Department of Human Services

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OUR REF:

YOUR REF:

Your ref: CB00004

28 September 2007

Ms Isabelle Arnaud
Director, Adjudication
Austuralian Competition and Consumer Commission
GPO Box 3131
Canberra ACT 2601
By fax (02) 6243 1211

Dear Ms Arnaud

Collective bargaining notification CB0004 lodged by the Australian Medical Association (Vic) Pty Ltd on 17 September 2007 - interested party consultation

I refer to your letter of 17 September 2007 inviting the Department of Human Services (**DHS**) to make a submission on the collective bargaining notice (**Notice**) lodged by the Australian Medical Association (**AMA**). The Notice was lodged by the AMA on behalf of a group of medical practitioners proposing to collectively negotiate their conditions of engagement with Latrobe Regional Hospital (**Latrobe Hospital**) in Victoria.

DHS provides the following submission in respect of the Notice. For the reasons set out in this submission, DHS considers that the public benefits of the collective bargaining arrangement proposed in the Notice (**Proposed Arrangement**) are negligible and would not outweigh the considerable public detriments of the Proposed Arrangement. Accordingly, the ACCC should object to the Notice.

Market Definition

In Appendix B of the Notice, the AMA describes the relevant market as the market for the provision of medical services in Victoria.

In DHS's opinion, there are a number of distinct markets for different craft groups. There is only limited potential for substitution between doctors in different craft groups, e.g. GPs are not substitutes for surgeons. Currently different payment rates apply to different craft groups based on a percentage of the Commonwealth Medicare Benefits Schedule (**CMBS**). In fact the CMBS attributes different values to similar activities for different craft groups. This reflects the different markets across craft groups.

Victoria

These markets for different craft groups may have different geographic boundaries. For example, the craft groups which provide time critical services, such as emergency and critical care services, are likely to principally service the local region surrounding Latrobe Hospital, whereas the craft groups which provide less time critical services, such as elective surgical services may, to some extent, service both regional and metropolitan areas (collectively, the **Markets**).

The differences in fees earned by medical practitioners employed in metropolitan and regional hospitals, such as Latrobe Hospital, means that the metropolitan and regional markets are necessarily distinct. Non-full-time medical practitioners who work in metropolitan hospitals almost invariably are paid on a sessional basis, whereas non-full-time practitioners servicing regional areas almost invariably are paid on a fee for service basis. This means that metropolitan medical practitioners are generally paid less than those that service regional areas.

In addition, the majority of the medical practitioners on behalf of whom the Notice is lodged reside in the local region surrounding the Latrobe Regional Hospital (refer to Section A, 2(a) of the Notice) (**Participating Practitioners**). This further indicates that there is a distinct regional market in which Latrobe Hospital operates.

DHS also observes that due to the geography of the region, very few doctors would service both Latrobe Hospital and Gippsland Southern Health Care Service.

Public Detriments

The AMA does not set out in the Notice how it proposes that the collective negotiations will operate in practice. As a result, it is difficult to comment on the benefits and detriments that are likely to flow from the Proposed Arrangement.
DHS considers that there are at least two possible ways in which collective negotiations under the Proposed Arrangement will proceed:

1 discrete negotiations will be conducted for each particular craft group; or

2 negotiations will be conducted collectively for all craft groups, for example to set a common percentage rate of the CMBS specified amount[1], and/or to obtain a percentage price increase that will apply for all craft groups.

In either case, DHS submits that the collective negotiations will have an anticompetitive effect.

In the first case, the collective negotiations will eliminate the competitive tension that currently exists between the medical practitioners in the distinct craft groups. While there is a restricted level of supply in the Markets and a high level of demand on the part of hospitals/patients in the Markets, this does not mean that there is currently no competition between medical practitioners within particular craft groups in the Markets. This competitive tension will be eliminated where discrete negotiations for terms and conditions are conducted for each craft group.

