Australian Competition & Consumer Commission

Draft Determination

Application for authorisation

lodged by

Australian Medical Association Limited

in respect of

collective negotiations with relevant state/territory health departments concerning contracts for visiting medical officers in rural and remote areas

Date: **12 November 2008**

Commissioners: Samuel
Kell
Schaper
Court
King
Martin
Willett

Authorisation no.: A91100

Public Register no.:C2008/1340

Summary

The ACCC proposes to grant authorisation to the Australian Medical Association Limited (the AMA) and its state/territory AMA organisations (except New South Wales) to collectively negotiate with relevant state/territory health departments the terms of contracts, including fees, 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) for a period of five years.

The authorisation process

The Australian Competition and Consumer Commission (ACCC) can grant immunity from the application of the competition provisions of the *Trade Practices Act 1974* (the Act) if it is satisfied that the benefit to the public from the conduct outweighs any public detriment. The ACCC conducts a public consultation process to assist it to determine whether a proposed arrangement results in a net public benefit.

The application for authorisation

On 19 August 2008, the AMA and its state/territory AMA organisations (except for New South Wales), on behalf of current and future members, lodged application for authorisation A91100. The AMA seeks to collectively negotiate with relevant state/territory health departments the terms of contracts, including fees, for rural general practitioners (Rural GPs) providing services as Visiting Medical Officers (VMOs) in public hospitals and health facilities in rural and remote areas of Australia (except for New South Wales).

The application for authorisation was made by the AMA including Australian Medical Association (Northern Territory) Limited (AMANT), Australian Medical Association (Queensland) Limited (AMAQ), Australian Medical Association (South Australia) Limited (AMASA), Australian Medical Association (Tasmania) Limited (AMATas), Australian Medical Association (Victoria) Limited (AMAVic) and Australian Medical Association (Western Australia) Limited (AMAWA) (collectively referred to as the AMA).

Assessment of public benefit and detriment

The ACCC considers that to the extent to which the state/territory health departments decide to engage in collective negotiations, some public benefit will result in some transaction cost savings and effective representation of GPs in negotiations.

The ACCC notes that the AMA will be in a strong bargaining position based upon its resources and experience and will provide GP VMOs with more collective bargaining power relative to individual negotiations. The ACCC notes that the AMA will be restricted to negotiations only on behalf of its members who are rural GPs providing services as VMOs, in a particular state. The AMA is also restricted to negotiating with the state/territory health department and not individual hospitals.

The ACCC considers the voluntary nature of collective negotiations will limit any public detriment which may result from the proposed arrangements. The ACCC notes that authorisation will not compel state/territory health departments to engage in collective negotiations and should they decide to, they will have the ability to opt out of negotiations at any time. In this regard, the ACCC considers that state/territory health departments and the AMA would only enter into an agreement if it is mutually beneficial to both state/territory health

departments and AMA members. The ACCC notes that state/territory health departments remain free to continue with their existing arrangements for GP VMO contracts.

Authorisation will remove the legal risk to the AMA to engage in negotiations on behalf of their members, rather than playing a solely consultative role.

On balance, the ACCC considers the small public benefit is likely to outweigh the limited public detriment.

Length of authorisation

The ACCC generally considers it appropriate to grant authorisation for a limited period of time, so as to allow an authorisation to be reviewed in the light of any changed circumstances.

In this instance, the AMA seeks authorisation for a period of five years.

When granting authorisation to a collective bargaining arrangement, the ACCC endeavours to allow sufficient time for an arrangement to be negotiated and implemented. In these circumstances, the ACCC proposes to grant authorisation for a period of five years.

The next steps

The ACCC will now seek further submissions from the applicant and interested parties in relation to this draft determination prior to making a final decision. The applicant and interested parties may also request that a conference be held to make oral submissions on the draft determination.

Contents

List of abbreviations

ACCC	Australian Competition and Consumer Commission
AMA	Australian Medical Association Limited. This reference encompasses both the Australian Medical Association Limited and the State/Territory Australian Medical Association organisations
AMANSW	Australian Medical Association (New South Wales) Limited
AMANT	Australian Medical Association (Northern Territory) Limited
AMAQ	Australian Medical Association (Queensland) Limited
AMARRG	AMA Rural Reference Group
AMASA	Australian Medical Association (South Australia) Limited
AMATas	Australian Medical Association (Tasmania) Limited
AMAVic	Australian Medical Association (Victoria) Limited
AMAWA	Australian Medical Association (Western Australia) Limited
GPs	General Practitioners
Health departments	refers to the relevant State/Territory health department
RACGP	Royal Australian College of General Practitioners
RDAA	Rural Doctors Association of Australia
RDAV	Rural Doctors Association of Victoria
Rural GPs	Rural General Practitioners
the Act	*Trade Practices Act 1974* (Cth)
VHA	Victorian Healthcare Association
VHIA	Victorian Hospitals' Industrial Association
VMOs	Visiting Medical Officers
VMPs	Visiting Medical Practitioners
WACHS	WA Country Health Service

1. Introduction

Authorisation

1.1 The Australian Competition and Consumer Commission (the ACCC) is the independent Australian Government agency responsible for administering the *Trade Practices Act 1974* (the Act). A key objective of the Act is to prevent anti-competitive conduct, thereby encouraging competition and efficiency in business, resulting in a greater choice for consumers in price, quality and service.

1.2 The Act, however, allows the ACCC to grant immunity from legal action in certain circumstances for conduct that might otherwise raise concerns under the competition provisions of the Act. One way in which parties may obtain immunity is to apply to the ACCC for what is known as an 'authorisation'.

1.3 The ACCC may 'authorise' businesses to engage in anti-competitive conduct where it is satisfied that the public benefit from the conduct outweighs any public detriment.

1.4 The ACCC conducts a public consultation process when it receives an application for authorisation. The ACCC invites interested parties to lodge submissions outlining whether they support the application or not, and their reasons for this.

1.5 After considering submissions, the ACCC issues a draft determination proposing to either grant the application or deny the application.

1.6 Once a draft determination is released, the applicant or any interested party may request that the ACCC hold a conference. A conference provides all parties with the opportunity to put oral submissions to the ACCC in response to the draft determination. The ACCC will also invite the applicant and interested parties to lodge written submissions commenting on the draft.

1.7 The ACCC then reconsiders the application taking into account the comments made at the conference (if one is requested) and any further submissions received and issues a final determination. Should the public benefit outweigh the public detriment, the ACCC may grant authorisation. If not, authorisation may be denied. However, in some cases it may still be possible to grant authorisation where conditions can be imposed which sufficiently increase the benefit to the public or reduce the public detriment.

The application for authorisation

1.8 On 19 August 2008, the Australian Medical Association Limited (AMA) lodged application for authorisation A91100 with the ACCC.

1.9 The AMA and its constituent state/territory AMA organisations (except New South Wales) (collectively referred to as the AMA) seek authorisation to collectively negotiate with relevant state/territory health departments (health departments), the terms of contracts for rural general practitioners (Rural GPs) providing services as Visiting Medical Officers (VMOs) in public hospitals and health facilities in rural and remote areas of Australia (except for New South Wales).

1.10 The AMA defines a general practitioner as a doctor who holds vocational recognition status under the *Health Insurance Act 1974* or has access to A1 Medicare rebates under Commonwealth Government workforce programs such as the Rural Other Medical Practitioners Program.[1] For the purposes of assessing this application, the ACCC adopts this definition of general practitioner.

1.11 The AMA notes that this group does not include medical practitioners other than GPs in rural or remote areas, 'rural generalists', or GPs or medical practitioners other than GPs in metropolitan areas.

1.12 The AMA seeks authorisation for a period of five years. The application for authorisation is lodged on behalf of all current and future members of the AMA who are Rural GPs providing services as VMOs in public hospitals and health facilities in rural and remote areas of Australia (except for New South Wales).

Chronology

1.13 Table 1.1 provides a chronology of significant dates in the consideration of this application.

Table 1.1: Chronology of application for authorisation A91100

DATE	ACTION
19 August 2008	Application for authorisation lodged with the ACCC.
12 September 2008	Closing date for submissions from interested parties in relation to the substantive application for authorisation.
14 October 2008	Submission received from AMA in response to interested party submissions.
12 November 2008	Draft determination issued.

