Department of Human Services

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Ms Isabelle Arnaud
Director, Adjudication
Austuralian Competition and Consumer Commission
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Dear Ms Arnaud

Collective bargaining notification CB0005 lodged by the Australian Medical Association (Vic) Pty Ltd on 11 October 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 Mercy Public Hospitals Inc.

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. In this regard DHS submits that the form of analysis applied by the Commission in its draft objection notice regarding the Latrobe Regional Hospital collective bargaining notification CB00004 (**Draft Objection**) will apply to the Proposed Arrangement. Accordingly, the ACCC should also object to this Notice.

Market Definition

In Appendix B of the Notice, the AMA once again adopts a broad market definition, being the market for the provision of medical services in Victoria. DHS notes the ACCC's conclusion in its draft objection that, in broad terms, the relevant area of competition relates to the provision of specialist medical services to hospitals. While DHS agrees with this general market description, Werribee Mercy Hospital has a number of unique characteristics which impact upon the geographic and specialist boundaries of the relevant markets.

Geographic market

Werribee Mercy Hospital is a large community hospital located 20 minutes from the Melbourne CBD. It services the western and south western areas of Melbourne. As noted by the AMA, it is located in the City of Wyndham, which can be defined as a 'metropolitan municipal district'. In prior submissions to the ACCC, DHS has made the distinction between the market for the provision of medical services in metropolitan and regional hospitals. Generally this distinction is that in regional areas non full time medical practitioners are commonly paid on a 'fee for service' basis, while in metropolitan areas and larger regional centres lower 'sessional' (meaning one half day) rates apply.

This is a reflection of the fact that it has been more difficult for regional hospitals to attract non full time specialists and therefore they have had to offer higher remuneration. It also reflects the fact that in metropolitan and larger regional centres areas practitioners are prepared to accept sessional rates for public patients, as they are compensated for the lower earnings by the learning opportunities and prestige that may be associated with an appointment to the hospital concerned. Importantly they will also gain access to that hospital's private patients, who they can then charge as private patients on a fee for service basis. In this regard DHS does not wholly agree with the AMA's description of VMO services to public hospitals being a form of 'partial pro bono' work by the practitioners concerned.

Werribee Mercy Hospital is unique in that, although it is a metropolitan hospital, it pays its VMO's on a fee for service basis. DHS understands that this has arisen because of historic difficulties in attracting medical practitioners from the wealthier suburbs of Melbourne to the outer west of the Melbourne city. In this regard DHS believes that the market for the provision of specialist medical services to Werribee Mercy Hospital should be viewed as a market having regional characteristics due to it being based in the western suburbs of Melbourne, even though specialists servicing patients at Werribee Mercy Hospital are sourced from the greater Melbourne metropolitan area.

Specialist medical services market

DHS remains of the view that there are a number of distinct markets for different craft groups. There is only limited potential for substitution between doctors in different craft groups. Currently different payment rates apply to different craft groups, based on a percentage of the Commonwealth Medicare Benefits Schedule (**CMBS**). The fact that CMBS attributes different values to similar activities for different craft groups reflects that there are different markets for each craft groups.

Unlike most regional markets, the non full time medical practitioners servicing Werribee Mercy Hospital are not substantially dedicated to one hospital, in fact, quite the opposite. Most do not live in the region serviced by this hospital. Further, while most craft groups represented in the Notice are paid on the basis of a percentage of CMBS, Werribee Mercy Hospital pays its visiting anaesthetists based upon the 'relative value guide' (ie payment based on units of time) and other aspects of payment differ between both individual practitioners and craft groups. For example, the percentage of CMBS paid to different craft groups differs and some practitioners receive additional benefits such as contributions toward the employment of an assistant.

Indeed we would say that the 26 practitioners subject to the notice have little in common, even within craft groups, which would provide any basis of claimed increase in efficiencies from their being able to collectively negotiate. For the most part they are independent businesses, engaged as independent contractors (not as employees) who provide services which, although complementary, are not substitutable. As they are based in a large metropolitan market, they have a large number of hospitals which they can and do service and, due to the tight market conditions, have a strong bargaining position with regard to an individual hospital, including Werribee Mercy Hospital.

