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



AUSTRALIAN MEDICAL  
ASSOCIATION

42 Macquarie St Barton ACT 2600

T | 61 2 6270 5400

F | 61 2 6270 5499

E | [info@ama.com.au](mailto:info@ama.com.au)

W | [www.ama.com.au](http://www.ama.com.au)

42 Macquarie St Barton ACT 2600

PO Box 6090 Kingston ACT 2604

Dear Dr Chadwick

**Re: Australian Medical Association Limited and state/territory AMA organisations application for authorisation A91100 - interested party consultation**

I refer to the above application before the Commission. A number of organisations have responded to the Commission's call for submissions from interested parties.

The AMA has prepared the attached material (annexure A) in response to some of the issues raised in these submissions. The AMA has attempted to briefly summarise each issue raised and then respond accordingly. There is significant similarity in the submissions made by the Victorian Hospitals Industrial Association and the Victorian Healthcare Association, so many of the responses provided by the AMA are equally applicable to both submissions.

In addressing the points raised in submissions, the AMA refers on a number of occasions to the conclusions reached by the ACCC in its determination that granted authorisation to the Rural Doctors Association of Australia (A91078) to collectively negotiate VMO contracts on behalf of rural general practitioners/rural generalists.

While the AMA acknowledges that the Commission considers each application on its own merits, it submits that the proposed authorisation is similar in all material respects to the authorisation granted to the RDAA. Many of the same objections that were raised by interested parties and considered by the ACCC in relation to the RDAA application for authorisation are now being put once again to the ACCC. In this context and on the basis that there is no evidence to suggest that conditions in the relevant market have materially changed in the period since that authorisation, it appears reasonable for the AMA to rely on the conclusions reached by the Commission when it finalised its determination in relation to the RDAA.

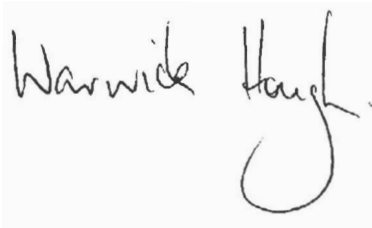
In the AMA's application, it is highlighted on page 9 that arrangements for VMOs are already generally made at State level – other than in Victoria. In those States where the health department establishes the terms and conditions, including the level of remuneration in VMO contracts, the departments often consult with organisations that represent doctors, including the AMA. The AMA's application seeks to take this one step further by allowing the AMA to negotiate, rather than just consult, with the

State/Territory health departments. This will make a significant, positive difference to the representation of rural GPs.

I note that the Commission has received a number of late submissions. In responding to the submissions lodged to date, the AMA obviously reserves its right to make comments on any additional submissions that may be received by the ACCC subsequent to this response.

If the ACCC believes that the AMA has not fully addressed any issues that interested parties have raised, then the AMA would appreciate an opportunity to meet with you to discuss these or any other outstanding matters before a draft determination is issued.

Yours sincerely

A handwritten signature in black ink that reads "Warwick Hough". The signature is written in a cursive style with a large, looping 'H'.

Warwick Hough  
Senior Manager  
General Practice, Legal Services and Workplace Policy  
[whough@ama.com.au](mailto:whough@ama.com.au)

