colleagues outside of their particular area of expertise.

Comments on Appendix A

5. Rostering and out of hours service is an issue that will be raised in our assessment of the Application as being of a vastly different dimension to that of pricing.

6. The issue of other conditions of engagement is raised, "including employment terms relating to attendance by participants at meetings covered by the Target, Continuing Medical Education and facilities to which participants will have access." (See Item 2 (iv) and Item 5 (iv). From the aforementioned, it is apparent that the application may seek as one outcome a mixed model of employment and contractor. Such a model is confusing, and a decision should be made whether the application is one by contractors as contractors or by contractors wishing to be employees. If it is the latter, we submit this application is redundant.

7. With regard to Item 6 (c) the Applicant has amended its draft application, which was received by the target and removed any reference to arbitration or third party decision making through the collective bargaining process. Such provisions were deemed to be inappropriate during the process. The target does not have a similar problem with the dealing of disputes throughout the term of the agreement.

8. In Item 7 of Appendix A, it seems to be proposed that the parties can "opt out" during the process. Given the underlying rationale for collective bargaining advanced by AMA, the proposed capacity to "opt out" during negotiations introduces an inherent instability in the proposed process that may be at odds with the Targets interests. Opting out is cautiously accepted provided that once agreement is reached such an "opt out" proposal is not accepted unless it occurs within and in accordance with the terms of the Agreement.

Comments on Appendix B

9. In our view, it is not open to the ACCC to determine that "the market is in fact the market of provision of medical services in Victoria." This is an assertion that does not stand close examination. In our view there are a number of markets in operation within Victoria. For example there is the metropolitan market; the large regional centres' market and the smaller rural localities market. Furthermore there is a market for particular medical specialties as well as a market for General Practitioners. To assert that the market is all of Victoria is singularly unhelpful, and inaccurate.

10. This assertion also fundamentally misunderstands the market. For example, the dominant mode of engagement in Metropolitan Melbourne is one of employment and a predominance of Specialists, Registrars and Hospital Medical Officers. In large rural communities, the base hospitals engage Specialists as both employees or sessionals, and infrequently on a fee for service basis. Whereas the smaller communities rely almost entirely on General Practitioners some of whom have highly developed procedural skills, all engaged on a fee for service basis as contractors with some notable exceptions.

11. Equally inaccurate is the statement that “public hospitals contract Specialists and general practitioners.” This, as stated above is a general statement, which is not helpful to the facts. GP’s as understood by the Public and actually as noted in the Appendix are not generally employed or engaged by metropolitan hospitals or large rural hospitals. GP’s are medical practitioners that provide general medical services to the public outside of hospitals or in community health organizations. They are understood to be medical practitioners in “general practice”. They are not HMO’s or Registrars.

12. The assertion that Medical Practitioners supply services to Public Hospitals out of a sense of professional; and ethical obligation is only part of the story. Equally to assert that the opportunity costs are significant in that their earning capacity is greater in private practice is another distortion. Medical Practitioners in hospitals supply services for many different reasons. We do not wish to speculate on these reasons, but some of those relate to opportunities for teaching and learning, having access to a wide spectrum of patients, being able to do procedures – both complex and simple, and access to colleagues and peer review. The AMA application in part lends support to the alternative reasons cited.

13. The emphasis on Private Practice is also confusing in that Specialists and GP’s run differently and their overhead costs are significantly different. Hence the opportunity costs vary between medical practitioners. Equally it is true to assert that Specialists need Hospitals. They need them to practice their craft. The same can be said of GP proceduralists. Hence opportunity costs are largely irrelevant in such cases. It is equally absurd to assert that “ services Doctors provide … should be viewed as partially “pro bono”.” There is no evidence provided on the income levels of Specialists or GP’s derived from Hospitals. There is no doubt that this varies significantly between the craft groups and between GP’s. The reasons are simple, the market and the demand varies between the rural communities and the metropolitan regions.

14. Equally, the assertion that there is little competition between Doctors in rural areas is unhelpful. If this were so, the “opt out” provision would be redundant to the AMA’s interests. The facts are that there are a number of regional centers that have sufficient doctors to provide services to the community and the hospital. The problem is that some medical practitioners elect to not supply such services to the hospital and/or provide such services only during specified times. In most of these cases they are “life-style” choices rather than the high demand for medical practitioners.