In the second case, in addition to eliminating the competitive tension that exists between the medical practitioners in the distinct craft groups, the bargaining power held by those craft groups containing a

[1] Presently, the CMBS specifies different amounts payable for doctors in the different craft groups and, in addition, further differentiation in the rates received by doctors in different craft groups is effected by payment of a different percentage rate of the CMBS specified amount for different craft groups (e.g. one craft group may be paid 100% of the CMBS specified amount for that craft group for an activity and another craft group may be paid 105% of the CMBS specified amount for that other craft group for that activity). Under a collective negotiation for all craft groups, the latter form of differentiation in payments rates for different craft groups may be eliminated (e.g. all craft groups may be paid 105% of the CMBS specified amount for their respective craft groups for an activity).

lower number of doctors servicing the region and/or those which provide essential emergency services, and thus doctors possessing a substantial degree of market power, would be leveraged to achieve higher fees for those craft groups that have a higher number of doctors servicing the region and/or provide predominantly elective services than would otherwise result where terms and conditions are negotiated individually.

Further, since there is a degree of substitution possible between particular craft groups (for example between general practitioner obstetricians and specialist obstetricians and/or specialist anaesthetists), this competitive tension will be lost in a collective negotiation scenario.

This reduction in competitive tension will in turn lead to the following public detriments in either case:

- an increase in the price that Latrobe Hospital is required to pay for services provided by the Participating Practitioners;

- Latrobe Hospital being faced with the potential to lose at the same time all of the Participating Practitioners under the second case, or all of the Participating Practitioners in particular craft groups under the first case, if collective negotiations fail. If the Hospital were to lose all of the Participating Practitioners it would be forced to suspend services, causing a major public health risk for the Gippsland Region. The Hospital does not face this risk under the current system where medical staff appointments are negotiated individually with the Hospital; and

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

While AMA contends in Appendix B that there are there are a number of 'substitutes' for doctors servicing Latrobe Hospital that will presumably offset any detriment caused if collective negotiations break down, DHS observes:

- general practitioners in the Gippsland region not currently working at Latrobe Hospital do not offer a market substitute because most of those general practitioners are distributed geographically throughout the region and many are working at other hospitals in the region;

- locums are not a substitute for doctors who reside locally and have an ongoing appointment at a hospital. We believe that because locums are unfamiliar with hospital systems and provide a 'stop-gap' clinical service only, such an arrangement substantially increases clinical risk and results in a lack of essential clinical leadership in areas such as safety and quality of care. A hospital cannot construct a service around locums;

- the assistance provided by the Medical Specialist Outreach Assistance Program is not a substitute for local doctors in the area of emergency services. Doctors who are supported by this program provide itinerant elective services only;

- while metropolitan hospitals may provide medical practitioners to rural and regional public hospitals to cover shortfalls in resources or expertise or for specialist services, this is an unusual arrangement and is not a substitute for doctors who reside in the area and provide essential emergency services;

- day procedure centres are not a substitute for services provided in acute hospitals. They provide elective, short stay services only and unless they are publicly-run there is a considerable cost barrier to many patients, particularly those who are uninsured; and

- transferring critically ill patients to Melbourne hospitals is required for some patients when services are not able to be supported in the local region, but designing the service system around inter-hospital transfer of critically ill patients would substantially diminish services to the community and cause significant public detriment. The care of many individual patients would be seriously compromised under such an arrangement. Patients would still require local medical support for stabilisation prior to transfer.

We envisage that if negotiations break down under the Proposed Arrangement, there would be a risk that the Latrobe Hospital would lose the services of a large proportion of its medical staff at one time. Given the absence of adequate 'substitutes' for the services of doctors currently servicing the Latrobe Hospital, this would result in a major health crisis in the region.

While Latrobe Hospital has the ability to opt out of collective negotiations and negotiate with doctors individually, the Proposed Arrangement puts pressure on Latrobe Hospital to participate in collective negotiations. If Latrobe Hospital were to opt out of collective negotiations, Latrobe Hospital could not exercise its ability to opt out with confidence that there would be no adverse consequences for its ability to secure adequate medical practitioners (both the required mix of specialisations and number of medical practitioners).