## ANNEXURE A

### Rural Doctors Association of Australia (RDAA)

Issue	Response
<p>1. <i>AMA application does not recognise the pre-eminent role of the RDAA in representing rural doctors</i></p>	<p>As outlined on page 11 of the AMA's application, it respects the role played by the RDAA. The comment made by the RDAA's is not relevant to the consideration of this application as the ACCC should simply determine whether or not the AMA is authorised to collectively bargain with the relevant state/territory health departments based on the merits of the application itself.</p> <p>The reality is that not all rural GPs are members of the RDAA. The AMA has a substantial rural membership base that wants effective input into the content of VMO contracts. As outlined at page 3 of the AMA's application, the AMA has existing consultative structures in place to ensure that the views of rural doctors are properly taken into account in the development of AMA policy.</p> <p>The AMA has actively pursued a number issues in relation to rural healthcare delivery in recent years. For example, the AMA worked with the RDAA to develop a proposed package of workforce incentives to attract and retain doctors in rural areas. The AMA has also pursued quarantined funding for rural hospitals in future Australian Health Care Agreements, extended support for medical specialist outreach programs and incentives to encourage more medical students to consider a career in rural practice.</p> <p>Clearly, the AMA has a substantial role in ensuring that the voice of rural doctors is not lost in the "noise of metropolitan doctors" (as suggested by the RDAA in its submission).</p> <p>Many members of the AMA, such as junior doctors, are likely to work in public hospitals and health facilities in rural and remote areas of Australia at some point in the future. Without broad rural GP input (including the input of potential future rural GPs) into the development of VMO contracts, it is likely that these contracts will not meet the needs of the current and future rural GP workforce. This will make it more difficult to attract and retain VMO services.</p>
<p>2. <i>Rural Generalists – scope of proposed authorisation</i></p>	<p>The AMA submission is clear in this regard - authorisation is sought for the AMA to collectively negotiate with relevant State/Territory health departments the terms of contracts for rural general practitioners providing services as Visiting Medical Officers in public hospitals and health facilities in rural and remote areas of Australia (except for New South Wales).</p> <p>For the purposes of the application, a general practitioner is defined as a doctor who holds vocational recognition (VR) status under the <i>Health Insurance Act 1974</i> or has access to A1 Medicare rebates under Commonwealth Government workforce programs such as the Rural Other Medical Practitioners Program.</p>

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<p>3. <i>Joint negotiations with the RDAA</i></p>	<p>The AMA is committed to an orderly collective negotiation process, which delivers outcomes that support the delivery of high quality medical services in rural Australia. The AMA has a strong history of cooperation with the RDAA on a range of rural health issues and we would see that cooperation continuing.</p> <p>That said, the AMA's ultimate position in relation to the structure and process of collective bargaining negotiations would be determined by the views of our rural GP membership and would need to have regard to relevant provisions of the Trade Practices Act.</p>
<p>4. <i>The authorisation to the RDAA already delivers the public benefits cited in the AMA application</i></p>	<p>The RDAA has not sought to dispute the benefits cited by the AMA. The AMA does not accept that the RDAA authorisation has 'exhausted' all of the available public benefits from collective negotiation.</p> <p>The AMA's application highlights that not all rural GPs are members of the RDAA and that the AMA has a substantial rural membership base in its own right.</p> <p>Under the RDAA authorisation, those GPs who are members of the AMA and not the RDAA are effectively denied effective input into future contracting arrangements. Granting authorisation to the AMA addresses this issue and means that GPs do not have to join both organisations - avoiding additional transaction costs.</p> <p>Unlike the RDAA, the AMA has an established office in each state/territory with significant local resources available to support the collective bargaining process. The AMA envisages that this will play a beneficial role in ensuring that collective negotiations can proceed in a timely and efficient manner and that the views of rural GPs are fully captured.</p> <p>The proposed authorisation will also provide the AMA with greater certainty in its dealing with state/territory health departments. While the AMA can be involved in a "consultation" process in the development of a VMO agreement for rural GPs, as highlighted on page 9 of the AMA's application, this involves a degree of legal risk and uncertainty. The granting of the proposed authorisation would remove this legal risk.</p> <p>The AMA application cites a range of public benefits that the proposed authorisation would deliver. Granting authorisation to the AMA would build on and enhance the benefits achieved through the RDAA authorisation.</p>
<p>5. <i>RDAA has already established the process of negotiation in a number of states.</i></p>	<p>The AMA has not been made aware of specific negotiations commencing in any state/territory and to that extent cannot comment on this. To the extent this is occurring, the AMA would seek to become involved to ensure its rural GP members' interests are adequately represented, and where appropriate, to cooperate with the RDAA in obtaining an optimal outcome.</p>

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### The Victoria Hospitals Industrial Association

