27 September 2007

General Manager
Adjudication Branch
Australian Competition and Consumer Commission
GPO Box 3131
CANBERRA ACT 2601

By email: adjudication@accc.gov.au

Dear Sir/Madam

Collective Bargaining Notification CB00004 lodged by the Australian Medical Association (Vic) Pty Limited on 17 September 2007 – Interested Party Consultation

Submission of the Australian Healthcare and Hospital Association (*AHHA*)

We refer to your letter of 17 September 2007.

Please find attached our submission in relation to the above Collective Bargaining Notification.

Should you have any questions regarding this submission, please contact me on (02) 6162 0780 or Alison Choy Flannigan, Partner Ebsworth & Ebsworth Lawyers on (02) 9234 2389.

Yours faithfully

Prue Power
Executive Director
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Collective Bargaining Notification CB00004
lodged by the Australian Medical Association (Vic) Pty Limited
on 17 September 2007

Interested Party Consultation

Submission of the Australian Healthcare and Hospitals Association

We refer to the letter from the Australian Competition and Consumer Commission dated 17 September 2007, and thank you for the opportunity to provide comments in relation to the Collective Bargaining Notification CB00004 lodged by the Australian Medical Association (Vic) Pty Limited on 17 September 2007 concerning Latrobe Regional Hospital in Latrobe City, Victoria (***Notification***).

The Australian Healthcare and Hospitals Association (formerly known as the Australian Healthcare Association) (***AHHA***) is the only national industry body representing the public health sector including hospitals, aged and extended care facilities, community health centres and primary health services, at area and regional and district levels.

This submission is a general submission on behalf of the AHHA and may not reflect the specific views of Latrobe.

We believe that this notification may be the first of a series of notifications by the AMA (whose various divisions represent medical practitioners across the nation). If this is the case, then it is important to note that different States and regions within States operate under different health budgets and each Notification must be determined with budgetary and localised factors in mind.

1. Executive Summary

In AHHA's view there are both advantages and disadvantages of the collective bargaining arrangements proposed under the Notification.

1.1 Advantages

The advantages include:

(a) "economies of scale" for hospitals in being able to negotiate with a number of medical practitioners at the same time;

(b) improvement of information; and

(c) the associated savings in administrative time and cost for the hospital.

The AHHA agrees with the implementation of arrangements to make the negotiation process for practitioners and health facilities more efficient.

1.2 Disadvantages

However, the AHHA has serious concerns where the following occurs:

(a) in the event that negotiations breakdown; or

(b) if there are subsequent disputes in relation to the performance of the collectively bargained agreement;

where:

(c) the participating medical practitioners collectively boycott the public hospital (whether it is in relation to boycotting services to the public hospital completely, or whether in relation to certain aspects of the service provision such as out of hours service or rostering); and/or

(d) the size and negotiating power of the collective is so great that the public hospitals are unable to fund the required medical services within tight budgetary restraints.

The strongest determining factor in public hospitals contracting with medical practitioners is budgetary restraints.

If payments to medical practitioners are forced to increase as a result of this notification process, then hospitals will be required to consider other options, including closure or amalgamation. In both of these circumstances, services will have to be reduced or ceased (eg no longer offering particular services within the region which means patients will need to travel further to obtain these services), or to operate with fewer medical practitioners (which may mean longer waiting lists).

The effect of such a boycott would be to disrupt and in the worse case stop much needed medical services. This will be catastrophic in a “regional” centre and is clearly a substantial public detriment.

Whilst the AHHA agrees that medical practitioners are ethical, some medical practitioners have been known to refuse to participate in on-call rosters and others have been previously the subject of ACCC investigation in relation to anti-competitive behaviours.

Public hospitals have always worked closely with medical practitioners, in both the metropolitan and regional areas. Public hospitals not only employ medical practitioners, but also accredit visiting practitioners so as to enable them to treat privately insured patients at public hospitals. As such, public hospitals are *completely dependant* on medical practitioner support.

Medical practitioners are already empowered within the health industry and the AMA is a particularly powerful and effective lobby group.

1.3 AHHA Recommendation

The AHHA suggests that, should the ACCC approve the Notification, it be approved subject to conditions and that there is a clear restriction on the collective group threatening or acting to boycott services which would disrupt hospital services. Further, any disputes that arise from the negotiations should be the subject of independent dispute resolution procedures (as opposed to AMA dispute resolution procedures). If there is a disruption to services then either the ACCC or the relevant Health Department or Minister for Health should be empowered to step in. There needs to be a safety net to ensure patients and community interests are protected.