Public Detriments

The AMA proposes that 'there is unlikely to be a pricing impact on consumers' from the Notice. As the Notice is to allow collective bargaining on price and it can be assumed that the Participating Practitioners are not seeking to lower their remuneration, DHS considers that the there will be a pricing impact of the proposed collective bargaining. While this may not impact public patients directly, the fact that the hospital will be charged more will indirectly affect the community and patients of Werribee Mercy Hospital.

Werribee Mercy Hospital is unusual in that it is a hospital owned privately by the Sisters of Mercy that provides the services to public patients; in fact, it is a campus of Mercy Public Hospitals Incorporated which is a scheduled denominational hospital under the Health Services Act 1988 (Victoria). Its full time employees are covered by the relevant State EBAs and these govern their terms and conditions. However, as a privately owned hospital, losses are its own responsibility and Werribee Mercy Hospital does not have any additional recourse to the public purse.

DHS understands that Werribee Mercy Hospital engages VMO's as contractors. DHS believes its ability to negotiate separate contractual terms with different craft groups and individual practitioners is critical to its achieving efficient market outcomes that reflect both the value of and demand for the particular skills of the particular craft groups. At the same time this ability to individually negotiate is a necessary ingredient to its continuing to provide a valuable public service, within its budgetary constraints.

As previously noted, 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.

Where discrete negotiations are conducted for particular craft groups, 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.

Where collective negotiations are conducted for all craft groups, 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 lower number of doctors servicing Werribee Mercy Hospital 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 Werribee Mercy Hospital and/or provide predominantly elective services than would otherwise result where terms and conditions are negotiated individually.

Further, since there is some limited degree of substitution possible between particular craft groups (for example between general practitioner obstetricians and specialist obstetricians and/or specialist anaesthetists), in those cases 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 Werribee Mercy Hospital is required to pay for services provided by the Participating Practitioners

- Werribee Mercy Hospital facing additional budgetary pressures that may compromise the level of service it is able to provide to the community

- Werribee Mercy 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. The Hospital does not face this risk under the current system where medical staff appointments are negotiated individually with the Hospital; and

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[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.

- Werribee Mercy Hospital being forced to reduce 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 Werribee Mercy Hospital, that will presumably offset any detriment caused if collective negotiations break down, DHS observes:

- The 99 general practitioners in the city of Wyndham not currently working at Werribee Mercy Hospital do not offer a market substitute, because they do not offer the skills sought by the hospital. This is demonstrated by the fact that only one GP from the city of Wyndham is currently contracted by Werribee Mercy Hospital;

- Locums are not a substitute for doctors who 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.

- Commercial recruiters of medical practitioners are useful to source medical practitioners, but there is limited ability to require that they provide particular medical services at short notice.

- Werribee Mercy Hospital has and will continue to have a number of medical practitioners as full time staff. It however has been found to be necessary to have these full time staff supplemented by part time specialists. This allows the hospital to meet the fluctuating demand for different services. It is not feasible for Werribee Mercy Hospital to only have employee medical practitioners and indeed the lower remuneration of full time employees is not attractive to many more experienced specialists.

- The western and south western suburbs of Melbourne do not have a significant network of additional public or other hospitals sufficient to provide a viable substitute of the services provided by Werribee Mercy Hospital;

- 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 other Melbourne hospitals is required for some patients, 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 still require 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 Werribee Mercy Hospital would lose the services of an approximately 60% of its non full time medical staff at one time. Given the absence of adequate 'substitutes' for the services provided by these practitioners, this would result in a major curtailment of the services provided by Werribee Mercy Hospital and significant public detriment.

While Werribee Mercy Hospital has the ability to opt out of collective negotiations and negotiate with doctors individually, the Proposed Arrangement puts pressure on Werribee Mercy Hospital to participate in collective negotiations. If Werribee Mercy Hospital were to opt out of collective negotiations, Werribee Mercy Hospital could not be confident that it could secure adequate medical practitioners (both the required specialisations and numbers). Indeed while the AMA asserts that a collective boycott will not result from the proposed Arrangements, the mere fact of the high degree of collusion required could result in this occurring, even in the absence of any express agreement to do so between the participating practitioners.

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 public hospitals

- relationships with the hospital are a function of the personalities involved. DHS does not believe that collective negotiation will decrease potential for animosity and conflict between medical practices and 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 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. However DHS notes that any public benefit flowing from these minor 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

Lance Wallace
Executive Director
Metropolitan Health and Aged Care Services