<p>6. <i>Hospital 1 and Hospital 2 (paras 6 - 8)</i></p>	<p>The VHIA highlights the experience of “hospital 1” and “hospital 2” in their submission, presumably to make an argument that the authorisation granted to the RDAA has led to a reversal of bargaining power of doctors as represented by the RDAA. There are a number of points to note in response:</p> <ul style="list-style-type: none"><li>• The behaviour described in the VHIA submission relates to negotiations between the RDAA (not the AMA) and individual hospitals. Negotiation at this level appears outside the scope of the authorisation granted to the RDAA. It is also outside of the scope of authorisation that the AMA has applied for.</li><li>• To AMA’s knowledge, there have been no negotiations between the RDAA and the Victorian Department of Human Services regarding VMO contracts for rural GPs. At this time, there is no evidence to show that activities consistent with the scope of authorisation granted to the RDAA have led to any negative outcomes whatsoever.</li><li>• Given that the conduct described by the VHIA does not appear to be within the scope of the existing RDAA authorisation, is not within the scope of the AMA application for authorisation, and nor does it relate to the activities of the AMA – then the AMA submits that it should have no bearing on the Commission’s consideration of the AMA’s application.</li></ul>
<p>7. <i>The application will inevitably result in central negotiations (para 9)</i></p>	<p>The AMA’s application acknowledges at pages 5 and 10 that in Victoria the current negotiation process for VMO arrangements takes place at the hospital level. There is nothing in the proposed authorisation that would compel or force the Victorian Department of Human Services to engage in a central negotiation process.</p> <p>The ACCC adopted the correct approach at page 17 of its determination in relation to the RDAA application for authorisation where it concluded that state/territory health departments are under no obligation to participate in negotiations and should negotiations commence, the state/territory health departments are able to opt out of negotiations at any time. Further, the state/territory health departments are not compelled to agree to terms, including price, they do not consider to be acceptable. Importantly, state/territory health departments are free to continue with existing arrangements.</p> <p>Importantly, the authorisation will in the first instance allow the AMA to represent its rural members in liaising with the Victorian Department of Human Services to make the case that a collective negotiation process can deliver a more appropriate outcome for all parties. The VHIA has no evidence to support any assertion that the arrangements will not be voluntary but that the AMA will ‘vigorously pursue them’.</p>

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<p>8. <i>Application to exempt Victoria from the Authorisation (paras 11 - 12)</i></p>	<p>The VHIA appear to put forward the proposition that the exclusion of NSW from the scope of the AMA's application provides some sort of basis to exclude Victoria from the scope of the proposed authorisation. If the AMA understands the position correctly, the VHIA is arguing that the ACCC is allowing the AMA to "run the agenda".</p> <p>The decision not to include NSW in the scope of the AMA application simply reflects the fact that the Australian Medical Association (NSW) Ltd lodged a separate application for authorisation and, on that basis, there was no need to include NSW within the scope of this application.</p> <p>The AMA application does not cover the ACT either. However, this simply reflects the fact that the ACT is not considered to be a rural location. It does not suggest that the AMA is being allowed in some way to "run the agenda."</p> <p>In any event, the contracting processes in Victoria are subject to change and there is no compelling reason why Victoria should be excluded.</p>
<p>9. <i>The real purpose of the AMA application is about funding, about increases in price for medical services, about maximum flexibility and guaranteed floor price for medical services. (paras 14 - 20)</i></p>	<p>The VHIA at paragraph 15 acknowledges that a common fee schedule is not likely to lessen competition. This is consistent with the arguments put forward by the AMA in support of its application.</p> <p>The VHIA submission outlines a series of assertions that are not supported by any evidence. The AMA submits that it carefully articulated the benefits of authorisation in its application to the Commission.</p> <p>The AMA application consistently highlights that state/territory health departments will only enter into collective VMO bargaining arrangements for rural GPs if they believe that this process will deliver a better outcome with respect to the delivery of rural health services. The ability of the AMA to lift the "price" of medical services in the collective bargaining process is significantly curtailed by this reality.</p> <p>The ACCC has previously identified that the anti-competitive effect of collective bargaining arrangements constituted by lost efficiencies is likely to be more limited where the following four features are present:</p> <ul style="list-style-type: none"> <li>• the current level of negotiations between individual members of the group and the proposed counterparties on the matters that they seek to negotiate is low;</li> <li>• there are restrictions on the coverage and composition of the bargaining group;</li> <li>• participation in the collective bargaining arrangements is voluntary; and</li> <li>• there is no collective boycott.</li> </ul> <p>The AMA submits that each of the above four features are present in the circumstances of the collective arrangements that are the subject of this application for authorisation.</p>