15. The assertion that peer review and accreditation procedures are somehow related to “powerful anti-competitive mechanisms” appears to be far fetched and misconstrues their purpose. Peer review may or may not occur. Accreditation is a once every 3 – 5 years exercise. The instances where accreditation is withdrawn or restricted are not widely known and occur very infrequently. Where it does occur, it is usually for very serious matters, or related to non-clinical issues.

16. No further comment will be made at this stage on the many similar assertions in Item 4 (a) and (b). Its relevance is also questionable in terms of this application. It is not apparent which if any of the factors cited – without any evidence – is relevant to the application under consideration. Similarly, the information provided and used in Item 5 – 10 is next to useless as it may or may not be applicable to the medical practitioners who are part of this application. Even if the quoted "facts" are relevant, it is not apparent as to how or in what way this supports or lends weight to the application. It seems that the argument made out in the application is that: ***"Medical Practitioners serve the public out of their own pocket and are rare overworked species in rural areas, and therefore they should be able to combine and bargain collectively?"***

17. To state in Item 11 that price is a "significantly less of a factor in medical services market than other markets" is an over simplification. The existence of waiting lists is in part a matter of price and access. What can be asserted is that price may not be as severe an inhibitor to competition as it might be in other markets. The relationship of trust is based on competence and necessity rather than price. One is certainly no substitute for the other.

18. Equally, the assertion or quote relating to "cluster markets" in Item 12 is not helpful. For example anaesthetic services are paid for usually per RVU in the case of contractors. This service is provided by either a Specialist or a GP Proceduralist. In most contracts, both receive the same dollars for the service provided despite a difference in qualifications and possibly skills.

19. No comments will be made on market characteristics in terms of what constitutes the Southern Gippsland region. However, we would submit that no conclusions can be drawn from this material in terms of this application. The contracts applicable to each of these facilities are different. The medical workforce and its profile available to each of these facilities is different. The reasons why patients attend one hospital rather than another is dependant a number of factors, including location, medical practitioner, procedure required, access, insurance, urgency etc.

20. Similarly the items dealing with "substitutes in the market" are mostly irrelevant. General Practitioners do not normally operate across the Gippsland or South Gippsland market. One large Health Service, for example, has been unable to find substitute medical practitioners to continue to supply after hours services to the Hospital. This is despite the highest payments in Victoria being made to the medical practitioners supplying after hours services to the Hospital. To state that there are substitutes in the region as asserted is flying in the face of facts. This issue is not restricted to Gippsland.

21. The assertions in the section on “substitutes in the market” are not necessarily incorrect per se, they are simply irrelevant to the application at hand since a case has to be made out which applies these assertions to the issue at hand and the application itself. Their relevance is seriously questioned.

PART TWO Assessment of Detriments & Benefits

22. In part the assessment of detriments is taken up by the comments above relating to the assertions made by the Applicant in the Notification itself and the attached Appendix A and Appendix B.

23. The consumer impact of the notified arrangements on pricing is difficult to assess. This will depend entirely on the outcome of the negotiations which will follow this application. It will also depend on how the market for medical services is in fact viewed. The market is a vague concept. It is a concept that cannot be viewed in theory or in a vacuum. It is difficult to pin down. Everyone is aware of certain shortages of medical practitioners in some rural areas. The impact of this shortage on the price structure is difficult to estimate. What we do know is that costs of medical services has increased substantially. The reasons for this may only be partially related to the so called market and the shortage of practitioners. In a sense to permit them to bargain collectively as contractors can only have one outcome; An increase in the price that might be greater than if derived from individual negotiations.

24. The sole purpose to combine is to increase the price, there would be no other substantive reason, unless it is solely based on efficiency. But even if it were, efficiency and price increases are not mutually exclusive. To combine and increase the price is super efficient in terms of the applicant. Costs to the participants are kept to a minimum. In a sense, the answer to this application should be that if contractors want to combine why should they not be regarded as employees? Certainly as employees, the price could come down as is evidenced in the AMA submission in Appendix G. Instead the attempt here is to have it both ways. Not just by wanting to combine but also to open the negotiations in such a way that a mixed model could be the outcome whereby medical practitioners are contractors for one part and employee on the other.