[1] Registration of certain medical practitioners as vocationally registered general practitioners is outlined in section 3F of the *Health Insurance Act 1974*.

2. Background to the application

The applicant[2]

2.1 The AMA is the peak health advocacy organisation in Australia, representing more than 27 000 doctors both in the public sector and private practice.

2.2 AMA membership encompasses all craft and special interest groups including salaried doctors, general practitioners, other specialists, academics, researchers and doctors-in-training. Membership encompasses rural, regional and metropolitan practitioners. Medical students are also eligible for membership.

2.3 The AMA is a national body with affiliated organisations in each state/territory. When a doctor joins the relevant state/territory organisation, they are granted membership of the AMA. Each state/territory organisation provides advice as well as representation and professional support to medical practitioners in their state/territory.

2.4 The AMA works at the national level to provide a variety of services to rural medical practitioners, including:

- lobbying and industrial support
- the provision of timely and relevant information to its members on current rural medical issues and
- policy development.

2.5 In 2005, the AMA formed a specific committee to consider issues relating to the delivery of health care in regional, rural and remote areas of Australia called the AMA Rural Reference Group (AMARRG). The AMARRG is comprised of AMA members in rural medical practice and was established to investigate the unique health needs of country Australians and communities and make policy recommendations through the AMA to the federal and state governments.[3]

The industry

2.6 The AMA's application for authorisation relates to VMOs providing medical services in rural and remote areas.

2.7 VMOs are medical practitioners appointed by a hospital board to provide medical services for hospital (public) patients on an honorary, sessionally paid, or fee for service basis.[4] These services may be provided as in-patient or after-hours services.

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[2] Information outlined in this chapter was largely obtained from the applicants' Form B, 19 August 2008.
[3] AMA media release, "AMA Rural Reference Group Ready for Action", http://www.ama.com.au/web.nsf/doc/WEEN-6DK3FZ.
[4] Australian Institute of Health and Welfare, *National Health Data Dictionary*, Version 13, (2006), June 2005, http://www.aihw.gov.au/publications/hwi/nhddv13/nhddv13_cdrom.pdf.

2.8 A general practitioner is a registered medical practitioner who is qualified and competent for general practice in Australia. A general practitioner has the skills and experience to provide whole person, comprehensive, coordinated and continuing medical care, maintaining professional competence for general practice.[5]

2.9 General practice in Australia operates predominately through private medical practice.[6] It is the first point of contact for the majority of people seeking health care, and often the first point of referral to other doctors, healthcare professionals and community services.[7] Around 86% of Australians attend a general practice at least once a year.[8]

2.10 In 2006, there were approximately 62 425 employed medical practitioners working in Australia. Among this group 80.9% worked in major cities, 12.7% in inner regional areas, 5.0% in outer regional areas and 1.4% in remote/very remote areas.[9]

2.11 In rural and remote Australia, geographical and demographic features lead to great diversity in both the ranges of presentations a GP may encounter and the facilities that may be available to them to administer primary care than their urban counterparts. Generally, rural GPs are more likely to be able to provide in-hospital care as well as private consulting room care, to provide after hours services, to engage in public health roles expected of them by discrete communities in which there are few doctors to choose from, to engage in clinical procedures, to engage in emergency care, to encounter a higher burden of complex or chronic health presentations, and to encounter larger proportions of Aboriginal or Torres Strait Islander patients in their overall patient load.[10]

Rural and remote Australia

2.12 The AMA submits that more than 6.8 million Australians live in regional, rural and remote areas. Individuals living in these areas generally have poorer health than their major city counterparts, reflected in their higher levels of mortality, disease and health risk factors.[11]

2.13 The AMA submits that people in country communities are finding it harder and harder to recruit and retain doctors. The Australian Government recently released a report on the results of an audit of the rural health workforce.[12] The report highlighted that the number of full time work equivalent GPs per 100 000 population is 97/100 000 in urban Australia, compared to 74.2/100 000 in outer regional areas, 68.2/100 000 in remote areas and 47.1/100 000 in very remote areas.

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[5] Australian Medical Association, *Comparison of Training Conditions and Vocational Training Costs in Australian Specialise Medical Training Programs*, http://www.ama.com.au/web.nsf/doc/WEEN-6CY3MF.
[6] Australian Medical Association, *General Practice/Rural Medicine Training*, June 2005, www.ama.com.au.
[7] Definition of General Practice and General Practitioner, RACGP website, www.racgp.org.au.
[8] Australian Institute of Health and Welfare, *National Health Data Dictionary*, Version 13, (2006), http://www.aihw.gov.au/publications/hwi/nhddv13/nhddv13_cdrom.pdf.
[9] Australian Institute of Health and Welfare, *Medical labour force 2006*, 31 October 2008, p. 25. http://www.aihw.gov.au/publications/hwl/mlf06/mlf06.pdf.
[10] Definition of Rural General Practice, RACGP website, http://www.racgp.org.au/rural/definition.
[11] Australian Institute of Health and Welfare, *Australia's Health 2008*, 2008.
[12] Australian Government Department of Health and Ageing, *Report of the Audit of Health Workforce in Rural and Regional Australia*, April 2008.

2.14 The report also stated that rural and remote Australia has experienced medical workforce shortages for a considerable period of time, particularly in terms of general practice services and some specialised services, such as obstetrics and gynaecology.

VMO appointment

2.15 Generally, in most states/territories, rural GPs are appointed to work in a hospital as independent contractors.

2.16 The ACCC understands that in order to be granted VMO rights, a doctor must be appointed by the Area Health Service, or a hospital. The doctor will generally be approved to provide specified medical services at a nominated hospital(s). The services provided by the doctor vary according to their individual skill mix however can include accident and emergency services, basic surgery, obstetrics and anaesthetics.

2.17 With the exception of Victoria, standard VMO agreements are set at the state/territory level. The AMA submits that currently the terms and conditions of VMOs working in public hospitals and health facilities in rural and remote areas are set unilaterally by the health department in the state/territory.

2.18 The situation differs in Victoria, where the state health department is not involved in the negotiations with doctors. In Victoria, individual public hospitals and health services in rural and remote areas negotiate directly with doctors regarding their appointment as VMOs.

2.19 Further discussion of current VMO employment in each state/territory is set out in paragraph 6.24.

2.20 The AMA notes that it currently provides advice and support to doctors negotiating with a state/territory health department for VMO terms and conditions. The ACCC notes that other industry bodies, such as the Rural Doctors Association of Australia (RDAA), perform a similar role for their members. The RDAA was recently granted authorisation to collectively negotiate with state/territory health departments the terms of contracts for GP or rural generalist VMOs in rural areas (see paragraphs 2.22 to 2.25).

Previous decisions

2.21 The ACCC has recently considered a number of similar applications for authorisation.

Rural Doctors Association of Australia (A91078)

2.22 The Rural Doctors Association of Australia Limited (RDAA) is a national body representing the interests of rural medical practitioners around Australia. RDAA membership includes rural generalists, GPs and specialists. The RDAA comprises the Rural Doctors Association (RDA) of each Australian state and the Northern Territory.

2.23 Doctors may be a member of either the AMA, RDAA or may choose to become a member of both.

2.24 On 7 December 2007 the RDAA, on behalf of its current and future members, lodged application for authorisation A91078 with the ACCC. The RDAA and its constituent

state associations sought authorisation to collectively negotiate with state/territory health departments the terms of contracts for general practitioner and rural generalist VMOs in rural areas, particularly with respect to payments for services provided to public patients and for on-call services, to apply state-wide.

2.25 On 14 May 2008 the ACCC granted authorisation until 30 June 2013. This authorisation does not extend to any collective decision by current or future RDAA members to engage in collective boycott activities, and authorisation does not extend to the RDAA negotiating on behalf of other medical specialists or to negotiations involving individual hospitals or any group of hospitals.

Australian Medical Association (NSW) Limited (A91088)

2.26 On 22 April 2008 the AMANSW lodged application for authorisation A91088 to collectively negotiate on behalf of VMOs in New South Wales with:

- the NSW Department of Health regarding the terms and conditions (including but not limited to remuneration) of VMO contracts in the NSW public hospital system and
- public health organisations regarding the terms and conditions (other than remuneration) of VMO contracts in the NSW public hospital system, at the local level.