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	<p>The AMA application at page 6 notes that the development of a “collective” agreement is not intended to preclude rural GPs from negotiating specific contractual arrangements with local hospitals to suit their mutual needs, should such circumstances arise. Such an arrangement would obviously need to meet the needs of the hospital and the doctor alike.</p> <p>The AMA also envisages that it would also be possible to build flexibility into a collectively negotiated agreement by incorporating appropriate provisions that allow scope for variation (if agreed by the parties) over and above any "base" agreement.</p> <p>This reflects the reality that while a collective VMO agreement will meet the needs of the vast majority of rural GPs and rural hospitals, there may well be circumstances where some individual local variation is desirable. These local arrangements will be negotiated on an individual, not collective, basis. The process is voluntary and must suit all parties.</p> <p>In its submission to the ACCC regarding the RDAA application for authorisation, the VHIA argued that a common fee schedule would reduce flexibility – and was therefore undesirable. The VHIA on this occasion seems to be suggesting the complete opposite by criticising the AMA application for proposing that there be some scope for individuals to reach agreement at the local level.</p> <p>In the AMA's view, such flexibility ought to be encouraged, rather than discouraged as the VHIA seeks to do.</p>
<i>10. Transaction savings (para 21)</i>	<p>The VHIA asserts that transaction savings in Victoria are a 'furphy' or myth. This is inconsistent with the view reached by the ACCC in relation the RDAA authorisation. The ACCC acknowledged the potential for transaction savings and concluded that the potential for savings is probably greatest in Victoria as individual doctors currently negotiate with individual hospitals. While the ACCC found that potential savings are limited, they certainly cannot be described as a 'furphy' or myth.</p> <p>The VHIA describes transaction costs as a 'cost of doing business', but this misses the point. The transaction costs exist and any costs incurred will be materially lessened if negotiations are collective rather than individual.</p>
<i>11. Retention (para 22)</i>	<p>The AMA's application at page 10 addresses this issue in some detail. The VHIA simply appears unwilling to accept the reasoning put forward by the AMA and the conclusions reached by the ACCC in relation to the RDAA authorisation and the more recent authorisation granted to the Australian Medical Association NSW Ltd (A91088).</p>

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<p><b>12.</b>     <i>Price of contractors vs the price of employees (par 24)</i></p>	<p>The contractual basis on which state/territory health departments and hospitals engage medical practitioners is at their own prerogative. The decision to engage a medical practitioner as an employee or a contractor will be based on the needs of the state/territory health department or hospital. Consideration will be given to a range of issues such as price, flexibility, ease of administration and so on. The preference of the medical practitioner may also be taken into account. However, it is ultimately the state/territory health department or hospital's decision as to which arrangement is adopted.</p>
<p><b>13.</b>     <i>"Me too" application (para 25)</i></p>	<p>The VHIA appears to miss the point being made by the AMA. The AMA's application highlights that not all rural GPs are members of the RDAA and that the AMA has a substantial rural membership base in its own right. It is these GPs who are at a disadvantage, not the AMA.</p> <p>Under the RDAA authorisation, GPs who are not members of the RDAA are effectively denied effective input into future contracting arrangements. Granting authorisation to the AMA addresses this issue and means that GPs do not have to join both organisations - avoiding additional transaction costs. It also removes the legal risks for the AMA with respect to involvement in any "consultation" process with respect to the development of VMO contracts for rural GPs.</p>
<p><b>14.</b>     <i>Better health outcomes for rural people (para 26)</i></p>	<p>The AMA application advances the proposition that effective collective VMO bargaining arrangements for rural GPs can help improve the recruitment and retention of rural GPs. This would impact positively on rural health services and improve access to services for rural patients – leading to better health outcomes. This is not a controversial proposition and the VHIA do not provide any evidence to suggest that this would not be the case.</p> <p>The AMA does not suggest that collective negotiation, itself, will solve these issues but rather that collective negotiation will contribute to better outcomes, and that this constitutes a public benefit.</p>
<p><b>15.</b>     <i>Public detriments (para 27)</i></p>	<p>The VHIA essentially repeat a number of propositions that appear earlier in its submission, and which have been comprehensively addressed by the AMA.</p>