25. To assert, as the AMA does in this Appendix G that collective bargaining engaged by medical practitioners has not resulted in better outcomes for those who negotiate independently is to ignore the differentiation between the employed medical practitioner and the contractor. The facts are, as attested by the AMA, is that the fee for service medical practitioners are rewarded much more generously than their counterparts who are employed as either full-time or fractional/sessional medical practitioners. In other words, the “fee for service” doctor receives better financial rewards – according to the AMA, three times better – than his counterpart in employment.

26. Add to this factor the additional power to bargain collectively on fee for service arrangements and the outcome would be an even further increase in prices.

27. Given the above, the public detriment is significant. This is in part due to the hybrid nature of the application. Contractors and collective bargaining and a scarce resource do not make for great bedfellows in terms of the public interest.

28. The major mitigating factor in this application, one that is non-debatable is the admission by the AMA that, and this is worth quoting in full:

" 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."

29. If this is the major determinant and accepted by the AMA then the target would accede to this application immediately. In other words, collective bargaining will save money because, instead of dealing with multiples, the target is dealing with one collective. Moreover the Applicant appears to accept that the budget of the Target is the major determinant and therefore increases in price, in the AMA's submission, will be offset with greater efficiency.

30. The above, if accepted at face value, and the negotiations would genuinely accept these perimeters; the target's objection to this application would largely dissipate.

31. The AMA further submits that the detriment are mitigated by the following factors:

- Capacity to opt out for individuals;
- Capacity for non-participation or effectively "opting in."
- Internal constraints such as patient care; and
- External Constraints.

32. All of the above are debatable mitigating factors. That is, the capacity to opt out or opt in may take away the value of the process in terms of efficiency. Should the parties opt out and opt in at various times, it will be an inefficient way of negotiating and may well be used as a negotiating tactic to apply more pressure on the Target. Negotiations are predicated on the parties being prepared to reach agreement. They should not be set up to fail. Although the voluntarism in this case is commendable, the strength of the collective bargaining process is considerably undermined if any of the parties can just walk away. This appears to indicate a lack of commitment. It is also, we submit, the antithesis of collective bargaining.

33. In terms of the internal and external restraints, we submit that the patient doctor relationship is extremely strong, but at the end of the day all the patients in the hospital, the majority of which are public patients are the responsibility of the Hospital, not the medical practitioner. On that basis, the medical practitioner can and does walk away. In addition the external guidelines as published by the AMA relating to professional conduct are useful, but not necessarily of prime importance in this application and in terms of mitigating the public detriment.

34. The alleged benefits of collective bargaining are stated as being the following:

- Leads to better outcomes for patients and the public;
- Collaborative approach between doctors leads to better outcomes;
- Promotes retention and collegiality;
- Promotes certainty;
- Empowers medical practitioners;
- Leads to quality and education becoming more widespread;
- Improves relationships with the Hospital and rectify the imbalance as well as provide adequate knowledge of the market;
- Define the Hours of Engagement;
- Greater efficiency in terms of time spend negotiating; and
- Extending the right to all medical practitioners, not just employees.

35. All of the above claims can contested. The assertions are loosely argued, and lack substance. There is little doubt, for example, that collaborative approaches by doctors can aid and abed better care for patients. The problem however is to make the same claim for collective bargaining. To extend the benefits of collaboration in the clinical field to collective bargaining on the price applicable to procedures and consultations is far fetched. Practitioners do not form a collegiate as such. They might be members of a profession, but they also compete in the market place. Thos that are contractors, especially GP's are small business persons, not just professionals. The same applies to other professions such as lawyers. Collegiality operates at certain level, not when it involves price for independent contractors.

36. The collegiality approach is also a perversion of the facts. The market for medical practitioners is specific and dependent on the region, the type of hospitals and health facilities available and the location. For example it is much easier to obtain medical services closer to Melbourne and within and around large rural cities. This is evidenced also by the price and fee structure. There is a significant price differential between employed medical practitioners and "fee for service" doctors. There is also a significant price differential between various employers/hospitals. The CMBS prices vary between 100% CMBS to 130% CMBS.