2.27 On 13 August 2008 the ACCC granted authorisation until 31 December 2013. This authorisation does not extend to any collective decision by current or future VMOs working within the NSW public hospital system to engage in collective boycott activities.

Royal Australian College of General Practitioners (A91024)

2.28 On 13 December 2006 the Royal Australian College of General Practitioners (RACGP) lodged an application for revocation of authorisation A90795 and its substitution with authorisation A91024.

2.29 The RACGP sought authorisation for GPs and OMPs[13] operating in a single practice within particular business structures to agree on:

- fees charged to patients
- fees that any locums the GPs engage, either individually or jointly, will charge patients for their services and
- fees that the GPs charge to a hospital as VMOs.

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[13] The RACGP defined OMPs as medical practitioners who are not vocationally registered, are not Fellows of RACGP and who render Group A2 Other Non-referred Attendance items in the Medicare Benefits Scheme. OMPs include a group of Medical Practitioners who were in general practice prior to the introduction of vocational registration, and who have not become vocationally registered. OMPs also include international (rather than Australian) medical graduates, who are working in general practice and who have not been assessed for Fellowship of the RACGP.

2.30 On 23 May 2007 the ACCC granted authorisation to the RACGP for intra-practice price setting arrangements and hospital agreements for a period of four years. The arrangements apply to GPs and other medical practitioners in general practice associateships and partnerships, who operate as a team, where they share patient records, have common facilities, a common trading name and common policies and procedures.

2.31 In its consideration of the application for revocation and substitution, the ACCC considered the public benefits and detriments resulting from collective negotiations among relevant GP VMOs and public hospitals. The ACCC considered that the benefits would outweigh any potential detriments, noting that the potential detriments were limited by that fact that the arrangements:

- apply only to GPs operating in one practice
- are voluntary and
- do not extend to collective boycott activity by RACGP.

3. The application for authorisation

3.1 On 19 August 2008, application A91100 was lodged by the AMA and its state/territory AMA organisations including Australian Medical Association (Northern Territory) Limited (AMANT), Australian Medical Association (Queensland) Limited (AMAQ), Australian Medical Association (South Australia) Limited (AMASA), Australian Medical Association (Tasmania) Limited (AMATas), Australian Medical Association (Victoria) Limited (AMAVic) and Australian Medical Association (Western Australia) Limited (AMAWA) (collectively referred to as the AMA). The application is not made with respect to New South Wales.[14]

3.2 The AMA seeks authorisation to collectively negotiate with relevant state/territory health departments the terms of contracts, including fees, for Rural GPs providing services as VMOs in public hospitals and health facilities in rural and remote areas of Australia (except for New South Wales).

3.3 The AMA anticipates that any contract collectively negotiated with health departments, on behalf of Rural GPs, will include a common fee schedule and may also include common arrangements for rostering and on-call services.

3.4 The AMA notes that the development of a collective agreement is not intended to preclude Rural GPs from individually negotiating specific contractual arrangements with local hospitals to suit their mutual needs, should such circumstances arise.

3.5 Authorisation is sought for a period of five years. The AMA advises that the timing of negotiations for arrangements relating to the provision of medical services in rural and remote hospitals and health facilities varies between states/territories. The AMA expects that any collective agreements would remain in force for an agreed period of time (usually a number of years), and would include an agreed fee indexation formula during the life of the agreement.

3.6 The collective negotiations may potentially raise concerns under the anti-competitive conduct provisions of the Act. Consequently, the AMA has lodged application for authorisation A91100 under section 88(1) of the Act to make and give effect to a contract or arrangement, or arrive at an understanding, a provision of which would have the purpose, or would have or might have the effect of substantially lessening competition within the meaning of section 45 of the Act.

3.7 Under section 88(6) of the Act, any authorisation granted by the ACCC is automatically extended to cover any person named in the authorisation as being a party or proposed party to the conduct. The AMA seeks authorisation on behalf of all current and future members of the AMA who are rural GPs providing services as VMOs in public hospitals and health facilities in rural and remote areas of Australia (except for New South Wales).

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[14] See paragraphs 2.26 to 2.27. AMANSW sought and was granted authorisation for collective bargaining on behalf of VMOs in New South Wales.

4. Submissions received by the ACCC

4.1 The AMA provided a supporting submission with its application for authorisation. The AMA submits that authorisation will result in a number of public benefits including:

- more effective representation of rural doctors to the state/territory health departments
- reduced transaction times and costs associated with the contracting of GPs and VMOs, including for individual doctors and
- a positive effect on the retention of rural GPs and VMOs.

4.2 The AMA argues there is little, if any, public detriment likely to result from the authorisation of the proposed collective arrangements. The AMA submits that any public detriment resulting from the application will be limited by the fact that the arrangements are voluntary for AMA members and the state/territory health departments. The AMA notes that an agreement will only be reached between the parties if it is beneficial to both AMA members and the relevant state/territory health departments. The AMA also notes that it has not applied for authorisation to engage in collective boycott activity.

4.3 The ACCC sought submissions from 47 interested parties potentially affected by the application, including state/territory health departments and various industry associations. The ACCC received public submissions from:

- Australian Medical Association (NSW) Limited
- Rural Doctors Association of Australia
- Rural Doctors Association of Victoria
- Department of Health WA
- Queensland Health
- Victorian Hospitals' Industrial Association and
- Department of Health and Ageing
- Consumers Health Forum

Australian Medical Association (NSW) Limited

4.4 The AMANSW supports the application for authorisation and submits that it would enable the applicants to better support their members who provide services in the public hospital system in rural and remote areas. Authorisation would assist them in ensuring the ongoing provision of quality health services in those areas.

Rural Doctors Association of Australia

4.5 The RDAA does not oppose the AMA's application for authorisation.

4.6 The RDAA notes that the AMA's application is not clear regarding whether authorisation is also being sought to negotiate on behalf of rural generalists who work as independent VMO contractors contracted to public hospitals.

4.7 The RDAA also notes that it was granted authorisation in similar terms to that of the AMA's application, and submits that it has already provided the public benefits cited in the AMA's application with rural VMO contract negotiations already being carried out under the terms of the authorisation granted to the RDAA.

Rural Doctors Association of Victoria (RDAV)

4.8 The RDAV reiterates the submission of the RDAA.

4.9 The RDAV notes that, in Victoria, the generalist VMO sector has shrunk considerably in the last 20 years with procedural GP VMOs much less common in metropolitan areas and large regional towns. The RDAV further submits that Victoria will not be able to preserve adequate rural services without a significant number of centres dependent on GP VMOs.

4.10 The RDAV notes that AMAVic and RDAV previously worked together to develop a standard contract which is currently in use for obtaining after-hours on-call payments for rural doctors. The RDAV has been lobbying the state government to resume the use of a state-wide package. The RDAV submits that it does not consider itself a competitor with AMA for providing services to GPs. At the national level, whenever possible, the RDAA works in collaboration with the AMA.

Department of Health WA

4.11 The Department of Health WA does not support the AMA's application for authorisation and submits that a number of public detriments will result from the AMA's application for authorisation. These are that:

- the grant of authorisation to the AMA will result in an increase in the types of arrangements for engagement of rural doctors in WA. The Department of Health WA submits that the grant of authorisation to the RDAA, and the possible grant of authorisation to the AMA's application creates the expectation that the department will conduct separate negotiations with each of the associations, potentially resulting in different outcomes. The Department of Health WA notes that doctors who are not members of either association will still need to carry out their own negotiations which may result in three separate sets of arrangements for the engagement of rural doctors. This will be difficult to manage, as well as time consuming and costly.

- while the Department of Health WA acknowledges that granting the application will not compel the Department of Health WA to enter into negotiations, the department considers it likely that the AMA would be in a position to exert considerable pressure on the department to engage in collective negotiations and

- in WA, the process for contracting with rural Visiting Medical Practitioners (VMPs) is currently managed and coordinated by the WA Country Health Service (WACHS). The Department of Health WA is concerned that, for the purposes of AMA's application, WACHS falls outside the scope of the authorisation because it is not the state department and authorisation would therefore remove the organisation best placed to negotiate engagement of VMPs in WA.

4.12 The Department of Health WA submits that it is essential that a high degree of flexibility is maintained as attraction and retention of doctors varies from region to region. A standardised contract and remuneration structure to apply across the state will make it more difficult to attract doctors to those regions where recruitment is already difficult.