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### Victorian Healthcare Association (VHA)

<p><b>16.</b> <i>Effective representation of rural doctors to state health authorities</i></p>	<p>The VHA submits that it is unable to identify in the Victorian context any evidence to support the notion that the effective representation of rural doctors to state/territory health authorities would provide a public benefit. The VHA made a similar submission to the ACCC in relation to the RDAA application. The VHA also suggests that the RDAA has a more legitimate claim to represent rural doctors. In relation to the latter, the AMA has thoroughly addressed this point in the earlier comments provided in response the RDAA submission.</p> <p>The AMA application outlines a number of points in support of the contention that the effective representation of rural doctors can provide a public benefit. The VHA submission does not argue that a public benefit does not exist, it simply says that it is unable to identify evidence for the proposition in the <u>Victorian</u> context. The VHA has not provided any evidence suggesting that public benefits do not exist and/or the processes employed to find any 'evidence' in the Victorian context.</p> <p>The AMA has made the point repeatedly that state/territory health departments will only engage in collective bargaining if they can see benefit in doing so. It is a voluntary process and the AMA has not sought authorisation for collective boycott.</p> <p>The AMA also notes that it proposes to introduce flexibility into its arrangements (as outlined above) to allow for local circumstances to be considered by individual doctors as appropriate.</p>
<p><b>17.</b> <i>Reduced transaction costs</i></p>	<p>The AMA has addressed this issue at point 10 in our response to the VHIA submission.</p>
<p><b>18.</b> <i>Positive effect on the retention of rural GPs as VMOs</i></p>	<p>This is addressed at point 11 in our response to the VHIA submission. The AMA does not accept the proposition that a collective agreement will undermine the sense of partnership at the local hospital level. The reality is that a common agreement that had broad professional support would improve partnerships at the local level. Rural GPs would feel that their voice had been heard and it would allow them to focus on the “clinical” aspects of the partnership with their hospital – rather than “industrial” issues that at times can be divisive.</p>
<p><b>19.</b> <i>RDAA has the capacity to consult with the AMA – giving significant representation by the AMA to contractual issues that the RDAA has approval to negotiate.</i></p>	<p>The proposition put forward by the VHA ignores the fact that the RDAA is under no obligation to consult with the AMA under the terms of its existing authorisation. Neither is the AMA protected from action under the Trade Practices Act under the terms of the RDAA authorisation. If the RDAA did consult with the AMA, the AMA would be at risk of contravening the Trade Practices Act if it sought to act collectively on behalf of its members, in certain respects.</p> <p>The AMA has a substantial rural membership base and these members would rightfully expect effective input into all contractual issues, which is best expressed by the direct input of their own membership body.</p>

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20. <i>Public detriment – impact on price</i>	This is addressed on several occasions in the earlier part of this submission in response. Eg points 7, 9, 12 and 16.
21. <i>Voluntary participation in collective bargaining arrangements – Victorian Department of Human Services is not involved in the negotiation of VMO arrangements</i>	<p>Contrary to the VHA submission, the AMA’s application acknowledges at pages 5 and 10 that in Victoria the current negotiation process for VMO arrangements takes place at the hospital level. There is nothing in the proposed authorisation that would compel or force the Victorian Department of Human Services to engage in a central negotiation process.</p> <p>AMA Victoria has a productive relationship with the Victorian Department of Human Services. If the application were successful AMA Victoria would approach the Victorian Department of Human Services to discuss the possibility of establishing a collective bargaining process. It is up to the Department as to whether it engages in this process.</p> <p>As set out above, contracting processes in Victoria are subject to change and there is no compelling reason why Victoria should be exempted. The fact that no collective bargaining process exists currently in Victoria should not prejudice the AMA’s application. The proposed authorisation simply establishes a framework in which collective negotiation can occur by legitimising arrangements and practices that may otherwise be illegal.</p>

### Other submissions:

#### *Queensland Health*

The AMA notes that Queensland Health has neither opposed nor supported the application. Queensland Health has confirmed that no public detriment would flow from the application. Queensland Health also asserts that no public benefit would flow from authorisation but has provided no evidence in support of these assertions.