The price for anaesthetic units also varies greatly. The use of “fee for service” doctors is largely restricted to the smaller base hospitals and rural hospitals.

37. The issue of CME or professional education as being fostered by collective bargaining is simply an attempt to flow on to medical practitioners on fee for service agreements to obtain the benefits available to employed doctors. The benefits of the Heads of Agreement between the VHIA/DHS and the AMA for employed doctors have never been available to contractors. Education and self improvement is their responsibility. Hospitals do not receive funding for CME of their non-employed doctors. Such an attempt, if successful would or could substantially add to the cost of engaging medical practitioners.

38. The assertion that collective bargaining is likely to lead to enhanced patient access to services is without foundation. There is no doubt that the relationship between the Hospital and its medical staff should be close and productive. However it cannot be argued that such a relationship through collective bargaining will enhance service delivery. Should that be the case, there would be plenty of evidence in those hospitals where collective bargaining occurs. Collegiality and productivity would be at an all time high.

39. The strain in relationships between Hospitals and medical practitioners where it is a problem, is largely due to historical factors. It has little or nothing to do with the fact that contractors could not combine to set the price. Relationships are people dependant and as such are always at risk when the parties cannot agree. At least the strain in the relationship if due to the current negotiation process is limited to individuals and the hospitals. In a collective bargaining situation such strains would apply to the collective and hence could become problematic.

40. To also claim, as does the submission, that medical practitioners do not have the knowledge of the market is mischievous and simply incorrect. Firstly the AMA makes the medical practitioners aware of the so called range of prices in the market and as stated by the AMA, the medical practitioners do have a network, albeit informal, which consist in part of information relating to what happens elsewhere in terms of pricing. It is simply a fact of the negotiation process that medical practitioners and the AMA (in cases where it represents the Practitioner) refer to prices elsewhere. It is also a fact, that the outcomes of the current negotiations are not relevant to prices paid elsewhere. As stated, the differences in the contracted prices are significant.

41. The issue of rostering is of particular interest. The ACCC has noted that *“Rosters are an integral part of delivering health care to the community, especially in rural and regional Australia.”* (G. Samuel/ACCC). The issue of out of hours service to hospitals in the rural sector is at risk. The facts are that there is an emerging trend in rural Victoria to both increase the price of after hour services and/or withdraw from supplying such services entirely.

That is, in a number of locations, medical practitioner are prepared to provide services to in-patients, but are not prepared to deliver such services to out patients after hours. The structure of A & E services supplied by rural hospitals and medical practitioners on a fee for service basis is at risk.

42. In the majority of cases it is an obligation under the contract for the medical practitioner to be available for on-call after hour services. It is usually a condition, which flows from the credentialing of the medical practitioner at the hospital. That is, the appointment that follows, includes a condition that specifies that on-call includes being part of an after hours roster. In the case of the Target, this may not be an issue as it employs a number of doctors that provide such services.

43. In this case, as in most of the submission, the AMA makes assertions about rural medical practice in general rather than apply its assertions i to their application. The target is simply not like a number of other hospitals. In fact, in many ways it is unique. Apart from the fact that collective bargaining will not necessarily improve or enhance rostering.

44. The roster issue is a live issue for rural Victorian communities. Without commenting on this further, we submit that this matter is not necessarily the same in the case of the target.

45. The issue of efficiency in terms of time savings is inaccurate at best. The usual way the contract negotiations occur at the target is by the target sending out their offer to individual doctors and the doctors, without much further ado, executing the individual contracts.

46. The argument or assertion that “for the market to operate in the same way is unsustainable in the medium to long term” is simplistic in the extreme. Given the fundamental misunderstanding of the market in this application, and given the generalities relied upon and their general in-applicability to the target under consideration in this application, it is likely that the detriments of collective bargaining will in this case outweigh the benefits

47. In concluding however, provided that the bargaining takes place in the context of the recognition and acceptance by the AMA that the biggest determinative factor of wages is the budgetary restriction of the Target (asserted by the AMA in its application), the benefits may outweigh the detriments.

25 September 2007