4.13 Further, the Department of Health WA notes that there is no evidence to suggest that there are significant transaction costs for medical practitioners who participate in individual negotiations and submits that the current contractual process has not been a barrier to recruitment with the number of doctors working in rural WA steadily increasing over the past five years.

4.14 The Department of Health WA notes its concern that the arrangements may act as an inducement to pressure non members to join the AMA in order to gain the benefit of the proposed collective negotiations.

Queensland Health

4.15 Queensland Health does not provide support or oppose the AMA's application for authorisation.

4.16 Queensland Health notes that should the ACCC grant authorisation, it does not anticipate that the current practice in Queensland would change. Therefore, a number of the public benefits claimed by the AMA will not result.

Victorian Healthcare Association

4.17 The Victorian Healthcare Association (VHA) is the peak health policy association in Victoria, representing the interests of the public healthcare sector in Victoria. Its members include public hospitals, rural and regional health services, community health services and aged care facilities.

4.18 The VHA opposes the AMA's application for authorisation, particularly in the Victorian context. The VHA submits that, within a Victorian context, there is no evidence to support the assertion that the AMA's representation of rural doctors to the state health authorities would result in a public benefit, and considers that the RDAA provides more effective representation than the AMA to rural doctors. The VHA considers that Victoria should be exempted from the authorisation.

4.19 The VHA remains concerned that the AMA will negotiate prices up which will be to the detriment of hospitals.

4.20 The VHA submits that the AMA's current advisory role already provides benefit to doctors. The VHA submits that the AMA could provide a pro-forma type contract to its doctor members as additional guidance to GPs to use when negotiating their contracts.

Victorian Hospitals' Industrial Association

4.21 The Victorian Hospitals' Industrial Association (VHIA) was established in 1994, and is a nationally registered organisation representing the interests of employers in health, aged care, disability, general practice, podiatry, dental and community services, both public and private. VHIA membership provides its clients with access to the expertise of industrial relations, legal and human resource consultants.[15]

4.22 The VHIA does not support the AMA's application for authorisation. The VHIA advises that the system in Victoria for negotiating VMO contracts is different to the other states in Australia. The Department of Human Services does not engage or employ Medical Practitioners. As such, the VHIA submits that Victoria should be exempted from the application. The VHIA notes its previous opposition to the application by and subsequent grant of the authorisation to the RDAA.

4.23 The VHIA submits that if the AMA's application for authorisation is granted, it will inevitably result in the Department of Human Services and the VHIA with little choice but to sit down and negotiate a central agreement.

4.24 The VHIA submits that the real purpose for the AMA's application is about funding, increases in the price for medical services, and obtaining maximum flexibility and a guaranteed floor price for medical services.

4.25 The VHIA is concerned that a state wide central agreement will have the effect of driving prices up as the highest rate becomes the common denominator.

4.26 The VHIA also submits that the proposed authorisation will not result in more effective representation of rural doctors. The VHIA submits that the AMA has not provided any evidence to support this claim and contends that GPs are currently properly represented in Victoria. Further, the VHIA submits that GPs are better represented at a local level as it provides a more effective platform for dealing with local issues.

The Commonwealth Department of Health and Ageing

4.27 The Department notes that it has no information which would indicate the supply of doctors to rural areas would be affected one way or the other by the use or otherwise of collective negotiation. The Department is keen to ensure that employment arrangements support the recruitment and retention of doctors in rural areas and should not affect the quality or amount of supervision provided to medical students and trainees by VMOs.

Consumers Health Forum of Australia

4.28 The Consumers Health Forum of Australia (CHF) notes that it is not in a position to comment directly on the negotiations proposed by the AMA, however notes a number of expectations which consumers would expect be met in the provision of services by medical practitioners, including ensuring safe and good quality healthcare to meet community needs.

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[15] VHIA website, http://www.vhia.com.au.

4.29 The CHF also notes health access issues in rural Australia including minimising the impact for patients on out of pocket costs and improving the availability of bulk billing and after-hours services.

AMA response to interested party submissions

4.30 In addition to the information provided in its application for authorisation, on 14 October 2008 the AMA provided a submission addressing the issues raised by interested parties. In particular, the AMA submits that:

- granting authorisation to the AMA will mean that GPs do not have to join both the RDAA and the AMA in order to benefit from collective negotiations with health departments
- the application has been made to provide the AMA with certainty and legal protection in its dealings with state/territory health departments. Negotiations will be voluntary and no health department, in particular the Victorian Department of Human Services or the Department of Health WA, will be compelled to carry out collective negotiations with the AMA.
- the ability of the AMA to lift the price of medical services in the collective bargaining process will be significantly curtailed by the fact that state/territory health departments will only enter into collective VMO bargaining arrangements for rural GPs if they believe that the process will improve the delivery of rural health services. If the AMA pushes the price too high, then the health departments are unlikely to agree to the terms of the agreements. The AMA notes that the state/territory health departments may opt out of negotiations at any time.
- the arrangements are voluntary and flexible, recognising that there may be circumstances where some individual local variation is required.

4.31 The views of the AMA and interested parties are outlined further in the ACCC's evaluation of the proposed collective negotiations in Chapter 6 of this draft determination. Copies of public submissions are available from the ACCC website (**www.accc.gov.au**) by following the 'Public Registers' and 'Authorisations Public Registers' links.

5. The net public benefit test

5.1 The ACCC may only grant authorisation where the relevant test in section 90 of the Act is satisfied.

Application A91100

5.2 The AMA lodged application for authorisation A91100 under section 88(1) of the Act to make and give effect to a contract or arrangement, or arrive at an understanding, a provision of which would have the purpose, or would have or might have the effect, of substantially lessening competition within the meaning of section 45 of the Act. The relevant tests for this application are found in sections 90(6) and 90(7) of the Act.

5.3 In respect of the making of and giving effect to the arrangements, sections 90(6) and 90(7) of the Act state that the ACCC shall not authorise a provision of a proposed contract, arrangement or understanding, other than an exclusionary provision, unless it is satisfied in all the circumstances that:

- the provision of the proposed contract, arrangement or understanding would result, or be likely to result, in a benefit to the public and
- this benefit would outweigh the detriment to the public constituted by any lessening of competition that would result, or be likely to result, if the proposed contract or arrangement was made and the provision concerned was given effect to.

Application of the tests

5.4 The Tribunal has stated that the test under section 90(6) is limited to a consideration of those detriments arising from a lessening of competition.[16]

5.5 However, the Tribunal has previously stated that regarding the test under section 90(6):

> [the] fact that the only public detriment to be taken into account is lessening of competition does not mean that other detriments are not to be weighed in the balance when a judgment is being made. Something relied upon as a benefit may have a beneficial, and also a detrimental, effect on society. Such detrimental effect as it has must be considered in order to determine the extent of its beneficial effect.[17]

5.6 Consequently, given the similarity of wording between section 90(6) and 90(7), when applying these tests the ACCC can take most, if not all, detriments likely to result from the relevant conduct into account either by looking at the detriment side of the equation or when assessing the extent of the benefits.

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[16] *Australian Association of Pathology Practices Incorporated* [2004] ACompT 4; 7 April 2004. This view was supported in *VFF Chicken Meat Growers' Boycott Authorisation* [2006] AcompT9 at paragraph 67.

[17] Re Association of Consulting Engineers, Australia (1981) ATPR 40-2-2 at 42788. See also: *Media Council case* (1978) ATPR 40-058 at 17606; and *Application of Southern Cross Beverages Pty. Ltd., Cadbury Schweppes Pty Ltd and Amatil Ltd for review* (1981) ATPR 40-200 at 42,763, 42766.

Definition of public benefit and public detriment

5.7 Public benefit is not defined in the Act. However, the Tribunal has stated that the term should be given its widest possible meaning. In particular, it includes:

> ...anything of value to the community generally, any contribution to the aims pursued by society including as one of its principle elements ... the achievement of the economic goals of efficiency and progress.[18]

5.8 Public detriment is also not defined in the Act but the Tribunal has given the concept a wide ambit, including:

> ...any impairment to the community generally, any harm or damage to the aims pursued by the society including as one of its principal elements the achievement of the goal of economic efficiency.[19]

Future with-and-without test

5.9 The ACCC applies the 'future with-and-without test' established by the Tribunal to identify and weigh the public benefit and public detriment generated by arrangements for which authorisation has been sought.[20]

5.10 Under this test, the ACCC compares the public benefit and anti-competitive detriment generated by arrangements in the future if the authorisation is granted with those generated if the authorisation is not granted. This requires the ACCC to predict how the relevant markets will react if authorisation is not granted. This prediction is referred to as the 'counterfactual'.