The closure of a public hospital will have significant political repercussions.

Given the short timeframe to respond, we have not had the opportunity to review in detail the powers under the Act to impose such conditions.

As noted above, the hospital system relies on the support of medical practitioners – this is a factor that is specific to the health care market (and in particular to public health care). The AHHA recommends that the ACCC consider the usual market forces of supply and demand in light of the fact that the demand generated by the community for public health care is acute, and that the supply of medical practitioners in regional areas is low.

2. Further Concerns

There are some points we would like to make in relation to the Notification.

2.1 Contractual payments for medical practitioners

The appointment of a medical practitioner at a public hospital may yield greater income than just the payments made by the public hospital to the medical practitioner, as the medical practitioner is paid for private patient care by Medicare, health insurers and self-insured patients. For the purposes of Section B, 3 of the Notification, the *total* income received by the participants should be considered and disclosed.

The permission to negotiate fees collectively should be limited to negotiations between the medical practitioners and the public hospital. As stated fees in relation to the appointment to the hospital can also impact other relevant parties such as health insurers.

2.2 Rostering

On-call rosters have long been a difficult issue for hospitals and medical practitioners. In order to operate hospitals, the facilities must have on-call rosters, particularly for specialties such as anaesthetics and obstetrics. As such, in agreeing to be appointed to a hospital, the medical practitioner is required to participate in the on-call register. It would be of substantial public detriment if medical practitioners boycotted or collectively acted in a way that resulted in the hospital having insufficient capacity to cover on-call requirements.

2.3 Dispute Resolution

The dispute resolution procedure for the collective bargaining arrangement should be independent, and with respect, the AHHA would not consider the AMA to be an independent mediator.

2.4 Market Definition and Substitutes

Public hospitals are experiencing great difficulty in sourcing medical practitioners in regional areas. Whilst hospitals have budgeting restrictions, the greatest problem facing hospital resourcing is the lack of qualified specialists who are willing to work in regional areas.

Whilst a hospital will try to source medical practitioners from all sources possible (including overseas), not many are willing to move to regional areas and in some regional areas, doctors from overseas may not be culturally accepted and therefore they are less able to supplement their income with private work and do not stay for an extended period of time. Therefore, it is not true to say all Australian doctors and overseas doctors are substitutes for local medical practitioners.

As such, the true market is not Victoria generally, but the proximate geographic region.

Further, the medical market is fragmented. The market for general practitioners cannot be a substitute for specialised medical practitioners such as anaesthetists, surgeons and obstetricians.

In addition, the AHHA does not agree that day procedure centres and private health facilities are complete substitutes for a public hospital.

Private health facilities have different funding models and choose for financial reasons not to perform low commercial yield services. Further, as private hospitals are mostly used by independent visiting practitioners (and they do not employ registrars) they are often not adequately resourced to provide the same level and/or type of services undertaken by the public sector (for example, emergency services). Also, admission to a private hospital is limited to patients with private health insurance or who are self insured or if there is a contract between the private hospital and public hospital. Similarly, day procedure centres provide limited services and are again not substitutes for a major regional acute public hospital.

It is not in the interests of patient care to rely on "fly-in and fly out" medical practitioners or locums. Doctors who are resident in the area are more likely to contribute to quality assurance committees and to be able to respond quickly to a medical emergency.

2.5 Number of Participants – Effect on competition

In the Notification the AMA notes that approximately 60 medical practitioners (specialists and general) are appointed to work as independent contractors at the target public hospital. The number of participants is approximately 40 – this is a significant number of practitioners for the hospital to be collectively negotiating with.

Should there be disputes either during or after the negotiation of the contract, this is likely to leave the hospital with a shortfall of medical practitioners (especially given that there is a shortage of regional medical practitioners). The AHHA would suggest that the number of participants in the group is too large and results in an imbalance in bargaining power and has the potential to result in significant public detriment.

2.6 Clinical review and education

Hospitals welcome and encourage the contribution of medical practitioners to collaborative clinical and education initiatives.

All hospitals have Medical Advisory Committees.

The current Trade Practices Act does not prevent these initiatives. However, it does prevent a group of doctors preventing another doctor from practising in an area for anti-competitive reasons.

3. Contacts

We would be pleased to meet with you to discuss this submission.

Should you have any questions regarding this submission, please contact Prue Power, Executive Director of the Australian Healthcare and Hospitals Association on (02) 6162 0780 or Alison Choy Flannigan, Partner Ebsworth & Ebsworth Lawyers on (02) 9234 2389.