DHS observes that in describing the region in which Latrobe Hospital operates, AMA asserts that patients could choose to attend a number of hospitals instead of Latrobe Hospital (namely Maryland Private Hospital, Gippsland Southern Health Service, Central Gippsland Health Service, West Gippsland Healthcare Group and Bairnsdale Regional Health Service). In fact the other hospitals do not provide the range of services provided by Latrobe Hospital and it is not practical for many patients to travel to those other hospitals for medical attention in the event that the services offered by Latrobe Hospital are suspended or contracted. Maryvale Private Hospital is only accessible to persons with sufficient economic means to purchase health insurance or pay significant out-of-pocket expenses. There are significant geographic and transport barriers to patients travelling to Gippsland Southern Health Service. In reality, most patients would be required to travel to Melbourne to receive medical services if they could not access them locally.

In addition, DHS submits that this Notice is likely to be the first in a series of similar notices to be lodged by the AMA in respect of different target hospitals. The public detriment that would result if the ACCC were not to object to this Notice and following notices would be immense. For example, if each hospital in the local region surrounding Latrobe Hospital were to be subject to a collective bargaining arrangement, then competition between medical practitioners in that region would be eliminated. As a result, each of the hospitals in the region might have to contract its elective services, forcing patients to travel even further for those services and medical practitioners that provide those services to relocate.

Public Benefits

In Appendix D of the Notice, the AMA refers to the public benefits that it considers will flow from the Proposed Arrangement.
DHS submits that there is no substance to the public benefits that the AMA asserts will flow from the Proposed Arrangement. Further, there is no reason that the following public benefits asserted by the AMA could not be achieved in the absence of collective negotiations:

- public benefits flowing from the collaboration between medical practitioners and hospitals and medical practitioners facilitated by the Proposed Arrangement;

- public benefits flowing from an increased likelihood under the Proposed Arrangement of consistent and more comprehensive training and education in rural public hospitals; and

- public benefits flowing from the Proposed Arrangement's facilitation of collective discussion of 'Hours of Engagement' and the roster. The ACCC will be aware of its statement in its

publication, 'Medical Rosters': ACCC Info Kit for the Medical Profession, 2004, p8, that a medical roster developed to facilitate patient access to medical services will not raise competition issues under the *Trade Practices Act* 1974.

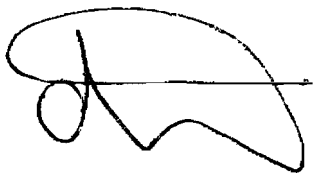
As these benefits are negligible and could be achieved in the absence of the Proposed Arrangement, the ACCC should not take them into account in assessing whether the public benefits of the Arrangement outweigh the public detriments.

AMA also asserts that the Proposed Arrangement will rectify the imbalance in negotiations between medical practitioners and hospitals. DHS observes that given the shortage of supply of doctors particularly in regional and rural areas, doctors have strong bargaining power in their negotiations with hospitals. Accordingly, DHS disputes that medical practitioners currently suffer from inequality in their bargaining position with hospitals.

Finally, while DHS accepts that the Proposed Arrangement may result in some efficiency savings in administrative functions, DHS observes that AMA's estimate that on average doctors spend approximately 8-9 hours of their time re-negotiating an existing agreement with a hospital is highly over-stated. In addition, DHS disputes that any efficiency savings flowing from the Proposed Arrangement are 'extremely significant' as alleged by the AMA. Any public benefit flowing from these efficiency savings would not outweigh the considerable public detriment that will result from the Proposed Arrangement.

Please contact me if you wish to discuss these issues further.

Yours sincerely



Dr C W Brook
Executive Director
Rural and Regional Health and Aged Care services

cc. Fran Thorn, Secretary
Lance Wallace, Executive Director, Metropolitan health and Aged Care Services
Peter Allen, Executive Director, Policy and Strategic Projects