Length of authorisation

5.11 The ACCC can grant authorisation for a limited period of time.[21]

Conditions

5.12 The Act also allows the ACCC to grant authorisation subject to conditions.[22]

Future and other parties

5.13 Applications to make or give effect to contracts, arrangements or understandings that might substantially lessen competition or constitute exclusionary provisions may be expressed to extend to:

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[18] Re 7-Eleven Stores (1994) ATPR 41-357 at 42,677. See also Queensland Co-operative Milling Association Ltd (1976) ATPR 40-012 at 17,242.

[19] Re 7-Eleven Stores (1994) ATPR 41-357 at 42,683.

[20] Australian Performing Rights Association (1999) ATPR 41-701 at 42,936. See also for example: Australian Association of Pathology Practices Incorporated (2004) ATPR 41-985 at 48,556; Re Media Council of Australia (No.2) (1987) ATPR 40-774 at 48,419.

[21] Section 91(1).

[22] Section 91(3).

- persons who become party to the contract, arrangement or understanding at some time in the future[23]
- persons named in the authorisation as being a party or a proposed party to the contract, arrangement or understanding.[24]

[23] Section 88(10).
[24] Section 88(6).

6. ACCC evaluation

6.1 The ACCC's evaluation of the proposed collective negotiations is made in accordance with the net public benefit test outlined in Chapter 5 of this draft determination. As required by the test, it is necessary for the ACCC to assess the likely public benefits and detriments flowing from the proposed collective negotiations.

The market

6.2 The first step in assessing the effect of the conduct for which authorisation is sought is to consider the relevant market(s) affected by that conduct.

6.3 The AMA's application for authorisation concerns the provision of VMO services to public hospitals throughout Australia. The AMA notes that each state/territory currently has in place its own system for engaging VMOs in rural and remote areas in their state/territory.

6.4 The AMA submits that the relevant market is the provision of VMO services by GPs, within defined local geographical areas, to public hospitals and health facilities in rural and remote areas of Australia.

6.5 The VHIA submits that the market for the provision of VMO services to public hospitals is in part local, in part a Victorian market, and in part a national market.[25]

6.6 The ACCC understands that GP VMOs operate predominately in rural areas. GPs operating in metropolitan areas do not generally provide VMO services to hospitals. Further, the ACCC has previously noted that public hospitals are likely to seek VMO services from doctors practicing in a localised geographic radius from a hospital.[26] The breadth of this region is likely to differ depending on the remoteness of the area.

6.7 The ACCC accepts the AMA's definition of the market. The ACCC also notes that the AMA's proposed collective negotiations for VMO services are to be conducted with each state/territory health department. Therefore the ACCC considers the market to be localised into these regions.

6.8 Overall, the ACCC does not consider it necessary to precisely define the market in this instance, as the outcome of the assessment would not be affected.

The counterfactual

6.9 As noted in Chapter 5 of this draft determination, in order to identify and measure the public benefit and public detriment generated by conduct, the ACCC applies the 'future with-and-without test'.

6.10 The AMA submits that in the absence of authorisation:

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[25] VHIA submission, dated 12 September 2008, p. 14.
[26] ACCC Determination, Application for authorisation A91078 lodged by the Rural Doctors Association of Australia Limited, 14 May 2008, ACCC Determination, Application for revocation and substitution of authorisation A90795 lodged by the Royal Australian College of General Practitioners, 23 May 2007.

- the status quo will continue into the foreseeable future and
- the AMA will not be in a legal position to fully represent the interests of rural GPs providing services as VMOs in public hospitals and health facilities in rural and remote areas of Australia.

6.11 The AMA submits that in the counterfactual, members of the AMA who are not also members of the RDAA, will not have the benefit of collective negotiation of VMO contracts, which may result in them taking up RDAA membership and incurring additional costs to do so.

6.12 The AMA also submits that in the counterfactual, it is likely that rural GPs over time will reduce the services they provide as VMOs in public hospitals and health facilities in rural and remote areas, and may withdraw from rural practice altogether.

6.13 The RDAA notes that, given that authorisation has previously been granted to the RDAA to collectively negotiate with state/territory departments the terms of VMO contracts in rural areas, the counterfactual is a situation where RDAA can collectively negotiate with the state/territory health departments. The RDAA notes that this process has already begun in a number of states and further negotiations are expected to commence within the next year.

6.14 The VHA notes that given that authorisation has been granted to the RDAA, this now forms part of the status quo. The VHA submits that the RDAA has the capacity to consult with the AMA in representing the interests of rural doctors, thereby already offering an avenue for collective negotiations with state/territory health departments.

6.15 The ACCC considers that in the absence of authorisation, it appears unlikely that the AMA would represent GP VMOs in collective negotiations, particularly with respect to the price of medical services, with state/territory health departments. The ACCC considers that in the counterfactual, the AMA will continue to play a consultative role and doctors will be required to negotiate the terms and conditions of their VMO contracts individually. In the counterfactual, doctors who want access to a collectively negotiated agreement would be required to join the RDAA.

Public detriment

6.16 The AMA considers that there is little, if any, public detriment likely to result from the authorisation of the proposed collective arrangements.

6.17 Collective bargaining refers to an arrangement under which two or more competitors in an industry come together to negotiate terms and conditions, which can include price, with a supplier or customer.

6.18 Generally speaking, competition between individual businesses generates price signals which direct resources to their most efficient use. Collective agreements to negotiate terms and conditions can interfere with these price signals and accordingly lead to inefficiencies. However, the extent of the detriment and the impact on competition of the collective agreement will depend upon the specific circumstances involved.

6.19 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 features are present:

- the current level of negotiations between individual members of the group and the proposed counterparty(s) on the matters to be negotiated is low
- participation in the collective bargaining arrangement is voluntary
- there are restrictions on the coverage and composition of the bargaining group
- there is no boycott activity.

6.20 A discussion of each of these features follow.

Current level of negotiations

6.21 Where the current level of individual bargaining between members of a proposed bargaining group and the target is low, the difference between the level of competition with or without the collective arrangements may also be low.

6.22 The AMA submits that the current level of individual bargaining between rural GPs for VMO services in public hospitals and health facilities in rural and remote areas of Australia, and the state/territory health departments, is low.

6.23 The AMA submits that state/territory health departments unilaterally determine the arrangements for the contracting of doctors in public hospitals and health facilities (with the exception of Victoria). The AMA notes, however, that generally the state/territory health departments will consult with a representing body.

6.24 The current practices in each state/territory for establishing the terms and conditions for rural GP VMOs in each state/territory is as follows:

- In Victoria the Department of Human Services has no direct involvement in setting the contractual terms for VMOs. In Victoria, this role has been devolved to individual hospitals.
- In South Australia the SA Department of Health, through Country Health SA (CHSA), operates as a single agency covering all health units in country SA. The CHSA works closely with a number of external stakeholders including rural doctors and their representative bodies (Rural Doctors Workforce Agency, South Australian Divisions of General Practice, Rural Doctors Association), the Health Consumers Alliance, Local Government and the Tertiary Education sector to set the fees for rural doctors.

  The ACCC notes that in response to the RDAA's application for authorisation, the SA Department of Health submitted that while the process results in a common fee schedule applied universally across country SA, it also allows sufficient flexibility in relation to other benefits to enable CHSA to remain competitive in the market for medical practitioners. The ACCC notes the AMA proposes its arrangements to provide flexibility to account for local circumstances.

- In Western Australia, the Department of Health WA sets the fees and conditions to apply to Visiting Medical Practitioners (VMPs) working in government non-teaching hospitals. Medical services are provided to rural hospitals in rural WA through a mix of salaried and contracted specialist and non specialist medical practitioners. Full time salaried employment is the predominant mechanism of engagement in hospitals in the north of the state. Most country doctors in the southern half of the state remain in private practice and provide VMP services under contract.