#### *Rural Doctors Association of Victoria (RDAV)*

The RDAV essentially adopt the submission made by the RDAA, a number of elements of which have been addressed earlier. However, three further points raised by RDAV do need to be addressed. The AMA’s position in relation to the application by the Australian College of Rural and Remote Medicine (ACRRM) for rural medicine to be recognised as a distinct medical specialty did not result in “more years’ delay and the necessity for COAG intervention”. The Australian Medical Council (AMC) is an independent body that oversees the process of recognising medical specialties.

The AMC reviewed the ACRRM application for specialty recognition and found that it did not meet the relevant criteria. ACRRM subsequently made application for accreditation as a training provider and standards setting organisation within the specialty of general practice. The AMC has now granted interim accreditation to ACRRM and the AMA supported that decision. The AMA cannot be held accountable for the outcomes of an independent and objective process.

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AMA President at the time, Dr William Glasson, formed the AMA Rural Reference Group (AMARRG) in 2005. It is made up of AMA members in rural medical practice. Some AMARRG members belong to ACCRM and/or the RDAA, however, they are appointed to the AMARRG as individuals – not representatives of any particular organisation.

With respect to the authorisation granted to the Royal Australian College of General Practitioners (A91024), the RACGP proposed to extend the scope of its original authorisation to include collective setting of fees for general practitioners working as Visiting Medical Officers (VMOs) at local hospitals. The AMA comments referred to by the RDAV simply pointed out that RACGP had not provided any evidence to support this change. The AMA also expressed the view that the benefits of an authorisation should be extended to all VMOs, not just those encompassed by the RACGP authorisation.

### *WA Health*

WA Health opposes the AMA's application for authorisation. The vast majority of WA Health's submission repeats (verbatim) the submissions made to, and considered by, the ACCC with respect to the RDAA authorisation. In addition, the AMA makes the following comments:

- The AMA has a significant rural membership and is entitled to represent its interest as those members see fit. The fact the AMA has members who are not rural GPs is not a reason to deny authorisation or to suggest that the AMA is not well placed to represent the interests of rural GPs. As acknowledged in its application, the AMA does "consult" with respect to current contracting processes. The AMA's participation in the process will, however, be enhanced if the AMA is granted authorisation because of the legal certainty with which it may then proceed to collectively represent its members interests.
- The Department of Health suggests that the granting of authorisation would "endorse removal of the control of arrangements for engaging rural VMPs from the organisation best placed to do so, and place it with the Department of Health instead". Authorisation will do no such thing; it will merely allow the AMA to collectively negotiate with the Department of Health if it is inclined to do so. Should the Department wish to continue with the prevailing arrangements, the AMA cannot force the Department to alter its arrangements (as acknowledged by the Department itself). Whether the AMA is successful in encouraging the Department to negotiate with it will depend on whether the AMA is successful in pointing to the benefits to all parties, of doing so.
- The AMA anticipates that its collective arrangements will allow sufficient flexibility for negotiation from a "base" agreement, to meet particular local needs.
- It is not correct to say that granting authorisation to the AMA will lead to increased complication and transaction costs. There is no "expectation" that the Department of Health would conduct separate negotiations with the AMA and RDAA. As stated above, the AMA has a strong history of cooperation with the RDAA on a range of rural health issues and the AMA sees that cooperation continuing as appropriate and having regard to the Trade Practices Act.
- The valuable input of the AMA and the RDAA into VMO contracts has been acknowledged previously by the Department of Health – so the arguments put by the Department go against the Department's previously stated positions.