  VMPs are engaged on the basis of a Medical Services Agreement (MSA). The body of the MSA sets out the conditions of the appointment including remuneration. The terms and conditions of the MSA are mostly non-negotiable however the content of the schedules to the agreement (which refer to remuneration) may be negotiated individually by the doctor to account for their skill level.

  The Department of Health WA notes that the current processes for contracting with rural VMPs are currently managed and coordinated by the WA Country Health Service (WACHS). The Department of Health WA is concerned that this organisation would not be able to continue to negotiate these contracts under any authorisation granted to the AMA because it would be classed as a group of hospitals rather than the state department. The ACCC notes that state/territory health departments may appoint an agent to carry out collective negotiations on their behalf (see paragraph 6.80 and 7.7 for further information).

  The Department of Health WA submits that the current level of bargaining between members of the proposed group and hospitals is high and submits that medical practitioners are not constrained in their ability to provide input into the terms and conditions of engagement. The Department of Health WA submits that some conditions will always be non-negotiable in order to maintain a proper environment for governance and patient safety, therefore collective bargaining will not provide any significant benefit that is not already achievable under the current arrangements.

- In the Northern Territory only specialists provide visiting medical services in rural areas. When negotiating the terms and conditions of the contract for VMO services with specialist VMOs, the Department of Health and Community Services deals with the Australian Salaried Medical Officers Federation and AMANT.

- In Queensland, the state government (acting through the Department of Health, the Department of Corrective Services and the Department of Communities) negotiates a VMO Agreement with AMAQ concerning the supply of VMO services by doctors who are engaged as employees. Following these negotiations, Queensland Health has the option to undertake an internal process to approve an increase to the rates payable to VMOs that are engaged as independent contractors. Queensland Health also advise that it engages rural practitioners as private practitioners on a retainer system and as salaried medical officers.

  Queensland Health notes that current negotiations between rural GPs engaged as VMOs and Queensland Health is low, as they are mostly engaged as individual contractors.

- In Tasmania VMOs are appointed under the Rural Medical Practitioners (Public Sector) Agreement.

6.25 The AMA submits that in the majority of states, GP VMOs do have some ability to vary their terms and conditions of their VMO contracts, including with respect to theatre access, after hours needs and quality and safety factors, to reflect their particular practice needs and that of the hospitals and populations they serve. However this limited ability is rarely exercised in practice by GP VMOs and the current extent of individual contracting is low.

6.26 Based on the information provided, there appears to be some negotiation about the remuneration levels outlined in the schedule of the MSA depending on the skills of the doctor in WA. However, in general the extent to which contracts between individual members of the AMA and the state and territory health departments are currently negotiated, particularly about the payment for services provided to public patients appears to be low.

6.27 The ACCC notes that in many states/territories there is some consultation with various bodies including the AMA around the level of fees to be paid for VMO services. However it appears that many individual doctors do not regularly vary the terms and conditions of the VMO contract offered by the department.

Size/composition of bargaining groups

6.28 The ACCC considers that where the size of bargaining groups is restricted, any anti-competitive effect is likely to be smaller having regard to the smaller area of trade directly affected and to the competition provided by those suppliers outside the group.

6.29 The AMA's application for authorisation is limited to rural GPs providing services as VMOs in public hospitals and health facilities in rural and remote areas of Australia (with the exception of New South Wales). The AMA notes that the group for which authorisation is sought:

- only relates to the craft group characterised as rural GPs providing services and VMOs (and to no other craft groups) and
- only relates to negotiations on behalf of rural GPs with relevant state and territory health departments (and not with public health organisations/individual hospitals).

6.30 Queensland Health submits that, in Queensland, the term rural generalist applies also to rural GPs who are in credential advanced rural practice. Queensland Health submits that this means that the size of the bargaining group will not be less than that of the bargaining group outlined in the authorisation granted to the RDAA.

6.31 The coverage and composition of the bargaining groups under the AMA's proposal is extensive, and, the pool of medical practitioners available to individual state/territory health departments as GP VMOs outside the bargaining groups is likely to be limited given the current shortage of doctors in rural and remote areas throughout Australia.

6.32 The ACCC notes that, in general, appointment of rural GPs as VMOs occurs at the state level (with the exception of Victoria).

6.33 The ACCC accepts that the collective bargaining power of GPs will be more prevalent with the AMA's representation of the collective bargaining group relative to individual negotiations. The ACCC notes the AMA has extensive resources and experience in carrying out representations on behalf of its members. While GP VMOs would, as a group, have a stronger bargaining position when dealing with a small rural hospital for example, their position would be different with the state/territory health department. The AMA will be restricted to negotiations only on behalf of its members who are rural GPs providing services as VMOs, in a particular state. The AMA is also restricted to negotiations with the state/territory health department and not individual hospitals.

Voluntary participation in the collective bargaining arrangements

6.34 The AMA advises that the proposed collective arrangements are voluntary for both AMA members and the state/territory health departments. The AMA notes that state/territory health departments will not be forced to engage in collective negotiations, and should they decide to, may opt out of negotiations at any time.

6.35 The AMA submits that negotiations will be carried out by each state/territory building upon the consultative processes already in place.

6.36 The AMA notes that individual rural GPs remain free to negotiate specific contract terms with local hospitals to suit their mutual needs.

6.37 The VHA submits that the AMA has not outlined how it proposes to introduce collective bargaining within Victoria, where negotiations are currently held with individual hospitals. While the VHA acknowledges that the arrangements are voluntary, for this reason the authorisation should not be granted in Victoria.

6.38 The VHIA submits that while the arrangements may be voluntary, they consider that the AMA will strongly pursue collective bargaining and that central negotiations will inevitably result. The VHIA questions how voluntary the arrangements will be given the experience and presence of the AMA.

6.39 Queensland Health and the Department of Health WA note that the authorisation would not mandate collective bargaining arrangements, and would not support any forced arrangements. The Department of Health WA is concerned that if authorisation is granted to the AMA's application, the AMA will be in a position to exert pressure on the department to carry out collective negotiations.

6.40 The Department of Health WA notes that currently the WACHS carries out negotiations in WA and not the Department.

6.41 The ACCC notes that authorisation removes the legal risk to the AMA if they were to engage in collective negotiations with state/territory health departments. Should authorisation be granted, the AMA will be able to carry out collective negotiations with state/territory health departments, but will not be able to compel them to engage in negotiations through collective boycott activity.

6.42 The extent to which the proposed collective bargaining arrangements are genuinely voluntary for all parties is critical to the ACCC's assessment of the AMA's application for authorisation. A consideration in the RDAA's application for authorisation was the fact that individual doctors may be able to exert pressure on state/territory health

departments by individually withdrawing VMO services. The AMA notes that this risk exists with or without authorisation. The AMA also notes that rural doctors have a history of commitment to providing quality services to public patients.

6.43 In the RDAA determination, the ACCC noted that there are many reasons why an individual GP VMO may choose to withdraw services. In general, such decisions when made individually are unlikely to raise trade practices issues. In the context of collective bargaining, a collective boycott occurs when a group of competitors agree not to acquire goods or services from, or not to supply goods or services to, a business with whom the group is negotiating, unless the business accepts the terms and conditions offered by the collective bargaining group (see paragraphs 6.48 to 6.49).

6.44 The ACCC notes interested party submissions that the AMA will be in a position to exert pressure on the state/territory health department to engage in collective negotiations, and accepts that the AMA may be able to exert some pressure. The ACCC considers, however, that given the absence of collective boycott activity, a state/territory health department will only engage in collective negotiations if it sees benefit in doing so.

6.45 The ACCC does not consider that the proposed authorisation will force state/territory governments to change their current practices for engaging GP VMOs in rural public hospitals.

6.46 The proposed authorisation will not impose any obligation on state/territory health departments to participate in collective negotiations, and in the instance where they decide to, have the ability to opt out of the negotiations at any time. The ACCC does not have any evidence that as a result of the RDAA authorisation, state/territory health departments are being forced into collective negotiations, and considers that this will not result from authorisation of the AMA's proposed arrangements. The ACCC notes that the application for authorisation does not extend to collective negotiations with individual hospitals.

6.47 The risk that doctors will individually withdraw their services if they are not satisfied with the terms and conditions of their contracts exists with or without authorisation. If there is evidence of any collective decision by doctors to withdraw their services, the ACCC would investigate.

Boycott activity

6.48 The AMA advises that state/territory health departments who choose to engage in collective negotiations are free to opt out of negotiations at any time.

6.49 The AMA has not applied for authorisation to engage in collective boycott activity. Accordingly, any such conduct, should it occur, would not be protected from legal action under the Act. Additionally, if such conduct did occur, the ACCC would investigate.

ACCC conclusion on public detriments

6.50 The ACCC considers that in a number of states, the difference in the level of competition amongst doctors with or without collective bargaining is likely to be small.

The ACCC notes that while the coverage and composition of the proposed bargaining groups is extensive the current appointment of rural GPs as VMOs mostly occurs at the state level.

6.51 With regard to the other states, in particular Victoria and to some extent Western Australia, the ACCC considers that the voluntary nature of the arrangements and the absence of collective boycott conduct limit the potential detriment. The ACCC recognises that each state/territory has its own system for engaging VMOs, and considers that the voluntary nature of the arrangements will not compel a state to change the way it does so. In this respect, the ACCC notes submissions from VHIA and Queensland Health that it is unlikely the system will change in these states whether authorisation is granted or not.

6.52 The ACCC considers that given the voluntary nature of the proposed arrangement, a collectively negotiated agreement will only be reached if it is mutually beneficial to both state/territory health departments and AMA members. The ACCC considers that the state/territory health departments remain in a position to choose whether to engage in collective negotiations or to continue with their existing arrangements for GP VMO contracts.

6.53 The ACCC considers that the detriment is likely to be much larger if negotiations were to be undertaken at an individual hospital level. However, negotiations with individual hospitals and groups of hospitals are specifically excluded from the AMA's application for authorisation.

Public benefit

6.54 The AMA submits that the proposed collective bargaining arrangements will deliver the following public benefits:

- more effective representation of rural doctors to the state/territory health departments
- reduced transaction times and costs associated with the contracting of GPs as VMOs, including for individual doctors and
- a positive effect on the retention of rural GPs as VMOs.

6.55 The ACCC's assessment of the likely public benefits follows.

Effective representation of rural doctors to the state/territory health departments

AMA submission

6.56 In the states where the health department currently establishes the terms, conditions and remuneration included in VMO contracts, the AMA submits that the departments often consult with organisations that represent doctors, including the AMA. The AMA submits that the grant of authorisation will give them the ability to actively participate in the negotiations, rather than being limited to a consultative role.

6.57 The AMA submits that the ability to negotiate, rather than just consult with state/territory health departments, including on matters such as price, will make a

significant and positive difference to the representation of rural GPs providing VMO services.

6.58 The AMA also submits that collective negotiation will not only allow it to have greater input into terms and conditions, including remuneration, it will also mean that it can ensure that broader policy issues are taken into account such as the maintenance of viable facilities and education and training.

6.59 The AMA notes that it is anticipated that specific advisory groups would be formed to oversee the negotiation process for VMO contracts and provide specific rural GP input to ensure broad professional supply of the arrangements. Further, the AMA notes that it has an established office in each state/territory with significant 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.

6.60 The AMA further considers that authorisation of its proposed arrangements will mean that the AMA members who would like the benefit of collective negotiations will not have to also join the RDAA.

Interested party views

6.61 The VHA notes that there is no evidence within the Victorian context to support the AMA's claim that collective negotiation will lead to better representation of rural doctors and notes that there are other industry bodies such as the RDAA which also represent, and provide better representation, to rural doctors.

6.62 The VHA and VHIA are concerned that the AMA's ability to negotiate price as a means for achieving more effective representation to rural doctors, implies that the AMA will pressure prices upward. Should this occur hospitals will be left with reduced funds in other areas.

6.63 The VHA also submits that the AMA could achieve its aim and service its membership by offering a pro-forma contract to its members for them to consider in their own negotiations, therefore ensuring they have considered broader policy issues and training matters.

6.64 Queensland Health submits that authorisation will not provide more effective representation of rural doctors in the Queensland context. Queensland Health submits that if Queensland did choose a collective bargaining approach for independently contracted rural VMOs, while the state would be willing to engage with any and all representative bodies, it is unlikely that another body will achieve more effective representation.

6.65 The VHIA submits that currently GPs are very well represented and that all issues can be more effectively dealt with at the local level.

ACCC's views

6.66 In many cases, the ACCC has identified that individually businesses have a limited degree of input into their contracts and are offered "take it or leave it" terms and conditions which does not often produce the most efficient contract. The ACCC has

accepted that collective bargaining arrangements can provide participants with an opportunity for greater input into contracts and accordingly deliver the opportunity for more efficient contracts.

6.67 In this regard, the ACCC notes that where state/territory health departments set the terms of the VMO contracts, it is not uncommon for the department to consult with organisations that represent doctors. To some extent, representation of GP VMOs through consultation may not differ significantly from representation of GP VMOs through negotiations. However, the ACCC acknowledges that the proposed collective bargaining arrangement will include negotiation and agreement on price, while current processes limit the AMA to a consultative role for fear of raising trade practices concerns.

6.68 The ACCC also notes that if authorisation is granted doctors may join either the RDAA or the AMA in order to obtain the benefits of collective negotiations.

6.69 In response to interested party concerns that the AMA will unreasonably increase the price of medical services, the AMA submits that state/territory health departments will only enter into collective bargaining arrangements for rural GP VMO contracts if they believe that this process will improve rural health services. The AMA submits its ability to lift the price of medical services in the collective bargaining process is significantly curtailed by this reality. The ACCC considers collective negotiations will only be carried out where it is mutually beneficial, given the absence of collective boycott activity.

6.70 The ACCC also notes that the AMA proposes to introduce flexibility into its arrangements to allow for local circumstances to be considered by individual doctors. The ACCC considers that the introduction of flexibility will provide better results for doctors and the public hospital or health facility to ensure that the terms and conditions are adaptable to its circumstances.

6.71 The ACCC notes that authorisation removes the legal risk for the AMA to engage in direct negotiations with the state/territory health department, rather than being limited to a consultation role, in instances where state/territory health departments agree to carry out collective negotiations. To the extent that more effective representation of rural doctors in dealings with state and territory health departments occurs, there will be public benefit.

Transaction cost savings

AMA submission

6.72 The AMA submits that the proposed collective bargaining arrangements will streamline the process for contracting rural GPs as VMOs, reduce 'red tape' and transaction times and costs, and remove the burden of negotiation from individual doctors.

6.73 The AMA notes there are significant costs for each individual doctor associated with entering into a VMO contract, even though doctors have very limited scope to alter the terms of the contract. These costs include obtaining professional advice and information.

Interested party views

6.74 The VHA submits that while the notion of a collective arrangement intuitively supports the contention of removing 'red tape', this would appear to be a business benefit as opposed to a public benefit.

6.75 The VHIA does not consider that collective negotiations would result in transaction cost savings and considers that the costs currently imposed are merely the cost of doing business.

6.76 Queensland Health notes that the transaction costs referred to by the AMA are not incurred in the current Queensland process, therefore the savings will not be realised in Queensland.

6.77 The Department of Health WA submits that transaction costs will increase for the department if authorisation is granted as it will result in the expectation that the department will carry out negotiations with the RDAA, the AMA and those doctors who are not members of either association. This will result in an outcome of three separate sets of arrangements for the engagement of rural doctors which will be difficult to manage, as well as time consuming and costly.

ACCC's views

6.78 The ACCC generally considers that transaction costs may be lower in implementing a collective bargaining agreement for a single negotiating process, as opposed to the situation where the target must negotiate and implement many agreements. The ACCC considers that to the extent that these transaction cost savings do arise they are likely to constitute a public benefit.

6.79 The ACCC recognises that, outside of Victoria, individual doctors generally have limited scope to alter the terms of a VMO contract supplied by a state/territory health department and that despite this restriction, individual doctors are still subject to costs such as obtaining professional advice. The ACCC accepts the AMA's assertion that collective negotiation of rural GPs will provide a means for consolidating these costs.

6.80 In Victoria, individual doctors negotiate with public hospitals and health facilities in rural and remote areas about the supply of GP VMO services. The ACCC would expect that any transaction cost savings generated by the proposed collective bargaining arrangements would be greater in this environment. The extent to which any transaction cost savings are realised in Victoria depends on whether the Department of Human Services, or an agent appointed by the department (such as the VHIA in Victoria or in WA the WACHS) decides to engage in collective negotiations.

6.81 In this context, the ACCC notes that granting authorisation in no way imposes an obligation on the Victorian government to negotiate with the AMA.

6.82 The ACCC notes that the Department of Health WA submits that authorisation may result in the expectation that it will be engage in three different sets of negotiations and arrangements for the appointment of VMOs which will increase their costs. The ACCC notes the AMA's submission that the AMA and RDAA have a history of cooperation and sees this cooperation continuing.

6.83 The ACCC accepts that there is a possibility that the RDAA and the AMA may both seek to negotiate with state/territory health departments. The ACCC considers that, to the extent in which the state/territory health department decide to engage in collective negotiations with these collective bodies, transaction cost savings will still result relative to the counterfactual in which individual doctors throughout the state seek to negotiate the terms of their contracts.

6.84 The ACCC considers that any transaction savings that may result from the proposed collective negotiations would be small.

Positive influence on the retention of rural GP VMOs

AMA submission

6.85 The AMA submits that reducing the administrative burden on individual doctors through collective negotiation, may result in an increase in the number of GPs providing services as VMO in rural and remote areas and therefore assist in retaining current levels of GPs providing these services.

6.86 The AMA submits that some doctors may find the current process too overwhelming and time consuming, and not have their needs adequately recognised, which may result in GPs withdrawing their services as rural VMOs. The AMA submits that collective negotiations will minimise this risk.

Interested party submissions

6.87 The Department of Health WA notes that in WA, issues associated with the attraction and retention of doctors vary significantly from region to region and notes that the way to address this issue is to provide doctors with greater flexibility to ensure their needs are met.

6.88 The Department of Health WA also submits that GPs are not evenly distributed across locations where there is a need to secure medical services for public hospitals. The Department of Health WA is concerned that by imposing a standard contract and remuneration package on a state wide basis there is a risk of escalating prices in locations where GPs are more readily available without providing any incentive to take up practice in those locations where recruitment is difficult.

6.89 The Department of Health WA also notes that the current process in WA has not proven to be a barrier to recruitment of GPs in rural WA, with the number of doctors working in rural WA increasing steadily over the past five years.

6.90 Queensland Health does not expect collective negotiations to have a positive effect on retention of rural GPs in VMO service and notes that the state determines a contract package to achieve its purpose in recruitment and retention.

6.91 The VHIA and the VHA note that it does not have any evidence which supports the assertion that collective negotiations will result in a positive influence on retention and submit that collective negotiations will remove the partnership currently shared by GPs and hospitals under the current system.

ACCC's views

6.92 The ACCC notes the shortage of medical practitioners and services in rural and remote areas of Australia and considers that a collective arrangement may make the process of VMO engagement easier for some doctors. To the extent that this occurs, there may be some positive influence on the retention of rural GPs.

6.93 The ACCC notes that the AMA's proposed collective arrangements promote flexibility in the terms of the negotiated contract in order to meet particular local circumstances and the particular needs of individual doctors. The ACCC considers this degree of flexibility, in conjunction with collective negotiation of remuneration and other terms of VMO engagement, may make engagement in rural areas more attractive and accessible.

ACCC conclusion on public benefits

6.94 The ACCC considers that the proposed collective bargaining arrangements may, to some extent, enhance the effective representation of rural doctors in dealings with state and territory health departments. Authorisation will remove the legal risk associated with the AMA negotiating with state/territory health departments on behalf of its members in circumstances where state/territory health departments agree to the collective bargaining process.

6.95 The ACCC notes that in states/territories which do not decide to engage in collective negotiations, the public benefits will be limited.

Balance of public benefit and detriment

6.96 The ACCC may only grant authorisation if it is satisfied that, in all the circumstances, the proposed collective bargaining arrangements are likely to result in a public benefit that will outweigh any public detriment.

6.97 In the context of applying the net public benefit test at section 90(8)[27] of the Act, the Tribunal commented that:

> ... something more than a negligible benefit is required before the power to grant authorisation can be exercised.[28]

6.98 The ACCC considers that to the extent to which the state/territory health departments decide to engage in collective negotiations, some public benefit will result in some transaction cost savings and effective representation of GPs in negotiations.

6.99 The ACCC notes that the AMA will be in a strong bargaining position based upon its resources and experience and will provide GP VMOs with more collective bargaining power relative to individual negotiations. The ACCC notes that the AMA will be restricted to negotiations only on behalf of its members who are rural GPs providing

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[27] The test at 90(8) of the Act is in essence that conduct is likely to result in such a benefit to the public that it should be allowed to take place.

[28] Re Application by Michael Jools, President of the NSW Taxi Drivers Association [2006] ACompT 5 at paragraph 22.

services as VMOs, in a particular state. The AMA is also restricted to negotiating with the state/territory health department or its agent and not individual hospitals.

6.100 The ACCC considers the voluntary nature of collective negotiations will limit any public detriment which may result from the proposed arrangements. The ACCC notes that authorisation will not compel state/territory health departments to engage in collective negotiations and should they decide to, they will have the ability to opt out of negotiations at any time. In this regard, the ACCC considers that state/territory health departments and the AMA would only enter into an agreement if it is mutually beneficial to both state/territory health departments and AMA members. The ACCC notes that state/territory health departments remain free to continue with their existing arrangements for GP VMOs contracts.

6.101 Authorisation will remove the legal risk to the AMA to engage in negotiations on behalf of their members, rather than playing a solely consultative role.

6.102 On balance, the ACCC considers the small public benefit is likely to outweigh the limited public detriment.

Length of authorisation

6.103 The ACCC generally considers it appropriate to grant authorisation for a limited period of time, so as to allow an authorisation to be reviewed in the light of any changed circumstances.

6.104 In this instance, the AMA seeks authorisation for a period of five years.

6.105 When granting authorisation to a collective bargaining arrangement, the ACCC endeavours to allow sufficient time for an arrangement to be negotiated and implemented. In these circumstances, the ACCC proposes to grant authorisation for a period of five years.

7. Draft determination

The application

7.1 On 19 August 2008 the Australian Medical Association Limited and its constituent state/territory Australian Medical Association organisations (except New South Wales) (the AMA) lodged application for authorisation A91100 with the Australian Competition and Consumer Commission (the ACCC).

7.2 Application A91100 was made using Form B Schedule 1, of the Trade Practices Regulations 1974. The application was made under subsection 88 (1) of the Act to make and give effect to a contract or arrangement, or arrive at an understanding, a provision of which would have the purpose, or would have or might have the effect, or substantially lessening competition within the meaning of section 45 of the Act.

7.3 In particular, the AMA seeks authorisation to collectively negotiate with relevant state/territory health departments, the terms of contracts for rural general practitioners (rural GPs) providing services as Visiting Medical Officers (VMOs) in public hospitals and health facilities in rural and remote areas of Australia (except New South Wales).

The net public benefit test

7.4 For the reasons outlined in Chapter 6 of this draft determination, the ACCC considers that in all the circumstances the arrangements for which authorisation is sought are likely to result in a public benefit that would outweigh the detriment to the public constituted by any lessening of competition arising from the arrangements.

7.5 The ACCC therefore **proposes to grant** authorisation to application A91100 for a period of five years.

Conduct for which the ACCC proposes to grant authorisation

7.6 The ACCC proposes to grant authorisation to the AMA and its constituent state/territory associations to collectively negotiate with state and territory health departments the terms of contracts for VMOs in rural areas and remote areas of Australia. Authorisation is proposed to be granted for a period of five years.

7.7 The ACCC notes that the proposed authorisation extends to negotiations between the AMA and any health department representative, or agent, of all the rural hospitals in a state or territory with respect to a state-wide arrangements for GP VMO contracts.

7.8 This draft determination is made on 12 November 2008.

Conduct not proposed to be authorised

7.9 The proposed authorisation does not extend to any collective decision by current or future AMA members to engage in collective boycott activities. Authorisation does not extend to the AMA negotiating on behalf of other medical specialists. Authorisation also does not extend to negotiations involving individual hospitals or any group of hospitals.

Further submissions

7.10 The ACCC will now seek further submissions from interested parties. In addition, the applicant or any interested party may request that the ACCC hold a conference to discuss the draft determination, pursuant to section 90A of the Act.